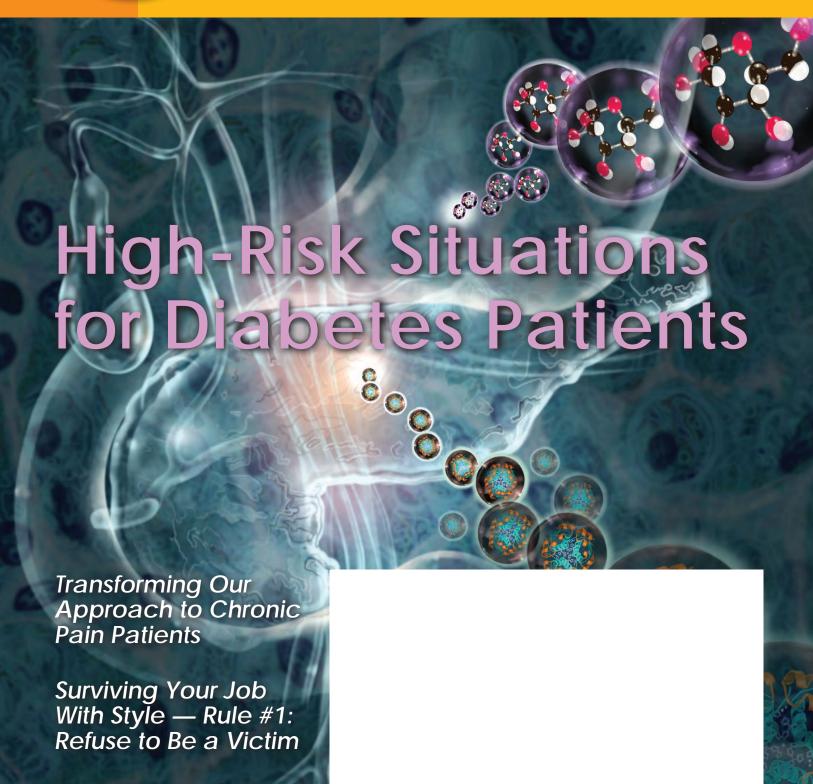
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The magazine of the National Commission on Correctional Health Care



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

**Infirmary-Level Care** 

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Send correspondence to Jaime Shimkus, CCHP, Vice President, Communications NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614
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# **NCCHC**news

### It's a First! Georgia Jail Accredited for Mental Health Services

by Barbara S. Granner, CCHP

ike jails and prisons around the country, Chatham County (GA) Detention Center has seen a steady rise in the mental health needs of its inmates. So as soon as he was elected, Sheriff John Wilcher made mental health care a top priority. "Correctional facilities have become the country's largest mental health providers," Sheriff Wilcher

> says. "The best way to tackle this problem is head on, by ensuring we provide high quality, effective care that can help people turn their lives around."

That commitment led Chatham County to become the first facility in the country to be NCCHC-accredited for mental health services, as well as the first to achieve dual accreditation from NCCHC in mental health and health services.

"Chatham County has taken a very smart, proactive step by seeking out accreditation for their mental health services," said NCCHC vice president

of accreditation Tracey Titus, RN, CCHP-RN. "The challenges presented by a large inmate population with mental health needs, ranging from serious mental illness to substance use disorder to unhealed trauma, can be daunting. The standards provide a blueprint for navigating those challenges, and NCCHC accreditation confirms that systems are in place to meet them."



The journey to that accomplishment began at an NCCHC educational conference, where representatives from Chatham County and CorrectHealth, the jail's new health

services vendor, attended a workshop led by Titus on accreditation for mental health services.

"We were looking for an efficient improvement process, so we jumped at the idea," says Todd Freesemann, CCHP, Chatham County's director of policy. "Since we were already working toward accreditation for health services, we knew NCCHC's is the best third-party accreditation in the field," adds Susan Hatfield, FNP-C, CCHP-RN, executive director of

clinical services at CorrectHealth.

Hatfield admits that preparing for the accreditation surveys was "quite the undertaking," involving weekly meetings, a color-coded spreadsheet listing each NCCHC standard and compliance indicator, and a huge amount of teamwork among the jail, vendor, county and NCCHCbut says it was well worth it.

"The entire process provided a lot of opportunity to learn and teach. It revealed ways to improve the program in more ways than we anticipated, from initial screening to referrals to community resources," she says. "We encountered challenges, but we figured things out."

For Freesemann, who was recently certified as a CCHP, working through the NCCHC standards was particularly eye-opening. "I'm not a nurse or a doctor, but I now see the importance of the guidance provided in the standards."

#### The Right Resources in the Right Places

Changes instituted at the jail include additional mental health staff, including a full-time psychiatrist and additional counselors; enhanced crisis intervention and mental health first aid training for police and corrections officers; an improved intake screening process and more.

For some, the idea of treating mental illness like any other chronic or acute health need requires a change in mind-set, Freesemann says. But many understand the importance.

"When you take care of mental health, it helps solve other problems too," he explains. "Security issues and length of stay are reduced. Fewer resources are drained.

"Like everyone, we are working with limited resources. But with the NCCHC standards as our road map, we now have the right resources in the right places."

Barbara S. Granner, CCHP, is manager of marketing and communications at NCCHC.

#### Calendarof events

Karen Forchette and

Sheriff John Wilcher

May 3 Accreditation Committee meeting

**April 7** CCHP exams, Nashville July 12 Accreditation Committee meeting

July 20 CCHP exams, Las Vegas

July 21-22 Correctional Mental Health Care

> Conference, Las Vegas Accreditation Committee meeting

September 13 October 12-16 National Conference on Correctional Health Care, Fort Lauderdale

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CCHP exams, Nashville October 13 See the list of all CCHP exams at www.ncchc.org/cchp.

# **Chairnotes**

### Meeting the Challenge of Mental Illness Behind Bars

by Thomas J Fagan, PhD, CCHP-MH

hen I began my career as a correctional psychologist more than 40 years ago, the population of seriously mentally ill individuals in correctional settings was quite small and manageable. Through a series of legislative initiatives (e.g., mandatory minimum sentencing) and changing social attitudes



in the 1980s and beyond, the population of individuals with serious mental illness slowly grew.

Correctional mental health providers quietly managed these individuals as best as they could, but with a growing awareness that systemic changes would ultimately need to be made in order to accommodate the special needs of this unique population.

Foremost among these changes was a need for greater flexibility in the management of these individuals to accommodate their cognitive and behavioral symptoms, their inability to follow commands and their difficulty with obeying institution rules. Allowing more flexibility in the management of mentally ill people in a system that prides itself on the strict adherence to its rules and regulations was not an easy transition, and in some ways we are still in the midst of this transition.

Correctional systems are aware that change is necessary to effectively manage this population, but still struggle with decisions about how to accommodate the unique challenges of this population while simultaneously managing the larger population. Additionally, administrators are faced with decisions regarding what constitutes adequate staffing and appropriate programming in an era of limited budgets and competing management needs.

In short, correctional systems are facing a serious—and growing—mental health challenge. I use the word "challenge" because of the staggering number of individuals in our jails and prisons with some form of mental illness. Estimates of those with serious mental illness (psychotic, major depressive and bipolar disorders) range from 12% to 20%, and when other mental health disorders (such as anxiety, posttraumatic, sleep and substance use disorders) are added to the list, estimates are as high as 50% to 70%.

