

CorrectCare[®]

The magazine of the National Commission on Correctional Health Care

Implants and Sensors and Bluetooth, Oh My! What Are the Security Concerns?

*Drugs of Abuse: What
Nurses Need to Know*

*Tips to Help Your
System Prepare for an
Accreditation Survey*

*The Practical Power of
Academic-Corrections
Partnerships*

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



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Cover design by Jill Cooper

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Farewell, but Not Goodbye

For 19 years, it has been my privilege to serve as editor of *CorrectCare*. When I joined the National Commission in February 2001 I was an experienced writer and editor, having done just that at the American Hospital Association for 10 years. But I was totally green about correctional health care. You'd



Your departing editor

think the topic might come up from time to time in the context of hospital emergency care or secure units, but nope.

So I relied on my coworkers (thanks Ed Harrison and Judy Stanley!) to show me the ropes, and on our extraordinarily kind, helpful, thoughtful and dedicated constituents to share their stories. My first interview subject was John Miles, MPA, with whom I would soon embark on a close relationship when he became editor of NCCHC's *Journal of Correctional Health Care* and I became its managing editor—positions we still hold.

Over the course of planning, writing, editing, designing and proofing 76 quarterly issues of *CorrectCare*, I have learned so much about the field of correctional health care, the challenges our readers face and the innovative ways they are tackling these challenges. I've been fortunate to work with hundreds of contributors, many whose bylines appeared in these pages and others who assisted me in other ways. I am grateful for every one of them.

Where am I going? Not far ... I will continue my work on JCHC and will edit

every edition of the *Standards* manuals (if you see a typo, mea culpa!). But my role is evolving as I pursue my interest in standards, policy and research. This year I became staff liaison to NCCHC's juvenile health and policy and standards committees, supporting them in developing position statements and other important resources for the field. I'm also lending a hand at NCCHC Resources, Inc., our consulting subsidiary.



Your new editor

Drumroll ...

And now I am delighted to introduce you to Barbara S. Granner, CCHP. Barb joined NCCHC five years ago as marketing and communications manager and today tacks on another title: *CorrectCare* editor. You've already experienced her talent in myriad mediums: CCHP profiles in this magazine, articles in *Corrections.com* and elsewhere, social media posts, conference promo, event photographs, the gorgeous annual reports, the graceful opening ceremonies at our fall conferences. Barb was the behind-the-scenes wizard who corralled the half dozen contributors to the Suicide Prevention Resource Guide and whipped it into shape. She even took on conference Raffle Diva duty after I hung up my tiara!

I truly cannot say enough good things about Barb. With her at the helm, *CorrectCare* will flourish, infused with her creativity, wisdom and wit. I am excited to see where she takes it.

Thank you all for your support over the years.

With warm regards,
Jaime Shimkus, CCHP



The first issue of *CorrectCare* that I edited, Spring 2001. It was a broadsheet "newspaper" then, drab with little color. We redesigned to trade magazine style in 2007. What comes next? Let us know your thoughts. Write to editor@ncchc.org.

Calendar of events

- March 25** CCHP exams, Galveston, TX
- April 3** Accreditation Committee meeting
- May 2-5** Spring Conference on Correctional Health Care, Atlanta
- May 3** CCHP exams, Atlanta
- May 3** Accreditation Committee meeting
- July 18** CCHP exams, Denver
- July 19-20** Correctional Mental Health Care Conference, Denver

See the list of all CCHP exams at www.ncchc.org/cchp.



CorrectCare Is Getting a Sibling! A fast, sleek, smart little sister

Announcing *CorrectCare Extra*, NCCHC's new e-newsletter! We've expanded the print publication to reach correctional health professionals more often and more easily. In our fast-moving field, it's important to connect with you more regularly to share news affecting your work and your patients. *CorrectCare Extra* is emailed to 21,000+ correctional health professionals every other week—26 issues a year—to keep you informed of industry news and important NCCHC updates. The e-newsletter uses artificial intelligence to deliver the most pertinent news to each individual reader, based on their past newsletter reading preferences.

If you have not received it in your inbox, sign up today at www.ncchc.org/CorrectCareExtra. To receive ALL news and information from NCCHC, log on to your account at my.ncchc.org and make sure we have your email address.

Showing Up to Advocate for Our Patients

by Robert E. Morris, MD, CCHP-P

When I first started going to NCCHC conferences, I asked former president Ed Harrison, "How do I join NCCHC?" He told me, "You don't join, you just show up."

Thank you for showing up every day for your patients and providing them with the best possible health care. They are some of the neediest, most frightened people in society, and need the unbiased, supportive care we can provide.

We also can show up by advocating for the welfare of our patients, beyond what we traditionally think of as direct care.

I have spent my career focused on juvenile justice and health care. We know so much more now than we used to. We understand that PTSD is much more than something experienced by war veterans. We know that many of our patients are victims of trauma. We know that the majority of detained youth suffer from multiple adverse life experiences that result in PTSD. We know that a childhood history of parental incarceration and juvenile justice involvement is associated with mental health conditions later on. We know that all of our patients are likely to have experienced many of these ACEs—adverse childhood experiences.

We can't change that reality. We can't change the past. But we might be able to do more than we have been doing.

What More Can We Do?

For instance, we can advocate for at-risk children while they are still young and not in the criminal justice system. How? Talk to the adults in our care about their kids. How often do they see them? Who is caring for them? Is there a plan vis-à-vis the family for when they are released? Do they know the possible negative long-term effects of having an incarcerated parent? You might even suggest that your patient talk to the other parent or guardian about mental health interventions for the children.

Likewise, if you talk to your patient's family, ask about the children. How are they doing? This is another opportunity to bring up mental health care for them—an opportunity for early intervention.

Although progress has been made, the rate of juvenile confinement in the United States is still three to five times higher than in any other country in the world. A lingering problem is the disproportionate incarceration of youth of



color. Today five times as many African-American youth are incarcerated compared to the rest of the youth population.

LGBTQ youth are also disproportionately represented at three times the rate of incarceration compared to non-LGBTQ youth. Why do LGBTQ kids end up in the justice system? Because they are kicked out of their homes, become homeless, turn to crimes of desperation and are subject to laws that are disproportionately applied to LGBTQ youth.

How Can You Help?

