How One County Jail Changed the ‘Grievances’ Paradigm

Hip Replacement and a Death Row Inmate
SMART: A Simple Skin Assessment Technique for Nurses
D-Day With a Correctional EMR
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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 New VP of Operations

The National Commission is pleased to announce an addition to its staff. Brent Gibson, MD, MPH, FACP, will join the NCCHC team as vice president of operations. He will provide senior leadership to all areas of NCCHC activities and will have a special emphasis on policy and programs, including the Correctional Health Outcomes and Resource Data Set.

Dr. Gibson has extensive experience serving in a variety of government and private-sector positions, including several key military administrative and clinical leadership roles. He comes to us from the Federal Bureau of Prisons, where he served as clinical director of the Medical Center for Federal Prisoners in Springfield, MO. Prior to that he was vice president of medical affairs at Atlas Research, LLC, Washington, DC, a management-consulting firm with an emphasis on health services research, policy and planning. A veteran of the U.S. Army, he is adept at managing complex, high-risk environments. He has also been active in teaching and research in preventive medicine, public health and health systems administration. He is an active speaker and writer, with more than 67 presentations, moderated events, posters and publications to his credit. Not surprisingly, he is the recipient of numerous honors and awards.

Dr. Gibson received his medical degree from the Medical College of Georgia, Augusta, and his MPH, with a focus on health services administration, from the Uniformed Services University of the Health Sciences, Bethesda, MD. He is board certified in occupational medicine from the American Board of Preventive Medicine and is a fellow of the American College of Preventive Medicine.

His first day on the job will be Oct. 19 at the National Conference on Correctional Health Care. Please join us in giving him a warm welcome!

Celebrate National Correctional Health Professional Week!

Correctional health professionals provide health care in some of the most challenging environments across the country, including adult jails and prisons, juvenile detention centers and a variety of alternative correctional environments. In recognition of their contributions, the Academy of Correctional Health Professionals proclaims October 21-27 as National Correctional Health Professional Week. During this week, NCCHC and the Academy invite you to celebrate the ongoing efforts and achievements of correctional health professionals across the United States. If you will be attending the National Conference on Correctional Health Care (Oct. 20-24 in Las Vegas), we encourage you to help us celebrate by participating in the special activities taking place during the meeting.

Calendar of events

October 20-24 National Conference on Correctional Health Care, Las Vegas
October 21 CCHP exam, Las Vegas
November 20 Accreditation committee meeting
February 23 CCHP exam, regional sites
April 20-23 NCCHC Spring Conference, Denver
April 21 CCHP exam, Denver
July 19-20 Correctional Health Care Leadership Institute, Las Vegas
July 21-22 Correctional Mental Health Conference, Las Vegas

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

In Other News...

Correctional Health Outcomes and Resource Data Set

As reported in the last issue of CorrectCare, CHORDS—NCCHC’s performance measurement system for correctional settings—completed its first test, collecting data on nine diabetes-related measures from 66 participants. The project is now moving into phase 2, developing new measures for other health conditions and then collecting data. The resulting aggregate reports will enable participants to benchmark performance and implement targeted quality improvement efforts. For more information, contact CHORDS project coordinator Mackenzie Bisset, MSHP, CCHP, at chords@ncchc.org. Bisset will also present a session on CHORDS at the annual meeting of the American Public Health Association on Tuesday, Oct. 30, in San Francisco.

NCCHC Resources Now on PsycEXTRA

A wide variety of NCCHC works are now archived on PsycEXTRA. This American Psychological Association research database houses the “gray literature” of the behavioral and social sciences, including materials such as conference abstracts and presentations, policy briefs, technical reports, guidelines, fact sheets, newsletters and more. The database delivers a bibliographic record and full-text PDFs of material. To access the fee-based site, visit www.apa.org/pubs/databases/psycextra.
First, Free the Data: Improving Health Care Performance in Jails and Prisons

by Robert Joy, MBA

Why is it so hard to improve performance in correctional health care systems? Because sometimes it seems like nobody cares about performance. Your executive team is distracted with budget, media and legal priorities. Staff are just hoping to make it through their shift without the computers going down (if they have them). And Joe Public thinks inmates don’t even deserve access to the health care you’re providing.

But you care. And because you care, you can make a big difference. So how?

The one essential ingredient for a successful health care performance management system is people who care. Improving performance requires people like you who are dedicated to providing quality care.

It also requires people who understand what “quality” really means on the yard. Articulating and prioritizing your objectives are prerequisites to performance improvement. For example, you may decide that some of the most important aspects of quality health care are:

- Providing timely access to appropriate services
- Following evidence-based clinical guidelines
- Adhering to nationally accepted practice standards
- Making sure patients with chronic diseases get help managing their conditions
- Avoiding preventable trips to hospital

These or other priorities may comprise the key health care performance objectives in your prison or jail.

Getting Started

Now that we’ve established (a) that you care and (b) the objectives you’re trying to achieve, what’s the first thing you need to do?

First, free the data. Find all that data lying around in pharmacy orders, lab results, hospital claims, scheduling logs, budget reports and offender management systems. Pull it off the clipboards, contractor emails, databases, computer files and online portals. You’ll be surprised how much of it you can use for your performance measures.

Second, define the high priority quality measures that map to your objectives, and determine their data requirements. If you’re not sure where to start, there are plenty of standardized health care performance measures out there. Match the data you found to the measures you’ve defined, and fill in the gaps with a little chart review if you have to.

If you look hard enough, you’ll even find metrics used by correctional health programs. NCCHC’s Correctional Health Outcomes and Resource Data Set initiative and the California Correctional Health Care Services dashboard are two such resources with correctionally minded metrics.

For example, CHORDS includes short-stay diabetes quality measures that are more appropriate for jails than the Healthcare Effectiveness Data and Information Set diabetes measures, many denominators for which require at least one full year of continuous enrollment. At CCHCS, because prevalence of hepatitis C is high in the correctional population, end-stage liver disease was added to the Agency for Healthcare Research and Quality list of ambulatory care sensitive conditions for which hospitalizations are potentially avoidable.

Third, set some targets. You may come up with internal targets, or maybe you can find some relevant external benchmarks (for example, AHRQ or HEDIS). You might even compare your clinic’s or facility’s performance to others within your organization.

Fourth, run the numbers and take action. See which areas require immediate attention based on how the results stack up against your targets. Now that you know which areas need improvement, pull together a team (or divert an existing workgroup) to figure out how to bring performance closer to expectations.

Sowing the Seeds for CQI

It may take a while to solve the problem, or even to find out what’s causing the problem in the first place. But at least you’ve defined what’s important, decided how to measure it, set some targets and pulled together the data to help you direct your energy to what matters most. You may not realize it, but by freeing the data, you’ve also sown the seeds for a cycle of continuous quality improvement.

And, most importantly, you cared enough to make a difference.

Robert Joy, MBA, is a senior manager at Hubbert Systems Consulting, Gold River, CA, which helps federal, state and local government clients, including jails and prisons, improve performance in delivering health and human services. He has more than 20 years of experience in health care performance management, informatics and quality improvement.

To learn more about performance improvement in correctional health care, attend the CHORDS session at the National Conference on Correctional Health Care, Oct. 20-24 in Las Vegas. For more information, visit http://ncchcnationalconference.org.
CONTINUING EDUCATION

The National Conference offers the opportunity for nurses, physicians, social workers and CCHPs to earn up to 32 continuing education credits. (The maximum number of hours includes participation in preconference seminars.) See the Final Program for details.

FIVE GREAT REASONS TO ATTEND

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2. Real-life examples and best practices
3. Actionable how-to's to proactively implement at your facility
4. Plenty of networking opportunities
5. Continuing education credit to propel your professional development

Your full registration for the National Conference includes the following:

• Admission to all educational sessions (Monday – Wednesday)
• Nearly 100 concurrent sessions
• Opening ceremony and keynote address
• Educational luncheons
• Roundtable discussions
• Exhibit hall receptions (Sunday and Monday evenings)
• Access to poster displays (Sunday – Tuesday)
• Exhibit hall lunch (Monday)
• Refreshments at exhibit hall breaks (Monday – Tuesday)
• Daily coffee and tea networking breaks
• Final program and session abstracts
• Conference proceedings on flash drive
• Continuing education credit
• Access to the NCCHC bookstore

WHO SHOULD ATTEND

Whether you’re a seasoned leader or a newcomer to corrections, you are sure to find valuable guidance at the National Conference. With sessions geared toward basic, intermediate and advanced levels of experience and knowledge, this conference will deliver an unparalleled array of opportunities to learn and grow.