The correctional system was never intended to care for large numbers of mentally ill people, and many jails and prisons remain ill-equipped to deal with this population. The current situation has left facilities asking: What do we do with these individuals? How do we care for them? What happens when they are released back into the community?

What can we do that will lead to potentially better outcomes, better success and less recidivism?

#### The Value of Standards

Some insight into these challenging questions can be found in NCCHC's Standards for Mental Health Services in Correctional Facilities manual, commonly known as "the brown book." Like the Standards for jail and prison health services, the mental health Standards cover assessment and treatment, behavioral consultation, clinical records, medication management, staffing and administrative issues, personnel and training issues, suicide prevention and intervention, and medical-legal matters—all focused on the provision of quality mental health care. The standards are an indispensable tool to help facilities determine proper levels of care, organize systems and demonstrate that constitutional requirements are being met.

By becoming accredited in mental health services, a facility can verify that it meets NCCHC's standards for delivering mental health care as efficiently and safely as possible. NCCHC also offers accreditation of health services for jails, prisons and juvenile facilities, and for opioid treatment programs. Your facility can earn one or more types of accreditation based on the programs, services and populations managed within your system. In other words, health services accreditation is not required in order to get accredited for mental health or opioid treatment programs. While basic mental health services are included in the health services accreditation, facilities with more robust mental health services may consider this specialized accreditation that focuses solely on the system of care for patients with mental health needs.

The mental health standards also serve as the foundation for NCCHC's professional certification in correctional mental health (CCHP-MH). By hiring professionals with the CCHP-MH credential, employers can be confident that their mental health staff knows the NCCHC standards and understands what it means to deal with this unique population in the correctional setting. By becoming CCHP-MH certified, mental health professionals demonstrate their expertise and gain credibility. I'm proud to carry the credential myself.

Thomas J. Fagan, PhD, CCHP-MH, is the chair of the NCCHC board of directors.

Standards for Mental Health Services in Correctional Facilities can be purchased from the NCCHC online bookstore (www.ncchc.org) or by calling 773-880-1460.

# Spotlight standards

by Tracey Titus, RN, CCHP-RN, and Jeffrey Alvarez, MD, CCHP-P

rior to publication of the 2018 Standards for Health Services for jails and prisons, an infirmary was defined as a place within a facility where patients in need of a higher level of care were housed. However, the physical location was often used to house other inmates whose health or custody needs required a more protective environment than that in general housing (e.g., juveniles, administrative or protective custody inmates, patients with medical equipment).

Thinking of an infirmary as a *location* caused two issues. The first arose when health staff applied the former G-03 Infirmary Care compliance indicators to inmates in the "infirmary" who did not need of that level of care. This wasted valuable staff time and resources. The second arose when there was a belief that the facility did not have an infirmary even when that level of care was being provided. The standard's requirements were not followed, although some patients truly needed more frequent monitoring and skilled nursing intervention. The 2018 *Standards* focus on the level of care provided, not a designated area.

#### **Definition and Policy Development**

Infirmary-level care is defined as care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy or assistance with activities of daily living at a level needing skilled nursing intervention. Typically, this includes patients who require more intensive care than can be provided in the general population and for a period of 24 hours or more. Patients who need skilled nursing care but do not need hospitalization or placement in a licensed nursing facility and whose care cannot be managed safely in an outpatient setting would qualify for infirmary-level care.

Administrators need to determine if patients who fall into this category will be housed in the facility. This frequently depends on the available resources and skill level of the health staff. If the facility does not have the appropriate resources for these types of patients, policies should be developed that outline how patients who need this level of care will receive it (e.g., transfer to local hospital, transfer to another facility). However, if resources allow infirmary-level care on-site, then policies should define the scope of medical, psychiatric and nursing care available to these patients.

#### **Logistical Considerations**

Once the scope of on-site care is determined, logistics need to be considered. Infirmary-level patients may be housed in a single designated area or in locations throughout the facility, as long as all requirements of the standard can be met. For example, patients in need of infirmary-level care must always be within sight or hearing of a staff member, which could be a custody or health staff employee. This is a change from the 2014 standards, where only a qualified

health care professional could be the person within sight or hearing at all times.

A qualified health care professional must also be able to respond in a timely manner. Administrators should consider the response times of qualified health care professionals when determining housing locations for infirmary-level patients. The more security barriers between the response personnel and the patient (e.g., multiple locked doors or sliders, housing on a complex far removed from health staff), the less likely it is that a qualified health care professional can respond in a timely manner.

#### Staffing

Health care staffing should be based on the number of patients who need infirmary-level care, the severity of their illnesses and the level of care required for each. It is recommended that patients who need psychiatric infirmary-level care be supervised by mental health clinicians. A supervising RN should ensure that care is being provided as ordered on a daily basis.

The frequency of nursing and provider rounds should be based on clinical acuity and categories of care provided. Many systems choose to adopt several level of care (e.g., level 1-4, color-coded levels), defining the types of patients in each category and determining the frequency of rounds for each. This type of system may help keep health staff consistent with following treatment plans.

#### **Documentation**

Patients should be enrolled in infirmary-level care by provider order. Health records should contain the following:

- Documented reason for infirmary-level care
- Treatment plan
- Monitoring plan
- Complete documentation of care and treatment provided When a patient no longer requires infirmary-level care, the discontinuation should also be by provider order.

#### **More Flexibility for Physicians**

As facilities transition to the 2018 standards, it is important to remember the shift in focus of this standard: It is not a physical location that defines infirmary-level care, but the scope of care provided. Whether or not there is a designated "infirmary" area, clinicians now have more flexibility to develop treatment plans for on-site care when, in their clinical judgement, resources are available to provide the ordered care. The changes also removed many specific documentation requirements, again giving the clinicians flexibility when documenting the treatment plan.

Tracey Titus, RN, CCHP-RN, is NCCHC's vice president of accreditation. Jeffrey Alvarez, MD, CCHP-P, serves on the NCCHC board of directors as liaison of the American Academy of Family Physicians and is vice chair of its accreditation and standards committee.

F-02 Infirmary-Level

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# Legalaffairs

### Breast Implant Care Escapes Charge of Deliberate Indifference

ndiana prisoner Susan Grund suffers with unrequited breast pain associated with breast implants she first acquired prior to her prison term beginning in the 1990s. In 2002 she began complaining about breast pain, then engaged an attorney to help her obtain specialized care.

An MRI showed a rupture and, following protracted litigation, Ms. Grund was sent to a plastic surgeon who removed and replaced her implants.

In about two years, she again began experiencing pain. The prison's physician did a physical exam and found no abnormalities and she was told she did not need a specialist or more testing. A routine mammogram a year later produced normal results.

Grund's complaints of pain were persistent but did not prevent her from exercising, sleeping and doing some prison work. Again, the doctor did an exam and found no abnormalities. He prescribed no pain medication and ordered routine monitoring.

Ms. Grund does have celiac disease, an autoimmune disorder related to gluten intolerance, and that may explain some of her pain.

In any event, the prison doctor would not budge on treatment related to the newer implants and Ms. Grund sued in federal court alleging unconstitutional treatment of

The lower court entered summary judgment for the defendants and in Grund v. Murphy (736 Fed.Appx. at 601; 7th Cir. 2018), the reviewing court upheld that result, finding emphatically no evidence of deliberate indifference.