Be aware that your patient may be lesbian, gay, bisexual, transgender or queer. Ask about life experiences. We know LGBTQ kids are reluctant to disclose because of negative results of previous disclosure. Encourage them to talk with their lawyer so he/she can present their life experiences to the judge to allow development of appropriate stipulations.

For instance, a gay boy who has been kicked out of his home and bullied at school would have difficulty adhering to the stipulation that he attend school and stay home. An appropriate, accepting out-of-home placement and a new school might be necessary in order for this boy to meet the stipulations of his probation.

We can support our patients by just providing an understanding climate in the medical department. For example, by using motivational interviewing we can help juveniles develop a desire to change their nonproductive behaviors without preaching, which we know turns them off.

Whether you have 50 or 500 or 5,000 patients, each one is an opportunity for change. Let's show up and advocate for them.

Robert E. Morris, MD, CCHP-P, is the 2020 chair of NCCHC's board of directors and board liaison of the Society for Adolescent Health and Medicine. This column is based on a speech he delivered at the 2019 National Conference on Correctional Health Care.



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connect.ncchc.org



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2020
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Join us in Atlanta

Feel the buzz and vibrancy of one of the fastest growing cities in America. A national civil rights history destination, Atlanta also has a terrific nightlife and food scene. With easy flights and plenty to do, a trip to the Spring Conference in Atlanta will boost your spirits — and your career!



CREATE new bridges between custody and health care teams

IDENTIFY the barriers to improving patient outcomes

PICTURE the results of using NCCHC standards

RECOGNIZE how evidence-based care is changing correctional health care

SEE how peers and experts are putting best practices into place

MEETING LOCATION AND HOUSING

All conference events take place at the Hyatt Regency Atlanta, 265 Peachtree Street NE. NCCHC has reserved a block of discounted hotel rooms. Please book your room by April 10 to ensure the special NCCHC rate of \$185 single or double.

Make your reservation at spring-conference.ncchc.org/hotel or call 1-800-233-1234.

Hyatt Regency Atlanta is a 30-minute train ride from the airport and a short walk to Atlanta's stadium and top attractions. All rooms feature separate living and work areas, with views including the Atlanta skyline or the pool. The Hyatt's chefs partner with 70 area farms to serve outstanding local dining experiences.

WHO SHOULD ATTEND

The Spring Conference delivers unparalleled education and professional development opportunities for all correctional health professionals, including:

- Administrators • Counselors • Custody staff
- Dentists • Legal professionals • Nurses
- Nurse practitioners • PAs • Pharmacists • Physicians • Psychiatrists • Psychologists • Social workers

GREAT REASONS TO ATTEND

- Expert education from the only organization dedicated solely to correctional health care
- Up to 26.75 hours of CE credit
- Networking with peers and experts from every segment of the correctional health field, from administrators to clinicians
- More than 50 sessions and preconference seminars to meet your challenges
- 70+ exhibitors showing new products and services

PRECONFERENCE SEMINARS

Topical, informative seminars will help you catch up and keep up on critical issues facing the field. Maximize your education and CE hours while getting in-depth education. Separate registration required.

Saturday full-day seminars, 7 hours, \$195

- An In-Depth Review of NCCHC's 2018 Standards for Health Services in Jails
- An In-Depth Review of NCCHC's 2018 Standards for Health Services in Prisons
- An In-Depth Review of NCCHC's 2015 Standards for Mental Health Services

Sunday half-day seminars, 3.5 hours, \$99

- Continuous Quality Improvement: Strategies and Techniques to Measure Change
- Medication for Addiction Treatment: Corrections-Community Collaborations to Eliminate Barriers and Establish Comprehensive Treatment
- Gender Dysphoria: Developing a Successful Program in the Correctional Environment
- Emergency! Nursing Response and Clinical Decisions

CRITICAL TOPIC LIST

NCCHC's education experts identify and select topics that have the most impact. You'll find sessions on:

Employee issues
Infection control
Jail-based MAT
Juvenile care
Legal concerns
Medical care
Mental health

Nursing
Quality improvement
Special populations
Standards
Substance abuse
Suicide prevention
Transgender care

Learn more at ncchc.org/spring-conference

Sickle Cell Anemia: The Battle Over Painkillers

by Fred Cohen, LLM

One of the distinguishing characteristics between prison and free-world medical care is the pervasive belief in prison medicine that inmates are hustling for unneeded medical care; that malingering is endemic in penal facilities. A prisoner has to make his case somehow; he has to demonstrate that the pain he reports is real.

In the free world, a valid insurance card gets you in the door and may well keep you there through a series of examinations and tests. The distrust in the penal system is not delusional. The rigors of the system dictate the actual type and intensity of the hustle phenomena.

It is not limited to challenging the diagnosis. It spills over into the care provided in *Lockett v. Bonson* (7th Cir. 2019). Wisconsin inmate Lockett had sickle cell anemia and regularly experienced the so-called sickle cell crisis, enduring severe pain.

The crisis is typically short-lived and, in this case, Lockett was not ignored. However, where an emergency room physician recommended oxycodone, Wisconsin staff preferred, and provided, Tylenol #3, a much milder type of pain reliever, which Lockett argued was not optimal for his condition.

Medication was missed on occasion, but Lockett appears to have had regular contact with clinical staff. He also regularly filed grievances but does not appear to have prevailed on any given claim.

So, here we have an inmate diagnosed with a serious medical condition, which carries with it episodic acute pain that may last a week or more. Lockett noted that the oxycodone worked for him while the Tylenol #3 basically did not. He claimed deliberate indifference in the selection and provision of his pain medication. The lower court rendered summary judgment for the defendants and is upheld in the opinion under discussion.

Discussion

Seriousness is a precondition to mandated correctional health care. Seriousness is not challenged by the defendants, who fought their winning battle over deliberate indifference.

Judge Ripple describes deliberate indifference as a subjective standard and it is more than negligence or even malpractice. The defendant must know the facts from which an inference of harm may be drawn, and he must actually draw that inference. Judge Ripple carefully explained the Seventh Circuit view that deliberate indifference is divided into two categories: the inmate is totally ignored, or, as here, there was care but it was deficient.