• Administrators
• Custody staff
• Health educators
• Pharmacists
• Psychologists
• Physician assistants
• Public health officials
• Counselors
• Dentists
• Nurses
• Psychiatrists
• Physicians
• Other correctional health professionals

SESSION TOPICS

Sessions are organized in tracks to indicate the breadth of topics and to help in your planning. Attend sessions in any track and move between tracks as often as you like. Below is a sampling of topics:

• Evidence-Based Nursing Practice
• Trends and Patterns of Jail Inmate Suicide
• Training Staff in Emergency Readiness and Response
• Protease Inhibitors for Treatment of HCV Genotype 1
• Creating a Patient Safety Culture
• Providing Treatment to Transgender Patients: Optimization of Care
• Preparing Inmates With Traumatic Brain Injuries for Reentry
• The Impact of Medication Shortages on Health Care Delivery
• Reviving the Art of the Physical Exam
• Ethics: How to Avoid the Land Mines

CONTINUING EDUCATION

The National Conference offers the opportunity for nurses, physicians, social workers and CCHPs to earn up to 32 continuing education credits. (The maximum number of hours includes participation in preconference seminars.) See the Final Program for details.

OPENING SESSION AND KEYNOTE ADDRESS

The opening ceremony on Monday morning will feature the most prestigious awards in correctional health care along with addresses by leading figures in our field. The keynote speaker is Thomas Grisso, PhD, a clinical and forensic psychologist who is professor of psychiatry, director of psychology and director of the law and psychiatry program at the University of Massachusetts Medical School, Worcester. For the past 30 years he has engaged in research and consultation to improve laws and policies applied to child and adult offenders, and to enhance the quality of forensic and mental health services in criminal, juvenile and civil justice systems. He seeks to blend research and practice so that each informs the other.
DON’T MISS THIS OPPORTUNITY to attend the premier education forum in correctional health care. Experts will discuss research and best practices on all aspects of correctional health care. In this continuously changing field there is no better way to stay abreast of the new and emerging issues. Choose from more than 100 sessions to create a curriculum tailored to your needs, and take advantage of opportunities to advance your knowledge, network with colleagues and even have a little fun.

Since 1977, this has been the must-attend event of the year for professionals seeking to expand their knowledge and professional network. The high-intensity environment is packed with lectures, panels, workshops, posters, exhibits and networking, giving you an unparalleled opportunity to recharge and return to the workplace ready to implement meaningful change.

CONFERENCE LEARNING OBJECTIVES

- Demonstrate understanding of correctional health care issues, including quality of care, access to care, financial management and workforce development
- Identify major health care, research and policy issues facing incarcerated individuals, including infectious diseases, mental illness, substance abuse and special needs (e.g., women’s issues, juvenile health, geriatrics, disability)
- Demonstrate increased understanding of skills necessary to better manage common medical, dental and psychological problems found in correctional settings
- Describe legal, ethical and administrative issues and develop solutions for the correctional setting

DON'T LET YOUR LEARNING END WHEN THE NATIONAL CONFERENCE ENDS!

Stay on top of your game year-round with essential training and education provided by the NCCHC Live Learning Center. The Live Learning Center connects you to recorded sessions from the 2012 National Conference as well as other NCCHC events. Select the Session Recordings Package when you register for the meeting to enjoy postconference access to all of your favorite presentations for only $79! Don’t delay—this price is only available before the conference.

PRECONFERENCE SEMINARS

Reinforce the foundations of your knowledge by attending the preconference seminars on Saturday and Sunday. Presented by highly respected and knowledgeable leaders, the seminars provide in-depth training on the fundamentals of delivering quality health care services in correctional settings. Registration for the conference is not required to participate in the seminars. Preconference seminars require additional registration, separate from main conference registration. Can’t decide which seminar to attend? Consider bringing a team. With each seminar priced at less than $200, it’s well worth the investment to cover all the bases.

Seminar fees are $185 for full-day sessions (7 hours of CE credit) and $99 for half-day sessions (3.5 hours of CE credit). Fees include all course materials and refreshment breaks.

**Saturday, October 20**
9 am - 5 pm
- An In-Depth Look at NCCHC’s Standards for Health Services in Jails
- An In-Depth Look at NCCHC’s Standards for Health Services in Prisons
- An In-Depth Look at NCCHC’s New Standards for Health Services in Juvenile Detention and Confinement Facilities
- An In-Depth Look at NCCHC’s Standards for Mental Health Services in Correctional Facilities

**Sunday, October 21**
9 am - 12:30 pm
- Practical Preparation for Initial NCCHC Accreditation
- Using CQI to Manage Processes and Improve Patient Outcomes – The Process Study

1:30 pm - 5 pm
- Using CQI to Manage Processes and Improve Patient Outcomes – The Outcome Study
- The Prison Rape Elimination Act: Understanding the Law and Complying With the Regulations

HOTEL INFORMATION

The conference headquarters is the Rio All-Suite Hotel, where every suite offers more than 600 sq. ft. of spacious luxury. Rooms are assigned on a first-come, first-served basis, so reserve early to ensure accommodations.

Rio All-Suite Hotel, 3700 W. Flamingo Rd., Las Vegas, NV 89103

2 WAYS TO BOOK:
- Visit http://ncchcnationalconference.org/hotel and click to the reservations website
- Call 888-746-6955; group code SRNCC12

REGISTRATION INFORMATION

Visit http://ncchcnationalconference.org to register online or to download a form, or call NCCHC at 773-880-1460 for other options.

- Regular: $465
- Academy Member: $390 (you may join when you register for the conference)
- One Day: $205 (entitles you to participate in all events that day)
- Guest Registration: $60 (exhibit hall only)
Massachusetts DOC Must Provide Sex Change Surgery
A U.S. district judge has ordered Massachusetts prison officials to provide sex-reassignment surgery to a transgender inmate serving a life sentence. Judge Mark Wolf wrote that "there is no less intrusive means to correct the prolonged violation" of the inmate's right to adequate medical care. The inmate, born male, has gender identity disorder and received hormone treatments in the community, living as a woman. After being incarcerated in 1992, she asked for treatment but for 10 years was denied, according to her attorney. The inmate filed suit in 1999, and in 2002 Wolf ruled that she was entitled to treatment, which took the form of psychotherapy and hormone treatments. In the latest ruling, Wolf noted that the DOC's medical experts testified that they believe sex-reassignment surgery was the only adequate treatment. The DOC's objections centered on security risks. Media reports cited cost estimates ranging from $20,000 to $80,000 for such a surgery. At this writing, the state had not yet decided whether to appeal the ruling.

NCCHC's position statement on transgender health care in correctional settings says that the management of medical and surgical issues should follow accepted standards developed by experts in transgender health. Determination of needed treatment should be on a case-by-case basis, and there should be no blanket policies that restrict specific medical treatments, including sex-reassignment surgery.
- www.cbsnews.com/8301-201_162-57505707/mass-judge-oks-sex-change-for-inmate
- ncchc.org/resources/statements/transgender.html

FDA Approves Once-Daily HIV Pill
The Food and Drug Administration has approved Stribild, a once-a-day combination pill to treat HIV-1 infection in treatment-naive patients. Made by Gilead Pharmaceuticals, Stribild contains the two drugs that make up Truvada plus two new drugs, elvitegravir and cobicistat, providing a complete treatment regimen. In two double-blind clinical trials with 1,408 treatment-naive patients, Stribild was found to perform as well or better than two other treatment combinations and lowered HIV levels to undetectable levels in 88% to 90% of patients after 48 weeks. The FDA cautions that the drug can cause a build up of lactic acid in the blood and severe liver problems.
- www.fda.gov/NewsEvents/PressAnnouncements/ucm317004.htm

CDC Updates Gonorrhea Treatment Guidelines
The Centers for Disease Control and Prevention no longer recommends cefixime as a first-line treatment option for gonorrhea because of data suggesting antibiotic resistance. Now, the CDC says that the most effective treatment is a combination therapy: the injectable antibiotic ceftriaxone (the only remaining effective drug) along with one of two other oral antibiotics, either azithromycin or doxycycline.
- www.cdc.gov/mmwr/pdf/rr/rr5807.pdf

ACA Coverage Expansion and County Jails
In 2014, the Affordable Care Act will expand health insurance coverage options for millions of people. A National Association of Counties issue brief examines how this may affect county jails, with a focus on enrolling predjudicated detainees and inmates preparing to reenter the community. The brief, County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage, is a free download.
- http://nicic.gov/Library/026253

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A ‘Mere Disagreement’: Hip Replacement and a Death Row Inmate

by Fred Cohen, LL.M.