#### **Discussion**

For this claim to succeed, there must be evidence of a serious medical condition (and that is conceded) and that defendants were deliberately indifferent in the failure to treat plaintiff or the manner of her care.

Deliberate indifference is a mental state of the same order as negligence, recklessness or intentionality. Deliberate indifference is conduct that is more culpable even than medical malpractice and it is a form of recklessness—of knowing a risk and then intentionally ignoring it.

The Seventh Circuit has adopted a particularly strict view of deliberate indifference, viewing it as conduct that is "so far afield from accepted professional standards as to raise the inference that it was not actually based on medical judgment" (736 Fed.Appx. at 604).

One might think that a constitutional norm would be applied in the same way in each of our federal circuits, but that's not the case. The above version of deliberate indifference is extremely rough for plaintiffs and it is as tough an approach to deliberate indifference as exists.

Ms. Grund is advised that her complaint is, in fact, a disagreement as to treatment and certainly not an example of the absence of professional medical standards. Expert witnesses confirmed that the best way to evaluate breast implants is with examinations. Routine MRIs are not

The court states, "A medical decision not to order diagnostic testing does not represent cruel and unusual punishment" (736 Fed.Appx. at 604).

Affirmed.

#### **Comment**

So long as deliberate indifference is the constitutional standard for evaluating correctional health care, it will remain difficult for federal courts to highly refine correctional health care. Keeping the lid on diagnostic tests, referrals to specialists and hospitalizations will keep costs down but all too often at the expense of early interventions. Preventive care will hardly ever be ordered in the correctional setting.

Fred Cohen, LLM, is editor of the Correctional Law Reporter. This article is reprinted (with minor modifications) from CLR with permission of the publisher. All rights reserved.

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Edited by Fred Cohen, LL.M., LL.B.

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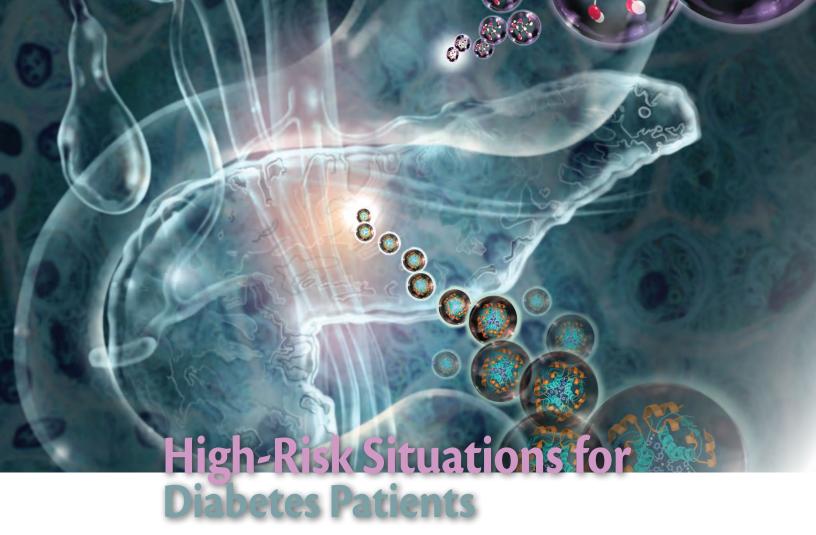
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by Ranee' M. Wright, MSN, RN, CCHP-RN, and Ambir L. Dorn, BSN, RN, CEN, SANE-A

he American Diabetes Association estimates that approximately 4.8% of the incarcerated population has diabetes. Although that might not seem like a lot, these patients can be tricky to manage. Caring for a diabetes patient in a correctional setting brings unique challenges. With the proper education for nurses, staff and the patient, serious complications can be avoided.

#### **Two Types of Diabetes**

Diabetes is an endocrine system disorder characterized by high blood glucose levels due to defects with insulin production or actions. Normally, the body changes food into glucose and the blood carries the glucose to cells throughout the body. The insulin "unlocks" the cell and allows the glucose in to be used for energy. Without insulin, the glucose stays in the blood, leaving the cell without an energy source. This can lead to many different complications.

Type 1 diabetes develops from an autoimmune disorder that attacks the cells in the pancreas. The pancreas stops making insulin or doesn't make enough. About 5% of all people with diabetes have type 1. It can occur at any age, but commonly presents under the age of 30. These patients must receive insulin from injections or an insulin pump to regulate the glucose in their bloodstream.

Symptoms of type 1 diabetes include frequent urination,

excessive thirst, extreme hunger, unintentional weight loss, extreme fatigue and irritability.

In type 2 diabetes, the pancreas does make insulin, but not enough. To supplement the deficit, either an oral medication or insulin is needed to assist in getting the glucose into the cells. Type 2 diabetes accounts for 90% to 95% of all cases. It has a gradual onset and generally occurs later in life. Some people can control it solely through diet and exercise. Since type 2 is associated with lifestyle factors that can be changed, patient education is important.

Symptoms of type 2 diabetes may include frequent infections, blurred vision, cuts and bruises that are slow to heal and tingling or numbness in the hands or feet. Often, however, there are no symptoms.

#### **Diabetes Treatment in a Correctional Setting**

Health staff and custody staff alike need to understand diabetes and the acute complications that may arise. In particular, both hypoglycemia and hyperglycemia can cause serious complications that require immediate treatment.

#### Hypoglycemia

The insulin and oral medications that are given to lower blood glucose levels could lower it too much, which would lead to hypoglycemia, a medical emergency. Symptoms of mild to moderate hypoglycemia include slurred speech, disorientation, tremors, sweating, light-headedness, irritability,

confusion and drowsiness. It is common to mistake these symptoms for alcohol or drug intoxication or stroke.

Typically, if recognized early, hypoglycemia is treated by consuming an instant form of glucose such as orange juice or candy accompanied by a form of protein such as peanut butter or milk. If not treated right away, or not treated effectively, it can become severe and life-threatening.

In severe hypoglycemia, a person cannot control their symptoms due to unconsciousness or cognitive impairment, or must be assisted by others. This would include patients who do not have their blood glucose meters, medications and/or snacks readily accessible and depend on correctional staff for assistance. Severe hypoglycemia can be quickly reversed with 10-15 grams of a fast-acting carbohydrate.

Symptoms of severe hypoglycemia may include inability to swallow, convulsions, unconsciousness and unpredictable and combative behavior. These behaviors can lead to a misdiagnosis if not identified quickly.

#### Hyperglycemia

Hyperglycemia is when the glucose in the bloodstream is not used and builds up, resulting in high glucose levels and cells without energy. Hyperglycemia can cause many symptoms and eventually lead to unconsciousness if untreated.

Symptoms of mild to moderate hyperglycemia include hunger, thirst and dehydration, headache, nausea, fatigue, blurry vision, frequent urination and itchy, dry skin.

Hyperglycemia can cause ketoacidosis, a condition that can lead to diabetic coma or death. Symptoms of ketoacidosis can be a fruity smell on the breath, which can be mistaken for the smell of alcohol. This could lead to a misdiagnosis and an inappropriate response.