For the second category the court uses a "professional judgment" standard: Was the decision informed by professional judgment? Here, a nurse practitioner did not follow an ER physician's recommendation to use oxycodone 20 mg. The rationale: the less addictive potential of Tylenol.

A mere disagreement, says the court, between treatment officials is not deliberate indifference. There usually is no simple pathway to adequate care and the court doesn't try to referee the medication call. It looks only to see if there is reasonable medical judgment to support the Tylenol.

Comment

There is more than a hint of reasonableness about Judge Ripple's opinion. What objections, then, am I hinting at? The plaintiff is complaining about the terrible pain he experiences during a sickle cell anemia attack.

There is nothing, literally nothing, on the pain experienced and how long and what was the comparative pain relief experienced with Tylenol. Oddly enough, I visited a therapist this very day about neck pain and he said, "I see you can take Tylenol, but I think it's useless." Hmmm!

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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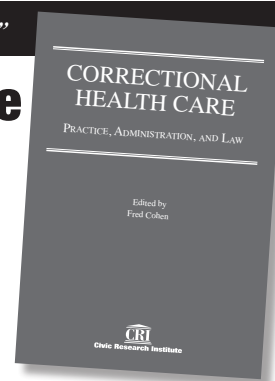
"Insight into the most significant issues in correctional health."

Correctional Health Care Practice, Administration & Law

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

We live in an era of unprecedented promise and uncertainty in health care—nowhere more so than in America's prisons and jails. New drugs and devices for treating infectious and chronic conditions are revolutionizing care, but often at very high costs. Courts are mandating better levels of service, while the resources available to correctional agencies are increasingly subject to severe budget constraints. The work can be incredibly rewarding—yet burnout is a constant threat to the well-being of caregivers and patients alike.

Written to help professionals meet these challenges, this contributed volume brings together the insights and experiences of thirty of the nation's top experts to provide a comprehensive working guide designed to benefit every correctional health care provider, from specialist physicians to GPs, PAs, nurses, and the correctional administrators who are responsible for the overall well-being and care of their residents.



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Implants and Sensors and Bluetooth, Oh My!



What Are the Security Concerns?

by LCDR Brian Buschman, MD, and LT Beth Zalno, PA-C

There are always concerns about giving inmates access to a medical technology that could be turned into an unapproved communication device

The medical field is experiencing an explosion as new technology improves the ability to care for patients. At times, these changes in technology present unique challenges in the correctional setting. This article discusses three emerging concerns: whether metal detectors affect implanted cardiac devices, the many new devices with cellular and Bluetooth technology, and challenges with the increased use of continuous glucose monitoring.

Metal Detectors and Cardiac Devices

Among the common tools used to maintain an orderly running of a correctional institution are metal detectors. In the federal penitentiary where I [Dr. Buschman] practice, inmates pass through metal detectors countless times a day. When I started nearly a decade ago, I was asked to provide medical duty passes advising that inmates had a rod in their femur or a pacemaker in their chest so that my custody colleagues would know to expect certain inmates to be unable to clear the metal detector.

I was pleased when we later began using a networked set of metal detectors; in this system, each inmate with metal in their body is “profiled” by walking through the arch of the detector 6 to 10 times and the metal is mapped. From then on, when that individual walks through a metal detector it should alert only if the amount of metal has changed.

This has been wonderful at helping reduce smuggling of metallic contraband hidden near areas of the body where metal is implanted.

But can pacemakers and implanted cardiac defibrillators pass through these machines? Before these types of detectors were employed, this was a moot point as the patient would be known to the officers as someone who cannot clear the metal detector and would then be pat searched more frequently.

At least monthly a patient arrives into my facility with a pacemaker or an ICD and most have been told they should not pass through the metal detectors. On researching the topic, I found more than 30 manufacturers of these devices worldwide, but three companies—Medtronic, St. Jude Medical and Boston Scientific—represent nearly 60% of cardiac device sales by revenue and have made every cardiac device I have seen in my prison career.

All three companies publish patient information on their websites that can be summarized as follows: The cardiac devices are believed to be safe for walkthrough or handheld metal detectors, but patients should not linger within the arch, nor should security personnel hold a handheld scanner directly over the device.

What the Research Finds

Two research studies conducted in Germany sought to examine possible device interference by metal detectors.

In a study published in 2003, walkthrough metal detectors were tested with 348 patients with pacemakers or ICDs. They were asked to walk back and forth several times, then pause within the arch for 20 seconds and also turn to make sure their chest was toward the transmitting side. There was no interruption in pacing or rhythm detection, nor any reprogramming or other malfunction of the device. Similarly, a study from 2011 used a sample of 388 patients with pacemakers or ICDs. The researchers interrogated them, then held a handheld metal detector, set at its strongest power, over the device for 30 seconds and then interrogated them again. Not a single case of device malfunction or reprogramming was found.

Given this information, it is clear there is a minimal risk of harm to implanted cardiac devices from metal detecting security systems with an exposure much longer than what is used in real life. On the other hand, there is a very high risk to safety of both staff and inmates if metallic contraband goes undetected. Considering these risks and benefits, I have implemented a policy of no longer writing medical passes requesting that custody allow patients to bypass normal security procedures. I did recommend that staff be instructed to not hold a metal detector directly over these devices.

Wearable Cardioverter Defibrillators

Not long ago, our medical staff was confronted with a question of, "What is this wearable defibrillator and what do we do with this inside the prison?" We had a patient with newly diagnosed nonischemic cardiomyopathy and the cardiologist said the patient is at risk of sudden cardiac death (SCD) but it was not yet time for an implanted cardiac defibrillator.

The reasoning was that as medical management is optimized, many patients end up not needing an ICD. Waiting three to nine months can result in the patient improving to the point that we can spare them the surgical risks of implanting the ICD. Some specialists have argued in favor of even longer waiting periods due to the time it takes to titrate medical therapy. Other diagnoses that frequently have similar waiting periods for ICD placement include being listed for cardiac transplant, a short life expectancy or recent MI.

If your patient is at increased risk for SCD but will not receive an ICD for several months, what is the risk of SCD in the interim? Many studies have been conducted on this topic and most are summarized in the guidelines produced jointly by the American Heart Association, Heart Rhythm Society and American College of Cardiology. In most cases, the low risk of SCD outweighs the risk of ICD placement before optimizing medical therapy during the waiting period. In some cases, the risk remains high for SCD, which leads to use of the wearable cardioverter defibrillator.