John Snow is a 69-year-old death row inmate confined at Nevada’s Ely State Prison. Snow brought a Section 1983 lawsuit for damages and declaratory judgment relief. There is no debate about the crippling of the osteoarthritis condition in both of Snow’s hips. Snow can barely walk and is in constant and severe pain.

Medical specialists have strongly urged that he have bilateral hip replacement, but Nevada officials repeatedly delayed or denied the operation, choosing to rely on a variety of pain medications, including opiates. In Snow v. McDaniel, 2012, the court reviewed a grant of summary judgment for the defendants and reversed, finding that a number of factual issues could be resolved by a jury in the plaintiff’s favor and result in a finding of deliberate indifference.

A Closer Look

We can put aside any questions of the seriousness and authenticity of Snow’s debilitating medical condition. Further, the condition severely limits one’s basic life activities: sleeping, moving, turning. The use of drug treatment here has caused a significant increase in Snow’s creatinine levels, which may cause a life-threatening situation.

As for the “mere disagreement” regarding treatment, this is not a case where the dilemma is one medication versus another. This is a qualitative difference; the difference between surgery (and a confident prediction of success by the specialists) and pain medication (at best, a management intervention).

Mr. Snow’s status as a death row inmate is the obvious elephant in the room. His age, shall we say, is the calf in the room. Indeed, there is testimony from a former nurse that the warden said, “if one of these [death row] inmates gets deathly ill, don’t knock yourself out to save their life. There’s plenty more to take their place.” Apparently, the warden is a follower of Ghandi and Albert Schweitzer.

Deliberate Indifference

The record here is replete with medical appointments, diagnostic procedures, medication for pain and even security exceptions (e.g., not required to have leg shackles) for Mr. Snow. The one thing the record does not show is the recommended hip replacement. Thus, if one simply does a numerical contact-type survey, one might conclude there is negligence (i.e., malpractice) but not the kind of recklessness required by deliberate indifference.

And, one would be wrong. It’s as though a type 1 diabetic prisoner’s medical file was replete with medical interventions except the provision of insulin. As difficult as it is to establish deliberate indifference, a prisoner need not show the complete denial of medical care. The court states, Here, Snow may prove deliberate indifference by showing that prison administrators or physicians denied, delayed, or intentionally interfered with surgery for his hip condition, or that the way prison staff delivered medical care indicated deliberate indifference.

The utilization review panel repeatedly denied the surgery recommended by specialists and Snow’s treating physician. The URPs approves joint replacement surgery when the condition significantly interferes with the person’s ability to function in prison. The URPs gave no medical reason for the denials or, indeed, any reason at all.

May I speculate? Could it just be the death sentence and Snow’s age? Possibly. In any event, the case goes back for trial or — hip replacement?

Comment

In addition to Snow’s age and sentence, the URPs’ denials are also likely based on the fact that degenerative hips are not life-threatening. The condition may even be characterized as a lifestyle interference. That is, one is no longer ambulatory or able to sleep well but one does not die from osteo of the hip (or knee or shoulder).

However, the pain of bone-on-bone weight support and movement becomes excruciating and while life does not cease to exist, life worth living may.

Thurman Arnold in his book “The Symbols of Government” (1935) wrote about the heroic and expensive efforts to physically revive a death row inmate who slit his wrists and then the psychological efforts to restore his mental health followed by his execution. Each individual step is described as rational but the final step, the execution, is irrational. With Mr. Snow, his crime and sentence cannot be the desideratum by which to decide on his needed medical care. Age? Perhaps.

However, suppose his execution was scheduled for a week after court-ordered surgery? Suppose he also developed pancreatic cancer and was estimated to have perhaps three months to live after the hip replacement?

And we will leave it at that.

Fred Cohen, LL.M., is the editor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2012 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

Stronger Together

At Corizon, we work tirelessly to be the best provider of correctional healthcare. When our strength and dedication is paired with yours, we both find purpose. By working together, our collective vision becomes a reality. Innovations become customized solutions. Efforts become results.

We provide care and service—to our clients, our patients and our communities. By working with us, you make it happen. And we’re both stronger together.
Grievances are costly to your organization and time consuming for staff. Changing your paradigm surrounding patient grievances can reduce costs and improve patient satisfaction. Maricopa County Correctional Health Services undertook the task of improving its grievance process and has successfully decreased the overall number of grievances, reduced costs, improved patient satisfaction and empowered staff. This article outlines key elements in how we changed the paradigm at CHS.

**Staff Attitudes and Empowerment**

The first step in changing the paradigm surrounding grievances is to explore staff attitudes regarding inmate-patients and patient complaints. Staff attitudes affect not only the manner in which staff interact with inmate-patients, but also will ultimately affect the way they view patient complaints.

Common staff attitudes include the feeling that patients get what they deserve—the “if you can’t do the time, don’t do the crime” attitude. Some staff view patients as chronic complainers or whiners. Others simply view inmate-patients as litigious. These attitudes invariably alter the manner in which staff interact with patients and respond to patient complaints.

Changing the way one views inmate-patients and patient complaints is an important step in changing the paradigm surrounding grievances. It is human nature to become defensive when our work or personal character is criticized. One of the first paradigm shifts regarding patient grievances is to view patient complaints as an opportunity to improve. This simple philosophy is a key tenet of good customer service and will allow your staff to view grievances in a different light.

Another key component of this paradigm shift is the belief that patients have valid concerns and that they want to resolve their issues. By shifting to this belief rather than the belief that patients complain for the sake of complaining or as a means to sue you, staff will be empowered to resolve grievances at the lowest level and ultimately improve their encounters with patients.

For staff to be empowered they must know the expectations and be held accountable to those expectations. CHS conducts ongoing training and education that is critical to providing staff with the tools to function autonomously. Development of practice guidelines and nursing protocols provides a solid foundation for staff.

**New Guidelines and Protocols**

Maricopa County Correctional Health Services made several changes to its practice guidelines and protocols that
addressed common patient complaints and grievances. Standardizing practice guidelines and protocols allows staff to function autonomously and consistently.

Medical Co-Pay
The first change involved the manner in which co-pays were charged for medications. Prior to July 2011, individual providers designated whether the patient was to be charged for a medication on a patient care encounter form. This practice led to frequent complaints from patients due to the variation among providers and between facilities.

In July 2011, a list of common over-the-counter medications and some common pain relievers was developed. The CHS contracted pharmacy provides a list of patients who received a medication on this list. Charges are based on this information.

Patients are notified of the co-pay process in a variety of ways. The co-pay process is discussed in the Rules and Regulations for Inmates, a handbook given to all individuals upon arrival in their housing unit. Patients also sign an authorization for health care that states they may be charged for medications, and the health needs request form contains language that informs the patient they may be charged for their visit. A list of the medications that are charged automatically is also posted in the clinics and housing areas.

Diet Requests
Another change to our processes involved diets. Patients would frequently submit requests and grievances alleging an allergy to specific food items and requesting a diet free of that item. A patient education sheet was developed that explains that if the patient has a true food allergy, he or she can request to have blood drawn to test for that allergy. The patient is informed that if the test is positive, a medical diet will be ordered for a diet free of that specific food item. If the test is negative, patients are informed that they may have to pay for the cost of the test, and no diet change will be ordered. Additionally, medical staff now issues Lactaid tablets to anyone who reports being lactose intolerant rather than ordering a lactose-free diet. These actions have significantly reduced the number of grievances regarding diet requests.

Complex Case Management
In addition to the changes to practice guidelines and protocols, CHS implemented a pilot program to manage patients with complex health needs. These may be patients who have pain management issues or who are high utilizers of health care resources. Providers make recommendations to a committee for inclusion in complex case management. Once accepted, the patient meets with the medical director or designee and together they develop a plan of care. Urgent needs are met by the clinic providers as needed, but routine matters are addressed at scheduled complex case management appointments.

External Appeals
Another key strategy in changing the grievance process was the development of criteria for third level external grievance appeals to be dismissed without requiring them to be sent to an external referee for disposition. For example, criteria were developed to dismiss grievances that are duplicative of previous grievances. Another criterion addresses reasons to dismiss a grievance appeal as not grievable, based on medical necessity and medical judgments.

Positive Outcomes
Since implementation of training and education and the changes to practice and protocols, CHS has reduced the total number of medical grievances submitted by patients from a high of 5,421 and 4.8% of the average daily population in 2005 to 1,893 and just 2.1% of the ADP in 2011.

In addition, the revision of criteria for external grievance appeals has enabled CHS to reduce the total percentage of such appeals being sent to the external referee from approximately 90% in 2005-2008 to about 35% in 2009 (the year of implementation) and 2010. In 2011, the rate declined to just 12%. This reduction in external referee review produced an estimated cost savings of more than $23,000 over the past four years.