#### **Correctional Nursing Implications**

Being mindful of the unique setting and events that can unfold in the correctional setting will help the correctional nurse. Remember to always be a patient advocate; this will be beneficial to the diabetes patient experiencing an acute complication. Recognizing that the behaviors exhibited are related to the diabetes and not behavioral or noncompliance issues is essential and potentially lifesaving. Also, patient education and custody staff education will assist in positive patient outcomes.

Patients who use insulin or oral medications may need snacks in order to avoid hypoglycemia. These snacks could be kept in the patient's cell or on the unit so they are readily accessible. If the snacks are in the medical treatment plan and prescribed by medical staff, there should be no concerns as to whether they will be allowed. Otherwise, the nurse could help the patient choose canteen menu for items to keep on hand until medical can evaluate.

When administering insulin or oral medications, the proper timing of meals will reduce the risk of hypoglycemia. This can be difficult because of the other duties the correctional nurse performs, but it is important. If the nurse is aware of the meal times, it can limit a potential risk for hypoglycemia.

#### **Patient Education**

Educating patients on diabetes-friendly food choices is the first step in helping them to control their blood glucose levels. They have little control over what food choices and canteen items are available, but with help and encouragement they can learn to make smart decisions. Again, the nurse might suggest options on the canteen menu that would be beneficial to have during a hypoglycemic reaction.

Educating patients on symptoms of low and high blood glucose is also important. Each person's symptoms may present differently. Having patients know their symptoms can result in quicker treatment in acute situations.

Teaching patients exercises that can be performed in the cells or recreational facilities will help in managing blood glucose levels. It is important to inform patients that if they suddenly become more active, they may feel hypoglycemic and might need to be seen by the clinician to tailor a new diabetic regimen for their lifestyle and body weight. Many mental health medications also affect body weight. These changes could affect the patient's treatment plan.

#### **Correctional Staff Education**

As a result of a 2003 court case for failure to provide appropriate care to people with diabetes, the Philadelphia Police Department and American Diabetes Association made a training video to assist law enforcement in recognizing the acute complications of diabetes that might present as a person under the influence of drugs or alcohol or being belligerent and uncooperative. (To view the video, search for "law enforcement training" at www.diabetes.org.)

Diabetes patients should always have access to prompt treatment of hypoglycemia and hyperglycemia. Correctional staff will be the first responder to the scene of an acute diabetic complication, and sometimes no medical staff member will be on-site. Training correctional staff on symptoms and interventions will improve patient outcomes and decrease the risk for misdiagnosis of a situation.

#### **High-Risk Situations Specific to Corrections**

dizziness

Most of the care we provide must be modified and tailored to meet the patient needs in the unique correctional setting. Looking at symptoms associated with hypoglycemia or hyperglycemia, it is evident that they could escalate a

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abdominal pain

Symptoms that resemble the effects of drugs or alcohol		
Characteristic	Hypoglycemia (< 70 mg/dL)	Hyperglycemia (≥ 240 mg/dL)
Onset	Rapid (minutes)	Gradual (days)
Mood	Labile, irritable, nervous, weepy, combative	Lethargic
Mental status	Difficulty concentrating, speaking, focusing, coordinating	Dulled senses, confused
Inward feeling	Shaking feeling, hunger, headache,	Thirst, weakness, nausea/vomiting,

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situation. From the fruity smell on the breath to the slurred speech, disorientation, irritability, confusion and unpredictable and combative behavior, these could all look like an uncooperative person who might be under the influence of drugs or alcohol. The following situations are already high risk without adding those symptoms to the mix.

#### Lockdown

A lockdown situation can cause meals to be delayed or different menu items to be provided. Patients should be encouraged to monitor their symptoms, and there should be a plan on how to provide snacks or a meal substitute if they have already taken their insulin. During this already stressful time, correctional staff must be aware that the symptoms of hypoglycemia can be behavioral.

#### **Religious Activity**

At times, a diabetes patient may fast or take medications at different scheduled times for religious purposes. A plan between the provider, patient and correctional staff will enable the patient to engage in religious practices without acute complications. Involving the chaplain might be beneficial, as is communicating with all staff to be cognizant of this high-risk situation.

#### Segregation/High Management Units

When diabetes patients are transferred to a segregation or high management unit, it is important to consider whether their diabetes regimen needs to be changed. For example, the canteen may no longer be available for hypoglycemia incidents, or they might not consume the same number of calories nor have the same energy expenditure throughout the day. Educating correctional staff on the behavioral symptoms of an acute diabetic complication will get medical attention more promptly. Monitoring and communication with the patient, provider and nurse is essential.

#### **Hunger Strikes**

A common high-risk situation that arises is hunger strikes. The practitioner should carefully evaluate the patient's diabetic regimen by, and staff should be aware of the acute complications related to hypoglycemia. The patient should be educated on all symptoms and complications related to

hypoglycemia. Nondiabetic patients also might exhibit signs of hypoglycemia, so correctional staff should be aware of potential changes in behavior and nurses should be ready to perform a blood glucose test in the event of a medical emergency whether or not the patient has diabetes. Again, communication between medical and correctional staff will improve patient outcomes.

#### **Gastrointestinal Illness**

Given the confined spaces in jails and prisons, it is not uncommon for a gastrointestinal illness to wreak havoc in a facility. The recommendations for hunger strikes also apply in these situations.

#### Infection

From skin infections to respiratory infections, battling against invading bacteria or viruses can cause blood glucose to rise dramatically. If left untreated, this can lead to diabetic. Patients suffering from respiratory illness, acute or chronic, are often prescribed steroids. Steroids are notorious for causing significant spikes in blood glucose levels. Providers must take this into consideration before prescribing the steroid or make temporary changes in blood glucose management during the period of steroid use.

#### **Insulin Syringes/Pumps**

The supplies needed for diabetes management could be considered contraband and a "sharp." Facilities need a consistent procedure for documenting the syringes, lancets and even insulin pumps that patients need. Insulin pens could be used to lessen the need for syringes.

#### **Tasers**

The American Diabetes Association reports a potential for adverse effects of tasers because of the force on the endocrine system on someone already compromised. However, there are no published studies on the use of tasers on a person with an acute diabetic complication.

Ranee' M. Wright, MSN, RN, CCHP-RN, is a nurse clinician at the Wisconsin Resource Center, Winnebago, Wl. Ambir L. Dorn, BSN, RN, CEN, is an emergency department supervisor at the Aurora Medical Center, Oshkosh, Wl.

#### You are a nurse in a large correctional facility . . .

Your patient, Mr. Beta performs Accu-Cheks daily and, based on his reading, gives himself a short-acting insulin before meals. You meet with him weekly to review his log and ensure that he is managing his diabetes adequately.

Although you've worked with Mr. Beta for a year, he did not talk much and always seemed upset. Recently he has been engaging more and has a brighter affect. You ask about his medications and he says that he was finally prescribed an antidepressant that helps get him out of his cell more. Mr. Beta has been spending time in the rec yard playing basketball and walking.

Since he is logging his Accu-Cheks four times a day and documenting his insulin intake, you have no concerns as he has not reported any symptoms. You tell him to keep up the good work.

The next day right before lunch, the facility goes into lockdown and inmates are returned to their units. Since Mr. Beta had already given himself insulin, he needed to eat something.

Concerned about the lockdown and meal time, you notify correctional staff that the diabetes patients need to eat something to prevent hypoglycemia, and that having them

wait any longer if they had already taken their insulin would be risky. The patients receive a meal substitute in their cells immediately.