At present, the LifeVest® WCD by ZOLL is the only wearable defibrillator available. The "garment" component holds two large defibrillation therapy electrodes in contact with the patient's back and one on the left side of the patient's thorax, with four sensing electrodes around the torso. It is

connected to the monitor, which contains the battery and is worn on the waist or on a shoulder strap. Patients are instructed to wear it continuously other than showering or bathing.

The WCD provides two benefits. First, it is designed to continuously monitor a patient's heart, detect life-threatening rapid heart rhythms (ventricular tachycardia or ventricular fibrillation) and automatically deliver a treatment shock to restore normal heart rhythm. If the treatment sequence is initiated, a warning sound gives the patient a chance to delay the treatment using response buttons and also alerts bystanders to not touch the patient. Secondly, data downloaded from the WCD is sent to the manufacturer's patient data management network, enabling its cardiologist to monitor for clinically actionable events and a variety of patient health data.

Batteries and Hot Spots

From a correctional medicine standpoint, there are two unique challenges. The easier to address is that the device comes with two batteries. Each day the battery must be changed and the one not being used should be charged. It was a simple process for medical staff to exchange batteries with the patient at a routine pill line.

The larger issue is the transmission of data to the manufacturer's network. This is handled through use of either a separate cellular hotspot device with the standard charger or an integrated charger that has an internal hotspot. The first option requires having an external hotspot inside the prison's patient care area, where it can be maintained by the medical staff.

The hotspot device resembles a smartphone but has other communications capabilities disabled. After discussion with the wardens and custody, the device was stored in the medication dispensing machine, where it would have the same accountability as an opioid medication. The machine kept a record of all staff who accessed the compartment with the device.

Bluetooth technology in the WCD monitor allows it to communicate with the hotspot. Bluetooth is typically limited to about 30 feet but in theory it can reach up to 330 feet in the open air, depending on the specific Bluetooth device used. Our experience showed the patient must be located pretty close to the device, just as our Bluetooth mice and keyboards cannot be too far from our computers. While we prefer to not give inmates access to devices that allow for unauthorized communication, it is very unlikely that someone could engineer the Bluetooth communications from the monitor for that purpose.

A second model of the WCD has a hotspot in the base of the battery charger. This design eliminates the need for the external cellular hotspot, but the functionality is the same. Thus, the charger base requires a cellular signal and close proximity to the patient to effectively transmit data.

When we learned that this patient was to be discharged from the hospital with this WCD device, we had a steep

continued on page 8

learning curve to reconcile quality medical care and sound correctional principles. After investigating the WCD, we knew that we could house the patient in the general population while wearing the device with no compromise to the orderly running of the institution. Ultimately, our patient wore the device for the next few months and cardiology discontinued it without the patient needing an ICD to be placed.

Continuous Glucose Monitoring

One of the latest technologies to enter the outpatient endocrinology field is the continuous glucose monitor. CGMs are designed to replace frequent finger sticks in monitoring a diabetes patient who is more difficult to control. Initially, CGMs were studied in type 1 diabetes patients, but they are increasingly used in managing type 2 diabetes. The CGM systems have a sensor that measures the patient's glucose level in the interstitial fluid of the subcutaneous tissues. Interstitial glucose correlates well with plasma glucose when recognizing the interstitial fluid glucose levels is delayed 10 to 15 minutes from the plasma level.

CGMs are primarily used to help the user adjust insulin for tighter glycemic control. They are also being studied as a component of what could eventually serve as an artificial pancreas. At present, Medtronic has developed what it terms a

“hybrid closed-loop system” that combines its CGM Sensor 3 with its MiniMed 670G insulin pump system.

The early models required daily calibration with finger sticks, but more recently approved products do not. All CGMs require a sensor, a transmitter and a receiver. Most sensors are placed on the skin and have a portion that punctures the skin to enter the subcutaneous space, and most are changed every five to 14 days. The exception is the Senseonics Eversense monitor (see description below). Professional models also exist, but data must be downloaded in the physician's office and is not otherwise available to patients.

Again, there are always concerns about giving inmates access to a medical technology that could be turned into an unapproved communication device. By their nature, all CGM products require the use of at least one of two communications technologies.

- Bluetooth communications can, in theory, extend to 330 feet, as described above. A relative disadvantage is that it requires more power and takes time to establish a connection.

- Near-field communications require the two devices to be within 4 cm of each other. Benefits of NFC include a near-instantaneous connection between the devices and the lower power requirements that prolong battery life for a sensor.

A Rundown of Available Models

Four brands of CGMs are currently on the market. They vary in how they operate, how often they need to be

changed and whether they require serum glucose finger sticks for calibration. Their commonality is a combination of a wearable sensor and a transmitter. The following information will help correctional physicians to determine which models may best serve the needs in their setting.

- Dexcom has produced several generations of its CGM product that may be encountered when a patient arrives at a facility. An older model, the G5, requires changing every seven days with twice daily finger sticks to calibrate. The G6 does not require finger sticks and can be changed every 10 days. The G7 is expected to come to market in 2020 and is projected to be fully disposable and have a working life of 14 days. Dexcom transmitters use Bluetooth technology to connect to a receiver. This can be either a dedicated receiver obtained from Dexcom or an Apple or Android device running a Dexcom application.

- Abbott's CGM product is the FreeStyle Libre that no longer requires calibration and can be worn for 14 days. Its sensor and transmitter are together in a single unit. Users hold the reader over the transmitter any time they wish to review their glucose numbers. Unlike the other devices, the FreeStyle Libre uses NFC to connect the sensor to the Abbott receiver or a smartphone that has NFC capabilities. NFC technology requires the reader to be within 4 cm of the sensor.

- Medtronic's latest Guardian Sensor 3 requires daily calibrations and can be worn for up to seven days. It connects directly to the Guardian Connect Transmitter, which uses Bluetooth technology to send data to an Apple or Android smartphone. The user can view or transmit the results so they can be accessed by their health care provider.