One of the most rewarding strategies CHS implemented is a patient satisfaction survey. The first survey was conducted in late 2010 and it was repeated in early 2012. With implementation of changes to practice guidelines and protocols as well as education and training regarding the grievance process, CHS has improved its patient satisfaction scores in every category. This information is shared at the clinic continuous quality improvement team meetings and

continued on page 12
with all staff. This provides them with positive reinforcement of the changes they have made.

Changing your organization’s paradigm surrounding patient grievances requires a review of staff attitudes that may impact perceptions of inmate-patients and patient complaints. Development of practices that alleviate variance between providers and facilities provides staff with the tools to function autonomously and empowers them to resolve grievances at the lowest level. Lastly, consideration should be given to the addition of patient satisfaction surveys, which demonstrate your organization’s commitment to quality patient care and provides staff with reinforcement for a job well done.

Jackie Griffin-Rednour, RN, BAS, CCHP, is the quality management coordinator for Maricopa County Correctional Health Services, Phoenix, AZ. To contact her, email jgriffin-rednour@mail.maricopa.gov.

The author presented on this topic at the 2012 Updates in Correctional Health Care conference in San Antonio, TX. It is available for a fee at NCCHC’s Live Learning Center as an audiorecording with PowerPoint presentation. To access it (Session 124), visit ncchcslivelearningcenter.com.

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**Patient Satisfaction Survey Results**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2010 N = 546</th>
<th>2012 N = 673</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel I receive the care and treatment I need.</td>
<td>85%</td>
<td>89%</td>
</tr>
<tr>
<td>I am able to see someone from the health staff in a timely manner when I have a medical problem.</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td>I have a chance to ask questions regarding my care and treatment.</td>
<td>91</td>
<td>93</td>
</tr>
<tr>
<td>My questions are answered in a manner I can understand.</td>
<td>89</td>
<td>93</td>
</tr>
<tr>
<td>I feel the health staff treat me with respect.</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>I feel I receive equal and fair treatment as compared to other patients.</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>I am satisfied with my overall treatment from the health staff.</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td>Overall</td>
<td>88</td>
<td>91</td>
</tr>
</tbody>
</table>

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**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, 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. 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.

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.
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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.
Skin problems are among the most common health concerns of inmate populations. How often you have read in health services requests the following statements: “I got bumps in the back,” “I have rash on my arms,” “My feet are cracked,” “I have jock itch” and “I have a spider bite”? During skin assessment, nurses often struggle to find appropriate words to describe the condition. Sometimes they resort to using unconventional and even comical terms, such as “the skin feels like a toad” or “the sole of the foot looks like a smashed eggshell.”

Often, a registered nurse will see the inmate with a skin problem first for triaging. Based on their assessment, RNs will make clinical decisions to use an approved protocol to address the skin problem or to make a referral to the primary care provider. By definition, rash is any changes in the skin color and texture. A lesion is an abnormal change in structure of an organ or part due to injury or disease, often one that is circumscribed and well-defined. Describing the skin lesion or skin rash correctly is important in identifying the cause of the problem and a key factor in communicating information clearly to the primary care provider for proper treatment. Documenting the skin problem using proper terminology and description will allow for clear understanding across health care disciplines and prevent confusion. It will also reflect the professionalism and skills of the nurse.

The SMART technique is an easy-to-remember acronym when performing skin assessment.

**OutSMART Rash! A Simple Skin Assessment Technique for Nurses**

by Richmond James Rada, MSN, RN, CCHP

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Describing the skin lesion or skin rash correctly is important in identifying the cause of the problem and a key factor in communicating information clearly to the primary care provider for proper treatment. Documenting the skin problem using proper terminology and description will allow for clear understanding across health care disciplines and prevent confusion. It will also reflect the professionalism and skills of the nurse.

The SMART technique is an easy-to-remember acronym when performing skin assessment.

**Size and Sensation**

- **Size**: When obtaining the size of the skin lesion or rash, use a standardized measurement tool for accuracy. Ask your manager or supervisor to provide disposable paper rulers or buy a small transparent, flat plastic ruler that will disinfect easily. Use millimeters for smaller lesions and centimeters for bigger lesions, and include dimension when taking the measurement (for example, 3 mm x 5 mm for length and width and note thickness if appropriate). If you have no ruler on hand, try comparing the size of the lesion to very common and universally known objects; for example, approximately the size of a penny or slightly bigger than a quarter. Do not make a comparison using objects or your body parts that are only known to you (e.g., about the size of my pinky, size of my ring, size of a shirt button).

- **Sensation**: Ask the patient to describe how the rash/lesion feels. Is it painful, tender to touch, burning, itching, tingling, decrease or loss of sensation (numb), or no changes/about the same?

**Moisture**

Document the skin moisture. Is the rash or lesion moist, wet, oily or dry? Is moisture or drainage coming out from the lesion? What is the color of the drainage? Here are some descriptive terms to use:

- **Skin moisture**: Dry, moist, oily, diaphoretic or sweaty, wet.
- **Drainage**: Pus (purulent, usually thick yellow to green), blood (sanguineous), clear (serous) or combination like serous sanguineous.

**Appearance**

Describe the color, shape and elevation of the lesion. Be clear when describing the color and use the standard color palette.

- **Color**: Red, white, blue, pink, yellow, purple, black, gray.
- **Shape**: Circular, irregular, linear; a circumscribed shape has a defined boundary—you can draw a line around it.
- **Elevation**: Flat, raised, depressed.

Common skin terminology used to describe the appearance of skin rash or lesion includes the following:

- **Macule/macular**: Flat, circumscribed area of change or alteration in skin color. You can see it and feel the elevation when you run your fingers over it. Macules usually have scaling or crusting as secondary qualities. Shape can be circular or irregular. Size is less than 1 cm.
  - **Patch**: A bigger macule, size greater than 1 cm in diameter.
- **Papule/papular**: Small, circumscribed, solid (no visible fluid), raised part of the skin (you can see and feel the elevation when you run your fingers over it). Papules usually have scaling or crusting as secondary qualities. Shape can be circular or irregular.
  - **Plaque**: Flat-topped palpable lesion. Think of papules that are grouped together tightly.
- **Pustule/pustular**: A raised lesion filled with pus. Pus is usually white, yellow or greenish yellow in color (such as with certain acne).
- **Vesicle**: A raised lesion filled with serous fluid that is less than 5 mm in size (example: chicken pox).
  - **Bulla/bullous**: This is the supersized vesicle, measuring more than 5 mm in size (example: foot blister or second-degree burn).
- **Nodule/nodular**: Solid, circumscribed elevation of the skin in which the greater part is beneath the skin surface (felt more than seen). Size is less than 2 cm. Think iceberg, You can see a portion on the surface but the greater part is beneath the sea.
  - **Tumor**: A large nodule greater than 2 cm in size.
Be SMART When Assessing Rash

<table>
<thead>
<tr>
<th></th>
<th>S</th>
<th>Size and Sensation</th>
<th>Use mm and cm to describe the size, and ask the patient to describe how it feels</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Moisture</td>
<td>Look for presence of dampness and drainage</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Appearance</td>
<td>Describe how it looks using the correct clinical terminology</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Region</td>
<td>Describe where it is located in the body using the correct anatomical position</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>Temperature, Texture and Time of Onset</td>
<td>Describe how it feels when you touch the rash, and ask when the patient first noticed it</td>
<td></td>
</tr>
</tbody>
</table>

- **Cyst:** A closed sac that contains liquid or semisolid (feels like a gel) material. When palpated, it is usually resilient (flexible or elastic).
- **Wheal:** Transient, slightly raised lesion with a pale center and pink margin (example: urticaria or hives). Usually the shape is irregular.
- **Burrow:** Visible tunnel in the skin like in scabies.
- **Ulcere:** Loss of epidermis and dermis, and can go down to subcutaneous and muscle tissues, with slow healing or no healing. Usually due to poor blood circulation.
- **Abscess:** A localized collection of pus in a cavity formed by disintegration or necrosis of tissue.
- **Excoriation:** Shallow linear abrasion caused by scratching.
- **Fissure:** Linear crack in the skin; often occurs between toes and fingers or in a skin mucosal joint, such as lips.
- **Scar:** A permanent lesion due to abnormal formation of connective tissue following injury. If the scarring shows excessive formation of connective tissue, describe it as keloid.
- **Tattoo:** Body modification made by inserting indelible ink into the dermis layer of the skin to change the pigment. Describe the image or the text of the tattoo, if possible. Example: A tattoo of an eagle with name “John Doe,” located on the left shoulder.