The following week, Mr. Beta says that he was starting to have symptoms of hypoglycemia and that he feels like that more often now but has not said anything.

You discuss with the practitioner possible changes to Mr. Beta's diabetes regimen now that he is more active and exercising. The practitioner agrees and makes the changes. At the next clinic, Mr. Beta reports that everything is going well.



Correctional healthcare is public healthcare. At Centurion, we believe the healthcare services we provide to inmates are an essential part of rehabilitation and the health of the community at large. Our innovative model delivers real managed care services by combining evidence-based, integrated healthcare services with modern managed care practices that ensure quality and efficiency. We engage inmates in their personal health and work towards a seamless connection to resources in the community so they re-enter society with a better chance of long-term success.



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# Transforming Our Approach to Chronic Pain Patients

by Jeffrey Keller, MD, CCHP-P

ne of the most fearful and frustrating events in my correctional medicine world used to be when a new chronic pain patient would arrive in my clinic. A typical patient would be a "Ralph," a middle-aged man who has had chronic back pain for many years. Ralph has had a couple of back surgeries, stimulators and various steroid injections, none of which has been effective. He arrived at the jail taking a long list of sedating medications such as muscle relaxers, gabapentin and sleeping aids, plus, of course, big opioids. In addition, Ralph has alcohol abuse issues. The reason he is in jail is a felony DUI charge. Now he is in my medical clinic, looking expectantly at me. How am I going to fix his pain problem?

The answer, of course, is that I am not. I am not that smart. He has already seen lots of doctors, including pain specialists and surgeons, who have tried almost everything that can be tried and they have not fixed his chronic pain problem. I'm not going to be able to, either.

In my opinion, the most common and serious mistake made in the treatment of chronic pain in corrections is when we imply that we can eliminate chronic pain. It is an easy trap to fall into; it works like this. Ralph will say, "I have chronic pain. You are now my doctor. What are you going to do about my pain?" And I would reply something like, "Well let's try X." "X" could be NSAIDs, gabapentin, duloxetine—anything really. What Ralph understands, though, is that whatever I have prescribed should reduce or eliminate his pain. Why else would a doctor have prescribed it?

But, of course it does not eliminate Ralph's pain. How often has one of your chronic pain patients come back to you and said, "Ya did it, doc! After years of chronic pain, that meloxicam prescription finally did the trick!" None of mine have ever said that, either.

No, inevitably, Ralph will say, "I'm still having pain." "Well, let's try Y then," I'll say. Of course, "Y" won't work to eliminate his pain, either. Repeat this pattern a couple more times and a severely dysfunctional dynamic has been firmly established. Since nothing I prescribe works, Ralph suspects I am not competent. A better doctor would have figured this out! Eventually, Ralph and other chronic pain patients become frustrated, angry and distrustful. The clinical encounters become adversarial and unpleasant. We doctors dread seeing these patients.

#### **The Wrong Treatment Goal**

But it does not have to be this way! The root problem here is that, without meaning to, I have set the wrong treatment goal for my patient Ralph, a treatment goal that I cannot achieve. I cannot eliminate Ralph's chronic pain. I should not imply that I can.

According to a great article published in the *Journal of the American Medical Association* titled Primary Care of Patients With Chronic Pain (June 20, 2017), I need to have a long conversation with Ralph in which I make clear that

elimination of his pain is not likely to happen. Instead, he and I need to focus on his lifestyle and keeping him active.

The article authors say, "The primary goal of caring for the patient with chronic pain is not the elimination of pain but the improvement of function."

This simple sentence has totally transformed my approach to chronic pain patients. The result has been that we get much more accomplished, I don't dread seeing them

and they are happier. My chronic pain patients and I are no longer adversaries.

Now, when I see chronic pain patients like Ralph, the first thing I do is come right out and say, "I am not going to be able to cure



your chronic pain. No one can cure most cases of chronic pain. If I could cure chronic pain, I wouldn't be here—I'd be spending my millions of dollars on some beach in the Caribbean" (that usually gets a laugh). "To some degree, you're going to have to learn to live with your chronic pain. I will help you with this."

We will then discuss Ralph's level of activity. If he is the Most Valuable Player in the prison basketball league, I probably have little to offer him. (Don't laugh; this was an actual chronic pain patient.) More likely, we will set a goal of improving his activity level. If he is in a wheelchair, I want him using a walker. If he uses a walker, I want him to progress to a cane and so on. For most of my chronic pain patients, I mainly want him not to vegetate in his cell. I want him walking in his dorm and in rec. I'll ask Ralph to track how much he walks and report back to me. I want him to increase his range of flexibility, as well.

#### **A Multidisciplinary Treatment Approach**

What I have asked Ralph to do is hard work and he will need help. One of my jobs is to get him this help by asking my colleagues for their expertise. The formal term for this is "a multidisciplinary approach to chronic pain."

For example, many (if not most) chronic pain patients have a mood disorder, usually depression, because dealing with chronic pain can weigh one down. I'll arrange for Ralph to see a mental health professional. Ralph and most other chronic pain patients should also see a physical therapist, and so I'll arrange that, as well. Cognitive behavioral therapy can be thought of as formal instruction on techniques for dealing with incessant chronic pain. CBT has been shown to improve function in chronic pain patients and is well worth the effort to set up at your institution.

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'The primary

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tion of pain but

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the improvement

# Surviving Your Job With Style Rule #1: Refuse to Be a Victim

by Susan M. Tiona, MD, CCHP

In her upcoming book, "Correctional Health Care: Twenty Rules for Surviving With Style," Dr. Tiona offers sage and practical advice on forging your way through a smart, successful and satisfying career in correctional health care. Applicable to a range of health care disciplines and experiences, these rules encapsulate the emotional, professional, and cognitive complexities of the worst job you'll ever love.

ou can't survive a career in correctional medicine if you are OK with being a victim. Inmates will make your life miserable, and you will compromise yourself and your coworkers in the process. Do not be so naïve as to think that it can't happen to you. If you've worked in a correctional facility, it probably already has.

You become a victim when an inmate manipulates you into giving him something that is not medically necessary. The motive behind the manipulation may never be fully understood, and it doesn't really need to be. You just need to know how to recognize it and how to handle it.

The additional challenge is that while you are working hard not to become a victim, you have to remember that even the antisocial, manipulating victimizer can get sick. Always maintain the balance between protecting your personal integrity and providing objective medical or nursing care.

The reason for the victimization problem is the inherent makeup of the incarcerated population. It is estimated that 70% to 80% of male (and about 40% of female) incarcerated people have some degree of antisocial personality disorder. In contrast, the prevalence of this disorder in the community setting is 5% and 1%, respectively. The explanation for this fact is simple: People with ASPD tend toward criminogenic behaviors, so they end up in prison, where the prevalence is thusly disproportional. The implication for correctional health care providers is that people with ASPD (hereafter abbreviated PWASP) are master manipulators, and they use this skill to victimize.

The PWASP is often charming and appears to be intelligent (although perhaps only criminally so), and seems ohso-nice when first encountered. This is because the PWASP is initially on a fact-finding mission. You are being sized up. Are you gullible? Are you naïve? Do you hate to say "no"? Do you want to be liked? Do you avoid conflict? Are you new to the correctional setting? Having any of these traits makes for a potential victim; have more than one, and you are very likely to be a target.