- Senseonics Eversense CGM takes a different approach. The sensor is implanted in the subcutaneous space and monitors glucose for 90 days; it does not require calibration. The obvious downside is that it requires a provider for insertion and removal. Primary care providers can be trained on the insertion and removal of the sensor by the manufacturer either in person or online. The sensor communicates NFC to an external transmitter that, in turn, communicates via Bluetooth to the user's smart device (Apple or Android). The company does not offer a separate receiver. If the transmitter is removed from the skin, the sensor will stop recording readings to conserve its battery. If the transmitter remains on the skin it will continue to collect readings and give a vibratory alert to outliers, even if it is out of range of the smart device.

LCDR Brian Buschman, MD, and LT Beth Zalno, PA-C, are officers of the U.S. Public Health Service. Dr. Buschman works at the Federal Correctional Complex – Allenwood, PA; Ms. Zalno also worked there before recently transferring to the Coast Guard Air Station Cape Cod.

This article is based on a series of articles that appeared in CorrDocs, the quarterly newsletter of the American College of Correctional Physicians. This information is used here with permission of the CorrDocs editor. Dr. Buschman and Lt. Zalno also spoke on this topic at NCCHC's 2019 National Conference on Correctional Health Care.





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Drugs of Abuse: What Correctional Nurses Need to Know (Part 1)

by Rane'e M. Wright, MSN, RN, CCHP-RN, and
Lana J. Winter, CSAC

Correctional settings have long been mental health providers for the underserved populations they house. These settings have also turned into withdrawal and treatment facilities for people with substance abuse disorders and dependence issues.

To help nurses better manage the challenges of providing adequate substance abuse services, this article gives a brief overview of commonly abused substances and substance abuse concerns unique to corrections.



Addiction

How does addiction happen in the first place?

It can vary for different people, but often it's a four-stage process:

1. Misuse of substance: emotional and mental addiction
2. Abuse of substance: change in dealing with life and others
3. Dependence: development of tolerance
4. Physical symptoms when withdrawing

For some, even a small amount of alcohol or other drug can "flip a switch" and change the person's

brain. Without the addictive substance, the brain will use the same signal as it does when the person is starving, making the drug powerful enough to become a necessity for survival. Many people addicted to a drug say they were hooked the very first time they tried it.

Heroin

- A DEA schedule I drug with no medical uses in the United States
- Also known as junk, smack, H
- Usually injected, sniffed or smoked
- High levels of physical and psychological dependence
- Duration: 3-6 hours

Heroin causes a surge of euphoria and is one of the most abused and physically addictive of all drugs. Typically it is a white powder with bitter taste; black tar heroin is a dark sticky form. Street heroin contains toxic contaminants, such as fentanyl, that can clog blood vessels resulting in irreversible damage. The drug acts so quickly that people who overdose can often be found with needles still in their arms. Tolerance can build quickly and the user needs more and

more of the drug to get the same effect. When the user doesn't get the drug, painful withdrawal symptoms begin.

Nursing Implications: Symptoms of heroin use include clouded thinking, wakeful and drowsy states, respiratory depression, dilated pupils and nausea. Nurses in a jail setting might observe withdrawal symptoms changing over time:

- Several hours after last use: anxiety, restlessness, irritability, drug craving
- 8-15 hours after last use: yawning, perspiration
- 16-24 hours after last use: sneezing, sniffles, anorexia, vomiting, abdominal cramps, bone pains, tremors, weakness, insomnia, goose flesh, convulsions, cardiovascular collapse

Clonidine can be used to ease withdrawal symptoms.

Overdose Concerns: Symptoms include low and shallow breathing, clammy skin, convulsions, coma, possible death. The antidote for overdose is naloxone, offered in injection or inhaled form.

Corrections-Specific Tips: Heroin addiction is difficult to overcome and usually requires professional help. An opioid-like high can be achieved via 50 mg of loperamide, so keep this in mind if patients are found stockpiling the medication, not completing proper mouth checks or requesting the drug often.

Marijuana (Cannabinoids)

- Also known as pot, grass, reefer, dope, Mary Jane, herb, weed
- Usually smoked or taken orally
- Physical dependence: unknown
- Psychological dependence: moderate
- Tolerance: yes
- Duration: 2-4 hours

Marijuana is commonly a dried green/brown or gray mixture of shredded leaves, stems and flowers of the hemp plant, *Cannabis sativa*. It contains the mind-altering chemical tetrahydrocannabinol (THC). Many states have now legalized marijuana for recreational and/or medicinal use. Although it can be beneficial for certain medical complications, it can still be abused. Studies have shown that heavy users have impaired attention, memory and learning skills for up to 24 hours after use. Some users compulsively use the drug even though they wish to stop.

Nursing Implications: People who smoke marijuana may have different reactions. Possible effects include euphoria, relaxed inhibitions, increased appetite, disorientation, impaired coordination, bloodshot eyes, laughing, impaired perception of time and distance, dry mouth, inability to concentrate, short-term memory loss and hacking cough.

Correctional Nurse Tip

Key Intake Interview Questions

- Do you currently use any type of legal, illegal or prescription drugs, or alcohol?
- If no, how about in the past?
- What type?
- How much/many?
- How often?
- Date and time last used?
- Have you had withdrawal symptoms or seizures when alcohol/drug is stopped?
- Have you ever been hospitalized for medical treatment of withdrawal symptoms?

Withdrawal symptoms include insomnia, hyperactivity, decreased appetite, irritability, anxiousness and increased depression.

Overdose Concerns: Overdose from marijuana alone is unlikely, if not entirely impossible. No known antidote.

Corrections-Specific Tips: Due to controversy over whether marijuana is addictive or harmful, symptoms of withdrawal are often overlooked. Compared to other substances, which exit the body at a much more rapid pace, marijuana tends to exit slowly, and so the physical withdrawal symptoms are less severe.

K2 “Spice” (JWH-018)

- Chemical compound that’s a synthetic copy of THC
- The chemical is sprayed on mix of dried herbs or flowers and then smoked
- Effects similar to marijuana but more potent
- Unpredictable side effects
- Dependence and tolerance: yes, for long-term users

Salvia

- Hallucinogenic plant, effects similar to LSD
- Can be smoked or taken in liquid form
- Tolerance: uncertain
- Dependence: unlikely
- Effect lasts less than 10 minutes; trips end before user can get in trouble

Designer drugs like K2 and salvia are crafted to produce effects similar to those of the original drug. The molecular structure is altered so that it is not considered illegal, nor will it show up on a urine drug screen. The chemical make-up enables clandestine chemists to continue altering and producing these substances once they become illegal. Many of these drugs are bought online.