Of course, you can combine these descriptions, such as “red papular and postular lesion in the upper back” to describe body acne or “red papular rash with burrowing” to describe scabies lesion.

**Region**

Describe where the rash or lesion is located in the body. Common terminologies in describing body regions or areas are as follows:

- **Anterior:** Toward the front of the body.
- **Posterior:** Toward the back of the body.
- **Superior/above:** Toward the head.
- ** Inferior/below:** Toward the feet or away from the head.
- **Proximal:** Closer to the trunk or the center of the body.
- **Distal:** Away from the trunk or the center of the body.
- **Medial:** Toward the midline of the body.
- **Right:** Reference to the right side of the patient and not the observer.
- **Left:** Reference to the left side of the patient and not the observer.

In specifying the region of the body affected, also describe the distribution of the rash or lesion.

- **Generalized:** All over the body or located in various parts of the body.
- **Localized:** Confined to a certain body region or body part.

- **Bilateral:** Both body parts (where there are left and right body parts) are affected, such as hands, shoulders, thighs and feet.
- **Unilateral:** One body part (where there are left and right body parts) is affected.

Finally, describe the body part where the rash is located, such as amput, hand, feet, chest, back, neck, palm, sole, cheek, neck, etc. Here are two examples:

- “Red irregularly shaped macular rash, approximately 5x7 mm, located in the anterior of the forearm, 4 inches below the elbow.”
- “8x12 mm bullae located in the medial area of the anterior neck just below the chin.”

**Temperature, Texture and Time of Onset**

- **Temperature:** Describe the temperature of the rash and surrounding skin; for example, if it is warm to touch or producing heat, cool or no changes.
- **Texture:** Describe the texture in terms such as rough, smooth, hard, soft, scaly, crusty and grainy.
  - **Crust:** Dried serum or exudates. Example: “yellowish red crust at the middle of the lesion.”
  - **Scale:** Thickened, loose, readily detached fragment of cornified layer.
- **Time of onset:** Ask the patient when the rash or lesion appeared or was first noticed. Ask what the patient was doing prior to noticing the rash, such as yard work or work in the laundry room.

**A Final Tip**

Skin problems are very common complaints in correctional settings. Performing a skin assessment is often a challenging task for RNs, but correct assessment is important to arrive at the correct diagnosis and determine the appropriate intervention to address the problem. By using the SMART technique, RNs can easily remember the many aspects of performing a thorough skin assessment.

Finally, make sure to use appropriate skin barriers if there is visible fluid on the skin, such as pus or blood, and always wash your hands before and after patient contact.

Richmond James Rada, MSN, RN, CCHP is a nurse consultant with California Correctional Health Care Services, Sacramento. Reach him at Richmond.rada@cdcr.ca.gov.
D-Day With a Correctional EMR: Mentally Preparing for a New Model

by Joseph E. Paris, MD, PhD, CCHP-A

The doctors and nurses were trained on the new electronic medical record system, they practiced with imaginary patients, they received a printed manual and had opportunities to ask questions ... but, are they prepared for the change in paradigm? To write this article, I drew on my personal experiences with EMR and observations made on multiple EMR in facilities where I performed NCCHC accreditation surveys.

Electronic medical records are spreading to correctional facilities with increasing speed. Correctional administrators yearn for paperless, standardized, always available, legible EMR. Regardless of where a correctional doctor works, it is very likely that, unless he or she has gone through the change already, the announcement will be made that on a certain date the EMR will be in place.

Anticipating D-Day, doctors wonder whether the EMR will be faster or slower and how much additional work will be involved but generally do not grasp a fact of profound significance: The doctor’s job description will change irreversibly in the direction of making providers the originators and recorders of much more clinical data than before. The majority of doctors today have serviceable keyboarding skills. The issue, however, is not keyboarding speed but the masses of clinical data to be entered in every case. Doctors need to prepare mentally and accept the reality of clinical data entry as a new component of their duties.

Old Patients, New Records
When an inmate-patient is entered on EMR for the first time, much data entry will be needed even if the patient had an extensive paper record on file. Problem lists and chronic clinic enrollment lists will need keyboarding, often with ICDM codes. Medication lists (even if present already in the EMR) need reviewing; care plans need keyboarding; permit, passes or profiles will need to be entered and so on.

The fresh EMR start for all patients plus lack of familiarity with the new technology and the need to enter fixed clinical data for all comers are certain to initially decrease doctor productivity by 30% to 50%. A return to previous productivity rates may take from 6 to 18 months, in my experience. Doctors, nurses and administrators need to prepare for a decrease in productivity and to make plans to avoid unpleasant backlogs and patient care delays.

The character of the clinical interaction between correctional doctor and patient is bound to change in subtle (or not so subtle) ways. In most prisons and jails where I have worked, it was possible to place a paper record flat down on a desk. The doctor maintained much eye contact and made the patient feel that the doctor was paying full attention, even if the doctor jotted down key data while talking.

With a computer in the room, the dynamics change. I have never seen a computer screen flat on the desk. Instead, they are placed upright. For these, it would be ideal to locate them at a slight angle so the doctor could look at the patient and glance to the computer screen inconspicuously. This way, the doctor may check previous key clinical information and access reminders of the data to be collected during the interview. If such arrangement of the layout is not possible, the doctor would have to frequently turn away from the patient and pay attention to the computer, with detriment to the doctor–patient rapport.

Facing a similar situation, when my D-Day came recently I opted for reviewing the EMR (and old paper) before bringing the patient in. During patient interviews I do not look at the computer screen. Instead, I have prepared a paper reminder of all the data to be collected, and I glance at it as needed. When the interview is over and the patient is gone I enter the data required. I did find that this new method forced me to memorize much more data than in the past.

EMR Quirks
The doctor should be prepared for a few quirks that most EMR seem to have. Forewarned is forearmed...

- Date of onset of medical problems: Where I used to write “10 years ago” (what the had patient told me), I now have to enter an exact date in virtually all EMR. So I write “01-01-2002” for a 10-year-old problem. Close enough.

Entering the date of the visit (a common EMR default) for old problems is dishonest charting and does not help anyone.

- Reviewing scanned data: Although most EMR incorporate laboratory data electronically, the ability to do so with emergency room visits, hospital discharge summaries, specialty consultations and radiology reports is not there yet. These reports are scanned and attached to the patient’s EMR. Unless the employee doing the scanning is given precise instructions on entering full descriptive names to the scanned files, it will be very hard for the doctor to find them. Sufficient training of scanning personnel is required. It is also essential that these paper reports be shown to the doctor for reviewing and initialing before they are scanned and attached.
- Paper records have certain functionalities that I miss a lot, but they are not coming back any time soon. When I saw a repeat visit, I was so easy to look at the paper record, reentering what did not change and entering a few changed clinical facts. Very few EMR today allow the nurse to copy the previous visit, pasting it into the new visit, useful for a few clinically relevant changes.

- Seeing it all at once, such as labs, consultations, problem lists, the last visit—so easily done by shuffling paper—is beyond the capability of present day EMR. There is just not enough room in today's computer screens.

- Entering physical exams: In my experience, this is the area where most doctors will have the most laborious learning curve. Depending on the EMR and its customization by whomever is in charge at a given jail/prison/system, physical exam templates for intake, annual physicals, initial or repeat chronic care visits and the like will vary between large ... and massive. Most EMR require 15 to 50 body areas to be charted. They also usually offer a “one click for normal” option for each area. Doctors frequently opt for the one click, thus generating entries such as:

  “Examination of the head, eyes, ears, nose and throat: Normocephalic, atraumatic, pupils equal, react normally to accommodation and light reflex, extraocular movements full, no nystagmus, tympanic membranes and hearing intact, tongue midline, normal dentition, intraoral cavity clear.”

A medically impressive and pretty record is thus generated with little effort. However, the doctor did not perform all of these examinations! Most of us conduct focused physical exams pertinent to the clinical situation on hand. I found no simple way of entering my clinical findings and pertinent negatives on EMR. Sometimes I click the “all normal” option and then I erase one by one the exams I did not perform. Other times I enter each of my physical findings manually. Either way, it takes me more time than in the past. Doctors should be cautioned not to enter long lists of normal findings for exams not performed. If any litigation arises, plaintiff attorneys will find embarrassing contradictions between these long lists of normal findings and the fact that the patient did develop over time major physical abnormalities.

I went through D-Day in the Florida Department of Corrections in 1993 and in the Georgia DOC in 1996. These were aborted trials that, mercifully, did not survive. I went through another D-Day in a Georgia jail in May. This time I expect the EMR to survive, warts and all. I hope this short list of my experiences will be of help to correctional doctors facing their D-Days.