#### **An Unintended Game of Wits**

Don't take it personally, though. Victimization is a way of life for the PWASP. This is what they know and have practiced relentlessly, even from the first time that Authority said "no" and they did it anyway. It's their way of satisfying

their very innate self-centeredness that makes them believe that only their feelings and needs count, and all others are just pawns to be played. But they also know that they have to present themselves as something completely different, or they won't be successful at the game. And this is your challenge—recognizing that you are the opponent in an unintended game of wits.

Being aware that you are a participant in the game gives you your first chance at survival. But why worry about it? It takes a great deal of mental strength to spar with the PWASP at every encounter. It would just be easier to give in. What's the harm in ordering the special pass for med line, or the extra mattress, or the knee brace, or that particular medication that he requests by name? When the requests are medically unnecessary, the harm is the end result: You have become his next victim.

But it does not stop with you, because the victimization passes down the line: to the correctional officer who has to allow the PWASP to cut to the front of the line, even though it's obvious that he doesn't need the privilege; to the housing officer who has to give the PWASP the extra mattress, even though it's against policy; to the medical assistant who has to issue the knee brace, even though he

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#### Beware the Diagnosis of 'Malingering'!

Try looking up the word "malingering" in the DSM-5 index. You won't find it, unless you know to look in a miscellaneous section titled "Other Conditions That May Be a Focus of Clinical Attention" near the end of the book on page 726. For a diagnosis that is given cursory attention in the "bible" of mental disorders, we sure seem to give it disproportionate attention in correctional health care.

In reality, though, whether or not a person carries this diagnosis is immaterial. It should not matter one iota in our objective evaluation and management of that person's day-to-day health care needs. Victimizing through manipulation is a behavior to which we must objectively respond. Malingering, on the other hand, is a diagnosis with uncertain clinical importance and doubtful practical relevance. We would do well to disregard it.

knows the PWASP will be going straight to the recreation yard to do lunges down the length of the football field; and to the nurse who has to repeatedly dispense the ill-gotten medication, even though she knows the only necessity he has for it is to augment his income in the yard.

Even if you think you are OK with the outcome—"It was just this once, and I was so tired of dealing with him"— there is still that nagging voice and that uncomfortable gut feeling that you've been had. You try to rationalize it, but it just won't go away. And if you don't have this nagging feeling, then you really should rethink your journey in correctional health care. Otherwise, not only will your own integrity be compromised, but you, too, will unwittingly become a victimizer.

And being a victim is not a one-time deal. In fact, this PWASP has emerged victorious and he is gloating in his glory, even as you are feeling sick about giving in. But don't worry, the PWASP assures you that you are the kindest and most competent provider at the facility; that you have been able to help him when no one else could; that you are the only provider he will allow to take care of him in the future. In his mind, he's the best, and you should be honored to have him as your patient.

Rest assured, the PWASP who has been successful in manipulating you is all too happy to share his story. Your weakness has been exposed, and now the game is on for every other PWASP in the facility who wants something. And this becomes your daily lot—dodging arrows of manipulation that are being shot continuously at that big, red target on your back.

#### **Maintain Control**

The key to refusing to be a victim is recognizing your own personality traits that might set you up for vulnerability. First, you have to be up to the challenge of mentally sparring with your PWASP opponent at every encounter. It's unavoidable. If you are not the sparring type, you need to learn to be. Always be one step ahead of the PWASP.

Every statement that the PWASP makes should go directly through the filter in your brain that asks, "What is between the lines on this one? If I agree with him, where is he going next?" It's like a game of chess, but you need to mentally keep track of where all the pieces are, and how his move is going to affect the outcome of the game three moves from now. If you find yourself getting tired, then end the appointment. That's one privilege you have in correctional health care. When you're done, be done.

Second, you have to accept that this patient may not like you. You may just need to say "no" to a request if the request is not medically indicated or against policy. If you don't give him what he wants, the chances are very good that he's going to say something objectionable about your character or your ability to practice medicine.

But knowing that he won't take kindly to your rebuffs doesn't mean you can't be compassionate and professional. In fact, it is even more important with the PWASP patient to maintain control of the encounter at all times, and this means monitoring your own reaction to the dialogue. If you find yourself being anything but calm and patient, it's time to end the appointment. Just let him know that you don't think the encounter is being productive, and you'll call him back another day.

Third, and probably most important, it's OK to listen, and even to give the tacit impression that you agree with the discourse. Nod, acknowledge, smile honestly, remark "that's interesting." Nothing says the encounter has to be confrontational. The PWASP will fly-fish as long as you allow it, and just when he is ready to sink the hook, you dodge. Your response is rehearsed, and protects your integrity: "I want to help you, but I can't honor your specific request. What I can offer you, however, is ..."

#### **Due Diligence**

If accepted, you've established yourself as one that cannot be played, and you've made a major breakthrough in your provider—patient relationship with this person. If rejected, you've still done your due diligence in offering appropriate medical care, and you can't be blamed for the rejection. Either way, you have refused to be a victim, and that is the right thing.

Of course, this brings me to Rule #2: You will be sued for doing the right thing. But that's a topic for another time.

Susan M. Tiona, MD, CCHP, has practiced medicine in the correctional setting since 2004. She is the former chief medical officer for the Colorado Department of Corrections and is currently a telemedicine provider for CoreCivc, as well as providing expert witness services and pursuing a master's degree in forensic psychology.

# Pregnant and Imprisoned: Some Outcomes Improve, But More Research Needed

s a population, incarcerated women commonly have well-known characteristics and afflictions: poverty, mental illness, substance abuse, minority status, low employment, homelessness, victimization, poor health, a lack of safety nets.

When pregnancy is part of the picture, we can add limited (if any) prenatal care and inadequate nutrition to the list of disadvantages and risks. Each of these conditions can have a negative impact on perinatal outcomes, contributing to preterm birth, low birth weight and neonatal abstinence syndrome (i.e., opioid withdrawal in the newborn).

In the April issue of the *Journal of Correctional Health Care*, Brenda Baker, PhD, RNC, CNS, reviews the research literature on perinatal outcomes for pregnant women in prison and areas for policy development aimed at improving perinatal outcomes for this population and their children. Baker is an assistant professor at Emory University's Nell Hodgson Woodruff School of Nursing as well as a hospital labor and delivery nurse.

The study purpose was to examine the perinatal outcomes of premature birth (less than 37 weeks), low birth weight and maternal mental health well-being—focused on depression, anxiety and mental health diagnosis—in women who gave birth while in prison in the United States or within a year after incarceration. The literature search encompassed publications from 2006 to 2016. Ultimately, nine articles that met the study criteria, including a study quality rating, were reviewed.

#### The Findings

Baker found that maternal mental health well-being was the most frequently studied topic in the articles reviewed. "[T]he studies provided evidence that incarcerated pregnant women are younger at first pregnancy, have more children than average, have limited social support, and face unique health and social issues compared to the general prison population," she writes. Findings concerning mental health status were inconclusive, Baker says, "but suggest significant risk to maternal role development when mother and infant are separated."

Concerning birth weight, the research shows a positive association with gestation at time of incarceration: Women who entered prison earlier in pregnancy delivered infants with higher birth weight. One study that captured data for 267 newborns in Texas found a statistically significant increase in mean birth weight with each additional prison prenatal visit when mothers entered prison in the first trimester; this association was not observed when incarceration occurred after the first trimester. A second study by the same researchers using the same data found a positive influence of earlier prenatal care for White women, but not for Black or Hispanic women. And the third study in the series found that infant birth weight is most improved when incarceration began in the first trimester and is not significantly influenced when incarceration occurs later.