Nursing Implications: Symptoms of K2 abuse include euphoria, rapid heart rate, vomiting, agitation, confusion and hallucinations. Patients with mild to moderate symptoms of synthetic cannabinoid intoxication can usually be observed and treated in the emergency department until symptoms resolve. Patients with severe intoxication with marked agitation or seizures should be sent to the emergency department because of the risk for rhabdomyolysis, lactic acidosis, stroke, intracranial hemorrhage and acute kidney injury.

Symptoms of salvia abuse include perception of bright lights and color, uncontrolled laughter, lack of control of body movements, distorted perceptions of objects, hallucinations.

Overdose Concerns: Patients with severe agitation require large amounts of sedation and warrant hospital admission. No known antidote.

Corrections-Specific Tips: Rapid urine drug screens will not detect synthetic cannabinoids. K2 is often laced with other drugs or chemicals, most often anticoagulants. Signs that someone has ingested synthetic cannabinoids laced with an anticoagulant can include nosebleeds, bleed-

ing gums, coughing up blood, excessive heavy menstrual bleeding and blood in urine or stool.

MDMA

- A DEA schedule I drug with no medical uses
- Also known as Molly, Ecstasy, XTC, beans
- Usually taken orally or injected
- Physical dependence: unknown
- Psychological dependence: unknown
- Tolerance: yes
- Duration: variable

MDMA sold as “Molly” resembles powdered cocaine. This confuses dealers and buyers. Many people buy Molly thinking it will be purer than the tablet form of Ecstasy, and it is actually the opposite. Molly can be laced with methamphetamine or other impurities. Effects begin within 30 minutes and can last 4 to 6 hours. Use typically is combined with strenuous dancing in hot, poorly ventilated clubs.

Nursing Implications: Symptoms of MDMA use include extreme euphoria, dilated pupils, blurred vision, teeth grinding, nausea, muscle pain, diarrhea, paranoia, loss of appetite, anxiety, insomnia, increased body temperature to the point of kidney failure, illusions and hallucinations, and altered perception of time and distance.

Overdose Concerns: Marked by a more intense “trip” episode, psychosis or possible death. Many ED visits are a result of overdose on MDMA that the user thought was cocaine. Overdose can cause hyperthermia, leading to organ damage and even death. Effective treatment takes place in a hospital emergency room where trained medical staff provide a continuum of care, starting with treatment of acute physical reactions. No known antidote.

Corrections-Specific Tips: Alcohol and Ecstasy are often taken together, which greatly increases risk of overdose.

GHB (gamma-hydroxybutyrate)

- A clear liquid sedative, but can appear in other forms
- Also known by names such as Georgia Home Boy and Grievous Bodily Harm
- Duration: up to seven hours

Rohypnol

- Sedative found in pill or powdered form
- Also known as roofies, rope and roach
- Effects similar to GHB

Ketamine

- Animal tranquilizer that is clear liquid or white powdered
- Also known as Special K or K, Vitamin K, cat
- At high doses, has hallucinogenic properties that can render the user unable to move until the effects wear off

continued on page 12

Correctional Nurse Tip**Tetrahydrozoline Poisoning**

Symptoms: Coma, difficulty breathing, blurred vision, change in pupil size, changes in blood pressure and heartbeat, headache, irritability, low body temperature, nausea and vomiting, nervousness, seizures

Tetrahydrozoline is the active ingredient in many OTC products used for allergy relief, such as Visine eye drops. It can be used as a date rape drug. Do you have this in your facility?

“Club drugs” comprise a number of sensory distorting drugs. These substances are often taken at nightclubs, raves and parties. GHB, Rohypnol and ketamine are the most common and have similar characteristics. Colorless and odorless, they are called “date rape” drugs as they can render someone vulnerable to sexual assault with no memory of what happened to them.

Nursing Implications: Club

drugs are known to slow breathing and heart rate; on occasion, however, rates may increase for some users. These substances are most known for causing short-term amnesia. Someone under the influence of club drugs may show signs of euphoria, sedation, confusion, dizziness, hallucinations, muscle rigidity and vision problems. Withdrawal symptoms may include nausea, vomiting, diarrhea, agitation, decreased or increased heart rate, slowed breathing, fluctuating abnormal body temperature. Symptoms can begin within 24 hours and last as long as three weeks.

Overdose Concerns: Symptoms include vomiting, loss of gag reflex, shaking, tremors, seizures, loss of consciousness and unresponsiveness, absence of pain response, rapid side-to-side eye movement, profuse sweating, lowered body temperature, decreased respirations. Someone who has overdosed on one of these substances is at risk of severe respiratory depression or arrest, aspiration of gastric contents, falling into a coma and even death. Flumazenil is known to have been used in Rohypnol overdose cases; there is currently no known antidote for the other club drugs.

Corrections-Specific Tips: Someone under the influence of club drugs may display bizarre behaviors and have distorted sensory perception. Keep your voice and demeanor calm and soft, as the patient may be having visual and/or auditory hallucinations. Heart rate and body temperature may fluctuate between dangerous levels.

Bath Salts

- Cathinones sold as a powder in small foil packages
- Appeared in United States in 2010
- Was sold in smoke shops and convenience stores as bath salts and labeled “not for human consumption”
- Now banned from sale

Flakka

- Powerful synthetic stimulant that mimics amphetamine
- Sold in white or pink crystals
- Ingested by eating, snorting, injecting, vaporizing in an e-cigarette
- Extremely cheap
- Produces a euphoria high that you cannot get from smoking crack
- Tolerance: yes
- Believed to be highly addictive

Synthetic cathinones are strong and dangerous stimulants. To keep up in the continuously changing and emergent drug scene, clandestine chemists use their laboratories to create newer versions of drugs once the FDA regulates them, changing the molecular compound to make new legal substances. People abusing these drugs believe they will have more energy, endurance and heightened sexual experiences; however, use of these chemicals often ends in permanent psychosis or death.