Joseph E. Paris, MD, PhD, CCHP-A, is deceased (see page 24). At the time he wrote this, he was a correctional health care consultant who also worked for several county jails in Georgia. He represented the Society of Correctional Physicians on the NCCHC board of directors.

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Correctional Nursing Practice: What You Need to Know (Part 11)

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.nccchc.org/cchp, where you can also view the entire text outline (see downloads).

Continuity of Care

Continuity of care is a process that must involve the patient and all members of the health care team. The correctional health care team should work to manage all care delivered and should always strive for quality in delivery of that care. Patients are seen by a number of providers for various types of encounters in many locations in the facility, which leads to concern about the potential for fragmentation of care. Correctional nurses play an essential role in the coordination of care for the patient. Nurses must embrace their role as a patient advocate and work closely with other members of the health care team to ensure that each patient’s needs are met in a timely manner.

Nurses are the eyes and ears of the health care program, typically providing care 24 hours a day, seven day a week at most correctional facilities. For all patients, the initial intake encounter is the first opportunity for the nursing staff to identify both immediate and long-term patient needs. The nurse must then communicate those needs to the appropriate members of the health care team and ensure that any care ordered is completed in a timely manner.

Nurses interact with patients during many other types of encounters, including sick call, disease management encounters, urgent visits, patient education sessions and medication administration. Each encounter is an opportunity for the nurse to identify potential patient need and to ensure that each identified need is appropriately addressed.

Common Challenges

All correctional facilities present unique challenges to the nursing team. For example, jails are typically fast-paced environments with a great deal of emphasis on the intake process. The rapid entry and exit of inmates presents a critical challenge to the nursing team. It is essential that the nursing team work closely with custody staff to identify inmates held in intake areas who have the greatest need of an initial evaluation. The nurse must ensure that those individuals are seen within appropriate periods of time and their needs are addressed.

Prison nurses usually focus on care needs for a population that will be in the facility for longer periods of time. Care here can focus on long-term care issues while being ever aware of the opportunity to identify a new need through the various nursing encounters that occur.

In both settings, nurses must ensure that their evaluation and interview skills are sharp so they can obtain the best possible information from the patient to develop a clear clinical picture of the patient’s needs. Nursing is vital to the success of positive patient outcomes and it critical that the nurse makes appropriate nursing decisions and takes appropriate measures for each patient encounter.

Certain aspects of care present a risk of disrupting the continuity of care. One of these is medication administration. This is one of the most challenging aspects of care for the correctional nurse due to the volume of medications administered combined with the processes necessary to obtain the medications in a timely manner, account for the medications, ensure the medications are available for each patient even if transferred within a facility, obtain renewed medications and document administration of medications and noncompliance. It takes strong teamwork and diligence to ensure that each patient is given all medications ordered by providers.
Another threat to continuity of care arises during the transfer process. It is essential that clear communication flows between the sending and receiving facilities. That communication should include information about current treatments, medications, scheduled appointments and diagnostic studies. The information to be shared should give the receiving facility a clear picture of the current treatment needs of the arriving patient.

Continuity of care can suffer when we are not functioning at our best level of performance. Correctional nurses must be keenly aware of the stressful environment in which they work on a daily basis. The nurse is continually faced with a high volume of work in challenging working conditions and, at times, conflict with custodial staff, other health care team members or patients. There are times when the nurse is unable to gain appropriate access to patients or feels frustrated with the overall constraints of a custodial environment.

Nurses must recognize those challenges and the impact they may have on their daily decision making. They must be vigilant to not let themselves become insensitive to patient need because of the stress they themselves experience. Burnout and failure to rescue a patient in need can easily occur in the correctional health care setting, and when it does, there can be dire consequences for the patient. The nurse manager must constantly guide and coach staff members on how to address this burnout. The focus of all actions must remain on the patient.

Well-Defined Processes
To address the needs of the patient population, correctional facilities should have clearly defined processes, including policy, procedure, forms and communication plans. Use of national standards that guide correctional health care is also valuable. Nurses are responsible to clearly understand each clinical process and to carefully follow those processes in their daily activities. Knowing and understanding the standards for their practice setting helps the nurse know how to properly handle the daily challenges that can arise. Just one failure to follow facility processes to address patient need can result in a negative patient outcome.

The nurse should be aware of the communication channels in the facility, including how to contact providers, make appropriate referrals at any time of the day and document care ordered so that other members of the health care team are aware and can complete the orders written.

Continuity of care requires a coordinated, interdisciplinary team approach. Each discipline brings a different perspective to planning. It is a process in which the nurse plays a critical role.

Rebecca Pinney, RN, CCHP-RN, is senior vice president, chief nursing officer at Corizon, Brentwood, TN. This column is coordinated by Larry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media. For correspondence, write to editor@ncchc.org.

The rewards of a career in correctional health care are many. But health professionals working in correctional settings also face unique challenges. Achieving professional certification is the surest way to prove that you have the tools to meet these challenges.

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For more information, visit www.ncchc.org/CCHP.
Dermatological Conditions in Texas Prisons

Although dermatologic disease is very common in the free world, with dermatology clinics seeing patients with a wide variety of problems, very few studies have examined the types of skin conditions in incarcerated populations.

A study in the October Journal of Correctional Health Care examines the dermatology diagnoses of patients at the University of Texas Medical Branch—Texas Department of Criminal Justice Hospital in Galveston, TX. The hospital provides inpatient and outpatient services for TDCC inmates, including an outpatient dermatology clinic.

The retrospective study gathered information on all dermatology visits between January 1, 2007, and August 25, 2009. After excluding inpatient consultations and patients younger than 18 years of age, 3,326 encounters were analyzed. Male patients made up 92% of the encounters. By ethnicity, patients were mostly White (43%) or Black (34%).

These visits produced a total of 4,449 diagnoses, which the researchers sorted into six categories: infections and infestations, inflammatory conditions, benign cutaneous tumors, malignant and premalignant cutaneous tumors, autoimmune processes, and miscellaneous skin conditions.

Inflammatory skin conditions were most common, accounting for 27% of diagnoses recorded in the study. In this category, the conditions seen most often were psoriasis, acne, and lichenification. Psoriasis was also the most common condition overall, accounting for 8% of all diagnoses.

“Miscellaneous” conditions made up 21% of the diagnoses. The category included conditions such as nonspecified hair disease, skin disorder and skin eruption.

The third major category was malignant and premalignant tumors, with 18% of the diagnoses. Here, actinic keratosis, history of skin cancer and skin cancer on the face were most often documented.

Closely following at 17% of diagnoses were infections or infestations, with chief complaints being tinea pedis, condyloma acuminate and tinea corporis.

Benign cutaneous tumors accounted for 15% of the diagnoses, the most common of which were keloid, epidermal inclusion cyst and seborrheic keratosis.

Fewer than 2% of the diagnoses were autoimmune skin conditions. Of these, pemphigus, vitiligo and lupus were seen most often.

The authors note that geographic location and facility-specific conditions may affect the types of skin disease seen in inmates. Because the study population largely comes from the South, sun exposure could account for the high number of skin tumors. To aid early detection, the authors suggest adding questions about personal or family history of skin cancer to patient visits. Increased photoprotection should also be considered. Finally, correctional physicians would benefit from working knowledge of the most common dermatologic conditions seen in incarcerated patients.

JCHC Volume 18, Issue 4

Insurance Status of Urban Detained Adolescents — Matthew Aalsma, PhD, Margaret Blythe, MD, Yan Tong, PhD, Jaroslaw Harezlak, PhD, and Marc Rosenman, MD

Overweight, Obesity, and Weight Change Among Incarcerated Women — Jennifer Clarke, MD, MPH, and Molly Waring, PhD

Perceptions and Influences of a State Prison Smoking Ban — Laura Thibeault, MSN, RN, David Seal, PhD, Douglas Jorenby, PhD, Kerri McCarron, and James Sossman, MD

Prison Dermatology: Experience in the Texas Department of Criminal Justice Dermatology Clinic — Cameron Courey, MD, and Brent Kelly, MD

Epidemiological Characteristics of HIV-Infected Women With and Without a History of Criminal Justice Involvement in South Carolina — Eren Youmans, PhD, MPH, James Burch, PhD, Robert Moran, PhD, Lillian Smith, PhD, and Wayne Duffus, MD, PhD

Ethical Challenges in Conducting HIV/AIDS Research in Correctional Settings — Gloria Eldridge, PhD, Rebecca Volino Robinson, MS, Staci Corey, MS, Christina Brems, PhD, and Mark Johnson, PhD

Each issue has a self-study exam that offers continuing education credit. Academy of Correctional Health Professionals members receive JCHC (print and online) as a benefit of membership. To learn how to obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
Meeting the Needs of Aging Prisoners

Although the U.S. prison population has remained relatively flat in recent years, the proportion of older prisoners has increased markedly. This demographic shift has significant implications for prison systems. To examine the challenges presented by the growing population of older prisoners, an interdisciplinary meeting of 29 national experts in correctional health care, academic medicine, nursing, and civil rights was convened in 2011. In August, a consensus report was issued that makes nine policy recommendations for improving the care of older prisoners. Key points from "Responding to the Needs of an Aging Prison Population" are summarized below.