For the third outcome of interest, preterm birth, no U.S. studies were identified.

#### 'Tragic Irony'

Although this small group of studies point to incarceration as improving birth weight outcomes due to conditions of confinement (e.g., safety, nutrition, prenatal care, absence of substance use), Baker describes this as a "tragic irony" and cautions that these outcomes do not reflect the pre- or postincarceration lives of these women, and that prison does not change the social conditions of their lives outside—conditions that commonly lead to recidivism.

She calls for rigorous, systematic research to support the development of policies related to services needed and models of care in order to improve outcomes.

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- Perinatal Outcomes of Incarcerated Pregnant Women: An Integrative Review
- Brenda Baker, PhD, RNC, CNS
- The Global State of Harm Reduction in Prisons
- Gen Sander, LLM; Sam Shirley-Beavan, MA; Katie Stone, MSc
- Substance Use Risk Indicators and Offending Patterns Among Local Jail Inmates
- Albert M. Kopak, PhD; Alyssa L. Raggio, MS; Norman G. Hoffmann, PhD
- Family Practitioner-Directed Hepatitis C Therapy With Direct-Acting Antivirals Achieves High-Sustained Virologic Response in Prison Population
- Sameera Mokkarala, MD, MPH; Cole Johnson, BS; Souvik Sarkar, MD, PhD; Robert J. Rudas, MD
- Prevalence and Correlates of Disability Among a Sample of Victimized Women on Probation and Parole
- Kirsten E. Smith, MSW; Amanda M. Bunting, MA; Seana Golder, PhD; Martin T. Hall, PhD, MSSW; George E. Higgins, PhD; T. K. Logan, PhD
- Cryptosporidiosis Outbreak Investigation in a Canadian Correctional Facility Using Novel Case Finding Tools
  - Jannie Wing-Sea Leung, MSc; Joyce Cheng, MPH; Florence Tanguay, MSc; BeLinda Roscoe, RN, BN; Donna Davies, RN; Susanna Tinney, RN; Avis Lynn Noseworthy, MD, MHSc, FRCPC; Anne Marie Holt, MHSc; Amy McCully, MScN, RN; Vidya Sunil, DVM, MSc
- Saskatchewan Provincial Correctional Nurses: Roles, Responsibilities, and Learning Needs
- Cindy Peternelj-Taylor, MSc, BScN, RN, DF-IAFN; Phil Woods, PhD, RPN, RMN

JCHC offers continuing education credit through an online self-study exam. Academy of Correctional Health Professionals members receive JCHC as a member benefit and Certified Correctional Health Professionals receive a complimentary online subscription.

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### Small Facilities Eligible for Federal Funds to Implement PREA Standards

The Department of Justice's Bureau of Justice Assistance is offering funding from \$20,000 to \$200,000 to help small, local correctional agencies implement the Prison Rape Elimination Act standards and increase the sexual safety of their facilities. This opportunity is offered through Impact Justice, the nonprofit that runs the PREA Resource Center.

Provided through the PREA Targeted Implementation Planning and Support (PREA TIPS) program, the funding is available for small and medium locally operated jails, juvenile facilities, community confinement facilities, lockups and tribal facilities with fewer than 500 beds, although the target is facilities with fewer than 200 beds. The program focuses on project design and implementation support.

This funding is available for facilities just beginning on the road to PREA compliance as well as those that have already had a PREA audit. Multiple agencies or small- to medium-size facilities collaborating within a region are also eligible to receive funds as a group.

PREA TIPS has a quick and easy application process. Applicants need not have a highly developed plan on how the money will be spent, but must be able to describe where they are in the process of PREA implementation, create a simple budget and have the support of the facility's or agency's leadership.

Impact Justice will deliver a webinar with detailed instructions on how to apply in spring 2019. Learn more and find the application at www.prearesourcecenter.org.

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### Readerresponse

To the Editor:

I was glad to see the article on health care lawsuits by Beth Boone in the Fall edition of *CorrectCare* [Anatomy of a Health Care Lawsuit: Issues and Strategies in Your Defense, Vol. 32, Issue 4]. Having been on the receiving end of numerous lawsuits during my 12 years at the Colorado Department of Corrections, I wish I had seen this article at the start of my tenure.

The insights on the anatomy of a lawsuit in a correctional medicine setting should be helpful for all the readers, and I thank Ms. Boone for taking the time to do it.

In my capacity as a medical expert for correctional medicine issues I see the same things that the author addresses all too frequently. Thanks for shedding a little light on the process.

Sincerely yours, J. William Wright, MD, CCHP-P Colorado Springs, Colorado Bill@MDCorrections.com

#### Chronic Pain (continued from page 12)

I'll also use medications, but medications must be tied to increasing function. If I prescribe gabapentin, say, it will be tied to a specific objective goal, such as walking with a walker instead of using a wheelchair, or flexibility that I can easily measure in my clinic. If the objective goal is not met, the medication has failed and will be stopped.

One great advantage of this approach is that I can objectively measure how well Ralph is doing. By using function as a goal, I can verify whether Ralph has reached his goals. Notice also that I am no longer responsible for Ralph's pain. Instead, I am giving him resources to help him manage his own problem. The shift in responsibility here is huge!

I can tell you that this shift in approach to chronic pain has made me a much more effective physician to my chronic pain patients.

Jeffrey Keller, MD, CCHP-P, is the medical director of Badger Medicine, Idaho Falls, ID. He also write two blogs: JailMedicine and Doing Time: Healthcare Behind Bars. Contact him at jkeller@badgermedicine.com.

For more on this topic, see the NCCHC position statement on Management of Noncancer Chronic Pain at www.ncchc.org/position-statements.

# **CCHP**page

# USPHS Commissioned Officer Earns NCCHC's Highest Certification: CCHP-A

by Katie Przychodzen, MA, CCHP

isty Rios, APRN, FNP-C, CCHP-MH, CCHP-A, joined the elite ranks of Advanced CCHPs on January 1, after taking the exam at the National Conference on Correctional Health Care last October. An 18-year veteran of the field, she had already earned basic CCHP and specialty certification, but she did not stop there. When asked what made her pursue advanced certification, she says, "It shows my dedication to progress and excellence in correctional health care."

#### **Professional Growth Through the Years**

Rios' first job in correctional health was with the Oklahoma Department of Corrections in a one-year drug offender program in a small, rural town. Upon receiving her commission with the U.S. Public Health Service in 2006, she was assigned to the Federal Bureau of Prisons. For the next 11 years, she worked in three BOP facilities in three states, first as a registered nurse and then as family nurse practitioner after completing her advanced degree and earning national board certification.

In 2016 Rios transferred to the Immigration and Customs Enforcement Health Services Corps, where she now serves as the health services administrator for one of the largest IHSC facilities in the country. As HSA, she is the designated health care authority overseeing all medical, dental and mental health operations for the facility, including medical staffing and meeting NCCHC accreditation standards.

The facility houses 1,850 adult male and female detainees and provides 24-hour medical care. In addition to treating conditions often encountered in the community at large—such as hypertension, diabetes and HIV—the medical staff also see a large number of detainees with substantial trauma histories, resulting in an increased need for mental health interventions.