Correctional Nurse Tip**Positional Asphyxiation**

Symptoms: Difficulty or inability to breathe; feeling sick; becoming limp or unresponsive; respiratory or cardiac arrest; swelling in face and neck; marked expansion of veins in the neck; petechiae to the head, neck and chest areas

When a person on any of the substances discussed in this article is placed in restraints, the risk for positional asphyxiation increases. It is a deadly process that starts when the person being restrained is not getting enough oxygen.

Nursing Implications: Effects of synthetic cathinones include dizziness, nausea, vomiting, confusion, high blood pressure, aggression, hallucinations, agitation, palpitations, overheating, delusions, increased energy, headache, insomnia, liver failure, kidney failure, paranoia and suicidal thoughts or actions. Excited delirium is another symptom that might lead to arrest. Excited delirium can include hyperstimulation, paranoia and powerful hallucinations, which can trigger violent aggression and self-injury.

Overdose Concerns: Toxicity can last for hours and is a medical emergency due to severe systemic distress and the potential for harming self or others. Treatment of overdose can include administering large doses of sedatives to relieve physical agitation and emotional distress. Psychiatric intervention is frequently needed during emergency treatment and for some time after. Deaths from overdose involve cardiac dysfunction, seizures, dehydration, kidney failure, hyperthermia, accidental injuries and self-harm. No known antidote.

Corrections-Specific Tips: Many of the urine tests used in institutions cannot detect many of these substances. It is important to recognize and treat the symptoms and activate emergency medical services if needed.

Ranee' M. Wright, MSN, RN, CCHP-RN, is a nurse clinician at the Wisconsin Resource Center, Winnebago, WI. Lana J. Winter, CSAC, is a substance abuse counselor at Sokaogon Chippewa Health Clinic, Crandon, WI.

Part 2 will discuss stimulants, benzodiazepines, hallucinogens, amphetamines/methamphetamines, and polysubstance drug use.

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Tips to Help Your System Prepare for an Accreditation Survey

by Lisa DeBilio, PhD, LPC, CCHP, Marci Mackenzie, PhD, LCSW, CCHP, Christine Prestien-La Penta, MSN, RN, CCHP, and Ellen Shelley, DNP, MSN, CCHP

Preparing for an NCCHC accreditation survey can be a daunting task. Although many staff members know that the intent of the *Standards for Health Services* is to ensure that correctional facilities adopt and adhere to policies and procedures to protect the well-being of staff and inmates alike, they differ in their level of understanding of the standards. This may limit their involvement in preparing for a survey and obtaining the necessary documentation that demonstrates that the requirements for each standard are met.

This article describes several strategies that Rutgers University Correctional Health Care, in collaboration with the New Jersey Department of Corrections health services unit, employs in preparing for their NCCHC reaccreditation survey. [Note: Each prison in the NJDOC is accredited separately, although surveys may be done as a group. — Editor]

Opportunities for Improvement

Before the reaccreditation survey in 2017, there was turnover in leadership and new managers scrambled to gather the supporting documentation for each of the 68 standards from the 13 prison sites across the state. The task went to a small group of seasoned staff who worked feverishly and clocked in long days (and nights!) to get ready.

When the 2017 survey was over, UCHC vowed to transform the survey preparation process to ensure all sites are “survey ready” every day—to be in a continuous state of

readiness. With this in mind, UCHC leadership and the NJDOC health services unit collaboratively brainstormed, selected strategies and created a work plan. UCHC naturally applied its award-winning continuous quality improvement strategy (2018 NCCHC Program of the Year) of “CQI: It’s everyone’s business!” to the survey readiness project. Like any good plan, we are testing our strategies and learning through this ongoing process what works and what needs to be changed. This article offers the tools we have found to be most helpful so far.

The survey readiness project had four goals:

- Increase participation in the process
- Utilize the expertise and skills of multidisciplinary staff
- Expand staff’s knowledge of the standards
- Provide learning opportunities for less seasoned staff

Increasing Participation

The survey preparedness plan began by identifying key staff from each of the 13 prisons as well as the directors and support staff from the central administrative office. Staff were assigned to one of 15 teams, with each team having a specific focus within the standards. Teams 1 through 7 focused on the health care (medical and mental health) services, and these teams involved the facility regional nurse managers, department nurse managers, nursing and support staff. Teams 8 through 15 included the statewide directors responsible for the following departments: infectious disease, pharmacy, medical records, training, quality improvement, grievances and dental. Central office staff were assigned to coach each team, give support to their

NCCHC 2018 STANDARDS: PREPARATION

Site: _____

NCCHC Standard #	NCCHC Standard Name	Items Required for NCCHC Survey	Received	Data Source
Section A: Governance and Administration (10 Standards)				
P-A-01	Access To Care	1. Inmate handbook (current year) with highlighted section on accessing medical care 2. An inmate co-payment charge with associated report showing deduction from inmate account (total 3, 1 per year) 3. Sick call request (MR007) for medical, show either JPAY or paper request that is time stamped w/associated sick call log, triage encounter within 24 hrs & nurse sick call visit encounter showing patient was seen w/in 24 hrs of triage (total 3, 1 per year medical) 4. Sick call request (MR007) for a MH & dental appointment with corresponding ITAG appointment schedule (total 2, 1 of each) 5. On-call weekly schedule for medical (total 3, 1 per year) 6. On-call weekly schedule for MH (total 3, 1 per year) 7. Referral from any other staff except nursing to MH (MR-049), w/corresponding MH Progress not addressing request (total 3, 1 per year) 8. CQI study if applicable	Y Y Y Y Y Y Y Y	1. NJDOC Site Administrator 2. RNM 3. RNM 4. RNM 5. RNM 6. RNM 7. Clinician Supervisor 8. RNM
	DOC Policy	MED.AGP.001: Access to Care, MED.AGP.002: Information on Health Services, MED.MHS.001.001: Access to Mental Health Services		
P-A-02	Responsible Health Authority	1. Facility organizational chart 2. Job descriptions: RNM, Site Medical Director, Clinician Supervisor & Dentist (see central office binder) 3. Sign-in sheet showing RNM on site weekly (total 3, 1 per year) 4. Policy & Procedure Attestation or Declaration cover sheet showing approval by RHA & NJDOC Site Administrator (total: 3, 1 per year) 5. CQI study if applicable	Y Y Y Y Y	1. Central Office 2. Medical Secretary 3. Lobby UCHC sign-in book 4. RNM 5. RNM
	DOC Policy	MED.AGP.005: Responsible Health Authority		
P-A-03	Medical Autonomy	1. Approved consult orders showing special transportation (wheelchair, van, etc.) & corresponding transportation log showing custody collaboration (total 3, 1 per year) 2. Order for restrictions (example: No Work – No Rec) (total 3, 1 per year) 3. CQI study if applicable	Y Y Y	1. Scheduler 2. RNM 3. RNM
	DOC Policy	MED.AGP.003: Medical Autonomy		

At the NJDOC, medical, mental health and dental services are provided by Rutgers, the State University of New Jersey, through its subsidiaries, University Correctional Health Care and University Behavioral Health Care. UBHC is UCHC’s parent organization.

sites and review the required documentation collected. An "NCCHC Preparedness Teams" memo (shown at right) listed team assignments and due dates for standards documentation by year.