**Recommended Actions**

- **Define "Older Prisoner":** Inconsistency and subjectivity in use of terms hinders the collection and reporting of standardized data. The recommendation is to define "older" or "geriatric" prisoners as those aged 55 or older.
- **Train Staff and Health Care Providers on Aging:** Training is needed to help to create a workforce aware of common health conditions and the diverse needs of older adults.
- **Define Prison-Based Functional Impairment:** Activities of daily living that are necessary for independence differ from those in the community. Delineating the differences would enable staff to identify older prisoners who need additional supervision, assistance, and support.
- **Develop a Tool for Correctional Dementia Screening:** Identifying patients with dementia by use of a cognitive screening tool has the potential to lower health care costs and contribute to a safer prison environment.
- **Expand Research on Older Women Prisoners:** Women, who make up 5% of the prison population aged 65+, differ from the men in health care needs and utilization. Research would shed light on their unique health and social issues.
- **Expand Research on Geriatric Housing Units:** Prison housing often is not equipped to accommodate the elderly. Special units for various levels of care may enhance safety, reduce costs and increase accessibility of care. Validated criteria for long-term-care classification should be developed.
- **Expand Research on Transitional Programs:** To maximize postrelease outcomes, it is important to develop plans for addressing inmate health and behavioral health needs upon reentry into the community.
- **Create Early Medical Release Policies:** Releasing prisoners who pose little risk to the community due to age or health can yield significant cost savings. But eligibility criteria must reflect the ways people experience serious illness and death.
- **Expand Research on Prison-Based Palliative Care Programs:** Palliative care provides guidance and symptom control for seriously ill people. In community settings, it has been shown to improve quality of life while reducing health care costs. Seriously ill prisoners would also benefit from such improvement in care.

**A Health, Safety and Fiscal Imperative**

The report concludes that "For health, safety, and fiscal reasons, criminal justice professionals, including those involved in correctional health care, must take steps to identify the diverse needs of the older prisoner population, and ensure that the care, expectations, and services provided in prisons are an accurate reflection of the health and safety needs of this group."

The interdisciplinary meeting was funded by the Jacob and Valeria Langeloth Foundation and held at John Jay College of Criminal Justice, New York City. The report was written by Brie Williams, MD, and Robert B. Greifinger, MD, and produced by Policy Research Associates. The report is available from SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Find it in the Topical Resources section, Integrating Services, at http://gainscenters.ssamhsa.gov.

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www.ncchc.org Summer 2012 • CorrectCare
Contraception for Adolescent Females: Safe and Effective, With Added Benefits

by Robert Morris, MD, CCHP, and Paula Braverman, MD

Adolescents in the juvenile corrections system have among the highest rates of teen pregnancy and for many girls, failure to use contraceptives leads to unplanned pregnancy and the medical and psychosocial problems that further complicate their lives. We encourage practitioners caring for these youth to explore contraceptive options for them.

Today’s low-dose hormonal contraceptives are safe, especially for adolescents. New technologies have produced a variety of combined hormonal contraceptives (combined oral contraceptive pills, contraceptive patch, vaginal ring) as well as progestosterone-only pills, injections and implantable and intrauterine devices that practitioners may choose to meet varying circumstances.

Very few of the absolute contraindications to prescribing combined hormonal contraceptives containing both estrogen and progestosterone apply to healthy adolescents. The contraindications applicable to the majority of adolescents include a thromboembolic disorder or thrombogenic mutation and migraine headaches with aura.

Combined hormonal methods and progestin-only pills generally have few side effects and do not cause significant weight changes. The contraceptive patch and ring provide options for combined methods that do not require daily compliance.

Additional Benefits

Many adolescent girls are aware of some, but not all, of the noncontraceptive benefits of hormonal contraceptives. These include reductions in acne, menstrual flow (thereby preventing anemia), dysmenorrhea and premenstrual symptoms. Hormonal contraceptives also offer some increased protection from sexually transmitted infection because they thicken the mucus in the cervical os. They are commonly used to regulate menstrual periods in cases of menstrual disorders with menstrual irregularity and heavy menstrual bleeding. They also reduce the clinical affects of excess endogenous androgens in polycystic ovary syndrome. Long-term use reduces benign breast changes. Finally, hormonal contraceptives have been shown to reduce the risk of ovarian and endometrial cancer. This is thought to be due to reducing cell turnover of the reproductive organs, thereby avoiding transcription mistakes.

The new implantable progestosterone rod,etrogestrel 68 mg. (Implanon), which was recently replaced by Nexplanon, lasts for three years. Nexplanon differs from Implanon in two ways: It is radiopaque and it comes in a preloaded applicator that reduces the risk of insertion errors. The company insists practitioners be trained to insert the rods by the company. Like other contraceptives, this method is reversible when removed.

Progestosterone-containing intrauterine systems are well-tolerated and safe for use in nulliparous adolescent girls unless they have an active pelvic infection. Risk for subsequent STIs is not an absolute contraindication for use. Studies have shown that it is the presence of an untreated STI, not the IUD, that causes upper tract disease. Practitioners must be trained to place these through the cervical canal and into the uterus. Most girls can have IUDs placed while in the office without anesthesia. The IUD with progesterone around the stem is effective for five years and

Continued on page 24
The Latest News From the CCHP Program

Board of Trustees Election Results
Congratulations to Ralf Salke, BSN, CCHP-A, who won the recent election and will serve a three-year term on the CCHP board of trustees. His term will begin in 2013. Salke works as vice president of operations for Corizon, Jefferson City, MO, and has more than 25 years of correctional health care experience in state and private settings. He has served on the board of the Academy of Correctional Health Professionals since 2003, including as chair and as treasurer. His background also includes 12 years of military service in the Medical Service Corps and the Military Police Corps as a former officer in the U.S. Army Reserve.

In his candidate statement, Salke said that one of his goals if elected is to improve development and scoring of the CCHP and CCHP-A examinations to make them more responsive to the needs of the correctional health environment.

New Resource for CCHP-RN Exam
CCHPs seeking RN specialty certification are advised to become familiar with the exam content areas that will be covered, and to study certain materials to prepare for the exam. A new book, Essentials of Correctional Nursing, has been added to the recommended reading list. Co-editors Lorry Schoenly, PhD, RN, CCHP-RN, and Catherine Knox, MN, RN, CCHP-RN, served on the task force that developed the specialty certification. They and their fellow task force members wrote chapters that closely align with the correctional nurse job analysis that informs the exam content. But the book's scope goes far beyond the exam; it provides a comprehensive body of current, evidence-based knowledge about the best practices to deliver optimal nursing care to the incarcerated population. Topics include legal and ethical issues surrounding correctional nursing; health screening, medical emergencies, sick call and dental care; common inmate-patient health care concerns and diseases; the unique health needs of juveniles, women and those at the end of life; and how nurses can safely navigate the correctional environment to create a therapeutic alliance with patients.

The Candidate Handbook has been updated accordingly; find it at www.ncchc.org/CCHP-RN. To order the Essentials book, visit ncchc.org/pubs/catalog.html.

CCHP Exam Dates

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We are seeking additional sites for regional exams as well as CCHPs to proctor the exams. If you would like to participate, contact the director of certification at 773-880-1460 or cchp@ncchc.org. Learn more at ncchc.org/cchp.

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http://careers.correctionalhealth.org
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

Joseph E. Paris, MD, PhD, CCHP-A
NCCHC board member Joseph E. Paris, MD, PhD, CCHP-A, age 71, passed away on Sept. 6, succumbing to cancer. A longtime leader in the correctional health care field, Dr. Paris was born and raised in Argentina, coming to the United States to complete his PhD degree in biochemistry. A few years later he earned an MD degree. After 10 years of work in hospitals and private practice, in 1985 he joined the Florida Department of Corrections, taking leadership roles in various facilities. A decade later, he joined the Georgia Department of Corrections and soon became statewide medical director. Upon “retirement,” he remained highly active, working at two county jails in Georgia, doing independent consulting and serving as an expert witness.