#### From Basic to Specialty to Advanced

Rios learned about the CCHP program at her first NCCHC conference and became excited at the prospect of demonstrating her expertise in this "unique and specialized field of medicine" through certification. She earned her CCHP in 2013 and her CCHP–Mental Health credential in 2014. Last year she decided to challenge herself even further by taking the CCHP–Advanced exam.

She believes correctional health professionals should be proud of the work they do and should continually seek ways to help improve the field. "Earning CCHP status is one way to do this," she says.

For Rios, along with the personal satisfaction that comes

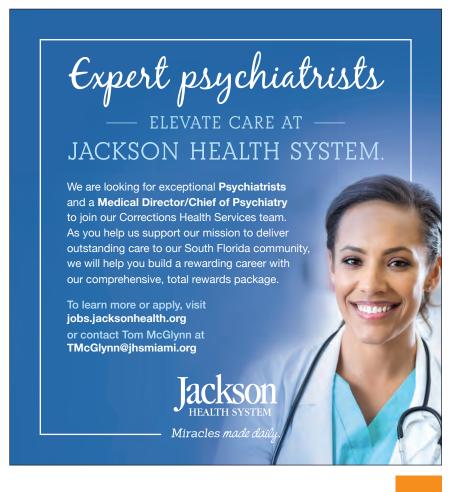
with bettering the field, rising through the CCHP ranks has resulted in achieving professional milestones. Rios says certification has played a significant role in developing her career: "I believe the CCHP credential has helped advance my career by better preparing me to accept positions with higher levels of responsibility," she says. "It has given me the confidence to seek these positions and to take on whatever challenges I encounter along the way."

CCHPs are eligible to apply for the CCHP-A exam after being certified for at least three years in the basic program. The advanced CCHP program is designed to gauge experience in and knowledge of the delivery of health care services in correctional settings. It requires the completion of a detailed application and a passing score on a proctored essay examination.



Misty Rios

Katie Przychodzen, MA, CCHP, is marketing and communications manager for NCCHC. To learn more about the CCHP-A credential and to apply, visit www.ncchc.org/cchp-a.





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#### Who Attended in 2018?

Mental health directors	33%
<ul> <li>Mental health services staff</li> </ul>	33%
Pharmacy directors	8%
Department managers/supervisors	8%
• Other	18%

#### **Categories Attendees Recommend or Buy**

- Education and training
- Mental health services
- Mental health care staffing Pharmacy services
- Pharmaceuticals
- Substance abuse treatment
- Screening and assessment Suicide prevention • Electronic health records • And much more!

#### **Benefits of Exhibiting**

Exhibitors at the Correctional Mental Health Care Conference receive the following:

- Free company listing with 25-word description in the official printed final program and online community
- One free staff full conference registration, including up to 15 continuing education credits
- · One full conference registration for an additional staff member at 50% off
- Preshow and postshow attendee mailing lists
- Exclusive opportunity to become a sponsor or advertise in preshow and on-site materials

To promote the conference, NCCHC conducts a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, web banners and direct outreach.

#### **About the Conference**

This sharply focused gathering features two days of concurrent sessions on today's most pressing mental health issues, along with networking and information-sharing events.

- Get the latest information from correctional mental health experts
- Discover innovations in mental health care research, delivery and treatment
- Find out how facilities are overcoming budget constraints while maintaining quality services
- Meet colleagues from all over the country

"The traffic to the exhibit hall was incredible. Kudos for high attendance." - past exhibitor

#### **Become an Exhibitor Today!**

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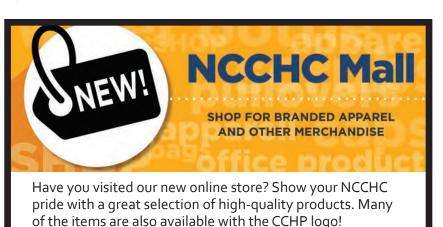
For information or to access listings, visit http://careers.correctionalhealth.org.

#### **MARKETPLACE**

#### **Standards for Opioid Treatment Programs**

These standards present the requirements for OTPs seeking NCCHC accreditation. This second edition adheres to the Substance Abuse and Mental Health Services Administration's 2015 Federal Guidelines for Opioid Treatment Programs and takes into account the issues

unique to correctional settings. The OTP Standards address the general areas of patient care and treatment, clinical records, governance and administration, personnel and legal issues. 2015. Softcover, 141 pages. \$69.95. Order at www.ncchc.org/ncchc-store or call 773-880-1460.



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# Standards Q & A

### Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

#### **Site-Specific Emergency Plans and Drills**

Standard D-07 Emergency Services and Response Plan for jails and prisons requires that mass disaster drills are conducted so that each shift has participated over a three-year period. This is what our jail has been doing. However, a new jail has been constructed, and the old one no longer houses inmates. We rehearsed the new disaster plan in the old building about four months before moving into the new one. Can we count that rehearsal as a drill or must we have another drill in the new building?

The intent of this standard is to ensure that all staff are prepared to effectively respond during emergencies. Some considerations in a good mass disaster plan can be verified only by rehearsing the plan within the specific environment. For example: Does everyone know where the emergency equipment and supplies are? Is the equipment operable? Are the needed supplies available? Where will triage be performed? Where will injured peoples be taken? If not on duty at the time of the disaster, which members of

the health staff will be called? Will security measures, such as automatic doors, impede transport of casualties? The layout of the building and the security measures may be different, necessitating new procedures that differ from what was envisioned before the facility opened.

Although classroom exercises and staff discussions can be useful, they are not sufficient to meet this standard. Therefore, another drill should be held in the new facility.

#### **CQI Program Development Tips**

As the health service administrator of a large jail, I have been asked to develop a continuous quality improvement program as we prepare for NCCHC accreditation. Can you give me some guidelines on where to start?

It is good to hear that you are preparing for NCCHC accreditation. A continuous quality improvement program (standard A-06) is essential as you make changes in your system. However, you may already have some of the elements of a CQI program in place, but you may not be thinking of them as CQI.

For example, does your facility have a grievance process for health care complaints? If someone is keeping track of the grievances, you may be noticing a pattern that could indicate an aspect of your services that needs improvement. Are you receiving environmental inspection reports? Do the same issues keep appearing in the reports? Are you noticing inmates from a particular housing area presenting at sick call with similar complaints? This could indicate that either a contagious condition is spreading in that unit or something in the environment is causing the problem.

Many of the ordinary, day-to-day activities of a facility, including monitoring compliance with NCCHC standards, fit nicely into a CQI program. Other areas that could be monitored in the CQI program are high-risk, high-volume, problem-prone aspects of the various services provided: medical, dental, mental health, pharmacy, food service, disaster readiness, etc. Just keep in mind that CQI is more than just monitoring. You are looking for areas to improve (i.e., areas that are falling below threshold levels). Those areas could be turned into the CQI process or outcome studies that are required in standard A-06.

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

For in-depth instruction on the standards, attend one of the preconference seminars that are offered at NCCHC's Spring and Fall conferences.





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excellence, commitment and contribution to the field of correctional health care and their relative discipline or profession. Advanced certification requires at least three years of participation in the certification program, and demonstration of extensive experience in and 360-degree knowledge of correctional health services delivery.

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