Throughout his career, Dr. Paris made countless significant contributions to the field of medicine and to correctional health care, generously sharing his time and expertise with professional associations, committees, government entities and others—and receiving many well-deserved honors. A good friend of NCCHC, he became a Certified Correctional Health Professional in 1991, the year the program launched, attained Advanced status in 2006 and served on the CCHP board of trustees for two terms. He also was an active accreditation surveyor since 1995. In 1992, he helped to found the Society of Correctional Physicians. He later served as its president and was honored as an SCP Fellow. Since 2009 he was SCP’s liaison to the NCCHC board of directors. A prolific writer and speaker, Dr. Paris contributed to hundreds of publications and conferences and was a frequent and popular speaker at NCCHC meetings.

The Society of Correctional Physicians
SCP now welcomes midlevel providers as limited members and encourages physician assistants and nurse practitioners to join. Learn more about the society at its new website, http://societyofcorrectionalphysicians.org.

The Academy and SCP
The Academy of Correctional Health Professionals and the Society of Correctional Physicians are sharing a new executive director. David Patt, CAE, assumed the management role for both organizations earlier this summer. A Certified Association Executive, Patt has 30 years of experience working on behalf of small organizations representing nursing home residents, competitive and recreational runners, event directors and community-based organizations. He wrote 200 Practical Decisions for Membership Organizations as well as articles for a variety of publications in the field of association management. He also has a rich and varied background as a volunteer leader.

Contraceptives

(continued from page 22)

has additional benefits of reducing menstrual flow and improving dysmenorrhea.

Patient Education

To successfully use hormonal contraceptives, the patient must understand the method and be motivated to use it. Concerns and misconceptions must also be addressed. Therefore, careful inquiry into the patient’s desire to use various methods and her knowledge about the methods and possible side effects is important. Patients need to know the warning signs of possible contraceptive complications and what to do if they miss pills, forget to replace a patch or vaginal ring or miss the appointment for their Depo shot.

It is also important to provide patients who are using short-acting hormonal contraceptives (e.g., pills, patch, vaginal ring and the every-three-month injected progesterone) with emergency contraception in case pills, the patch or ring are missed or the patient is overdue for her injection. Since emergency contraception is most effective when used soon after unprotected sexual intercourse (up to 72 hours), it is best for the patient to have a prescription in advance and to fill the prescription in case it is needed. At minimum, all adolescents should know about emergency contraception and the fact that it is available over-the-counter for those age 17 and older.

In summary, hormonal contraceptives provide both contraceptive and noncontraceptive benefits. They are safe for healthy adolescents, and newer long-acting methods require no compliance once placed. Juvenile corrections practitioners should consider their use for the well-being of the adolescent girls they care for.

Robert Morris, MD, CCHP, is professor emeritus with the Department of Pediatrics, University of California – Los Angeles and represents the Society for Adolescent Health and Medicine on the NCCHC board of directors. Paula Braverman, MD, is a professor of pediatrics in the Division of Adolescent Medicine, Cincinnati Children’s Hospital Medical Center as well as medical director at the Hamilton County Juvenile Court Youth Center, Cincinnati, OH. Both serve on NCCHC’s juvenile health committee.
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Big Numbers, Big Opportunity
With 2.3 million people incarcerated in the United States on any given day, it is a huge, costly endeavor to provide constitutionally mandated health care to these individuals. And as inmate populations grow older, their health care needs—and related expenditures—are rising. 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.

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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.

The Value of Personal Contact
• To make an initial, face-to-face visit with a potential customer, the cost without an exhibition lead is $1,039, on average. With an exhibition lead, it is only $215!
• 61% of marketers considered exhibiting as the best means to effectively build brand image, and 63% considered in-person events as the best tactic to generate qualified leads. Source: Forrester Consulting Services on behalf of American Business Media

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• 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.

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NEW! Essentials of Correctional Nursing
Written and edited by correctional nurses with thousands of hours of experience, this essential text provides a comprehensive body of current, evidence-based knowledge about best practices to deliver optimal nursing care to the incarcerated population. Topics include legal and ethical issues, health screening, medical emergencies, sick call and dental care; common patient health concerns; unique health needs of juveniles, women and those at the end of life; and how to safely navigate the correctional environment to create a therapeutic alliance with patients. American Nurses Association standards are woven throughout, which is useful for nurses studying for the CCHP-RN certification exam. Edited by Lorry Schoenly, PhD, RN, CCHP-RN, and Catherine M. Knox, RN, MN, CCHP-RN. Springer Publishing Co. (2012). Softcover, 404 pp, $75

Rehabilitating Sexual Offenders: A Strength-Based Approach
Research has shown that an aggressive treatment approach that confronts denial does not alter criminogenic factors related to sexual reoffense. This book presents a motivational approach used in prison and community settings that has achieved a broad range of treatment targets and reduced recidivism. It reviews research and theory on sex offender treatment, including assessment, procedural factors, personal and interpersonal factors, problems with common cognitive-behavioral approaches and evaluation of treatment programs. It describes three treatment programs developed for the Canadian prison system: The Preparatory Program engages offenders in the process of change, the Primary Program targets criminogenic factors known to predict reoffense, and the Denier’s Program also targets criminogenic factors but is tailored to those who deny committing a sexual offense. By William Marshall, PhD, Liam Marshall, PhD, Gerss Serran, PhD, and Matt O’Brien. American Psychological Association (2011). Hardcover, 260 pp, $69.95

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Expert Advice on NCCHC Standards

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

Facility Construction Standards?

Q My question is whether NCCHC provides regulation or guidance on the construction of correctional facilities as it relates to accreditation.

A NCCHC’s standards focus on the recommended requirements for the proper management of a correctional health services delivery system; we do not provide guidance on facility construction. However, there are a number of standards that you may wish to consider. For example, the standard on infirmary care (G-03) requires that patients be within sight or sound of qualified health care professionals at all times. Patient proximity to the nursing station, call lights, etc., would come into play here. Another relevant standard addresses privacy of care (A-09), which includes the privacy of health care encounters and discussion of patient information. Privacy during clinical encounters might be a key factor to consider in designing clinic areas. The standard on clinic space, equipment and supplies (D-03) addresses the need for sufficient and suitable space and items. Another essential that comes to mind is standard G-05 on suicide prevention; the monitoring of potentially and actively suicidal inmates could be facilitated by efficient design of their housing. It may be helpful for you to familiarize yourself with the Standards for Health Services as the construction plan progresses.

Mental Health Staff in Administrative Meetings

Q Do the standards require someone from mental health to attend the administrative meetings? Right now, our health services administrator goes, but we want to know if mental health should be going as well.

A If mental health operates under a separate structure than that of medical, then the designated responsible mental health clinician or designee should also attend the administrative meetings according to standard A-04 Administrative Meetings and Reports. A designated mental health clinician refers to a psychiatrist, psychologist or psychiatric social worker who is responsible for clinical mental health issues when mental health services at the facility are under a different authority than the medical services, according to standard A-02 Responsible Health Authority.

On the other hand, if medical and mental health staff report to the same authority, then only the responsible health authority or the RHA’s designee is required by the standard to attend. Usually, the health services administrator or the responsible physician is the RHA or serves as the designee. The intent is that there is joint monitoring, planning and problem resolution by the facility’s health and correctional administrators.

The standard also intends that all health staff, including medical, dental and mental health, are kept informed about facility operational issues and receive current information on all aspects of the institution’s health care delivery.

Jennifer E. Snow, MPH, CCHP, 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. Send your question to accreditation@ncchc.org.

Q&A and Spotlight Archive

For more insight into the nuances of the Standards for Health Services, visit ncchc.org/resources/standards.html. Here you will find an archive of past Q&A topics as well as the Spotlight on the Standards column, which explores the rationale behind various standards, the intended outcomes, compliance concerns and more.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s National Conference on Correctional Health Care.

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Dana Neitlich, MSW  
Assistant Dir. of Clinical Services  
Joel Andrade, PhD, LICSW  
Program Manager & Dir. of Clinical Services

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Results? Through a collaboration with custody staff, our mental health clinicians have successfully implemented quality mental health treatment to this special population in a safe and secure setting. The provision of these programs has aided in the decrease of negative outcomes, created safer institutions, protects us and our clients from litigation, is cost effective...and is the RIGHT thing to do.

Delivering correctional mental healthcare the right way costs less. To find out how, contact Dr. Joel Andrade at 800.416.3649 or jandrade@mhmservices.com.

MHM Correctional Services, Inc.  
The Public-Private Partner for Healthcare

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