The Crosswalk

Several years ago, UCHC developed a crosswalk that included the NCCHC standards by section, the facility documents needed to verify that each standard is being met and the corresponding NJDOC policies pertaining to each standard. The tool was revised to match the 2018 edition of the *Standards*, and it was tailored for on-site nurse managers as well as coaches to use as a checklist to document any missing information. See an example on the facing page.

Communication and Collaboration

An initial meeting was convened to present and initiate the plan with the staff on the preparedness teams. The NCCHC crosswalk was introduced and the teams were trained to use it while preparing their facilities. A calendar of weekly conference calls was also established to provide a forum for teams to share their progress, ask questions and offer suggestions and feedback about the project.

The health services unit employs several quality assurance coordinators (QACs) throughout the state. The HSU assistant director and the UCHC director of health operations agreed to have the QACs conduct visual inspections using a checklist developed from the standards that covers all health care areas of the facility and any affiliated satellites.

Inspections are conducted monthly, and the QACs and the UCHC regional and department nurse managers meet to discuss the findings. They work collaboratively to present any areas that need correction to the facility administrators for resolution (e.g., signage in required areas, removal of old or damaged medical equipment, cleanliness of clinics in administrative segregation units).

A Systematic Approach

The strategies outlined in this article can be used in whole or in part and are offered as a systematic and organized approach to survey preparation. So far feedback from our field sites has been positive. We invite others to share what has been helpful for them in the hope of creating a network of colleagues who are responsible for survey readiness at their sites.

Lisa DeBilio, PhD, LPC, CCHP, is UCHC's director of quality improvement, Marci Mackenzie, PhD, LCSW, CCHP, is UCHC's director of health operations and accreditation, Christine Prestien-La Penta, MSN, RN, CCHP, is UCHC's administrator of nursing, and Ellen Shelley, DNP, MSN, CCHP, is assistant division director, operations, for the New Jersey Department of Corrections.

RUTGERS HEALTH

NCCHC PREPAREDNESS TEAMS

Teams	Facility	RNM	Coaches
1			
2			
3			
4			
5			
6			
7			

Teams	NCCHC Standard	Coaches
8	Infectious Disease	
9	Pharmacy	
10	Medical Records	
11	Training	
12	CAPS/PI	
13	All MH Files	
14	Grievances	
15	Dental	

DEADLINES (FILES)

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The Practical Power of Academic–Corrections Partnerships

by Leissa Roberts, DNP, CNM, Jennifer Clifton, DNP, FNP-BC, CCHP, Tom Rowley, DNP, FNP-BC, & Chase Roberts, MBA, CCHP

This article is the last of a three-part series on NPs.

Academic institutions employ health care providers who educate thousands of nurses, nurse practitioners, medical doctors and ancillary health care providers each year. Yet they are largely overlooked by correctional facilities as a source of staffing. Conversely, correctional facilities provide health care to innumerable patients each year, yet they are largely underutilized by academic institutions as opportunities for education and professional development.



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In a few large cities, academic health science systems have established successful, large-scale academic–corrections collaborations. However, this arrangement may not be feasible for many correctional facilities given the limited number of

academic health science systems. Collaborating on a smaller scale—with local schools of medicine, nursing or ancillary health services—can be advantageous for both partners.

Academic systems benefit by gaining access to an inter-professional collaborative practice site. The partnerships also enable faculty to effect policy, advocate for incarcerated individuals and precept undergraduate and graduate students as well as residents in a diverse clinical setting.

This article will focus on the benefits of these partnerships to correctional systems.

Enhanced Provision of Evidence-Based Care

When a residential justice facility collaborates with a college of nursing or other school within a university, it benefits from the faculty's commitment to high-quality care based on the most current health care practices. For example, in Colorado, nursing faculty have brought best practices to one of the correctional obstetrics clinics by initiating group prenatal care based on the centering model, which may reduce preterm deliveries and increase patient participation and satisfaction with health care.

Having students conduct quality improvement or doctoral projects is also an asset. In Utah's juvenile justice system, for example, an NP doctoral student did a project in which she created a detailed medication administration training protocol to prepare all nonmedical employees to safely administer medications to youth. At the start of the project, not a single JJS employee participating in the survey knew the five "rights" of medication administration—right patient, right drug, right dose, right route and right time. These rights are considered standard for safe medication

administration. Other student projects have included educating staff on motivational interviewing, teaching youth about safe tattoo practices and acne management.

Faculty and students can also target training for JJS staff in caring for youth with hypertension, diabetes and other chronic illnesses, leading to higher quality care. In Colorado, college of nursing faculty and midwifery students have held educational sessions for correctional staff, discussing women's health care issues such as preterm labor symptoms, vaginal discharge (normal vs. abnormal) and management of an opioid-dependent pregnant inmate. In Utah, faculty have educated staff on vital signs, management of common illness and the difference between the flu and a cold.

Opportunities for Corrections-Specific Research

The correctional setting remains largely understudied and can benefit from greater academic research involvement. Standard treatment recommendations are often based on clinical trials of healthier community-based populations and may not apply to the correctional setting. Chronic stress, lack of dietary options and limited exercise opportunities are just a few of the reasons why medications and therapies commonly prescribed in the community may not be beneficial or available to incarcerated individuals. Other issues such as infection control, drug abuse treatment strategies and case management best practices could also benefit from corrections-specific research.

In Utah, NP faculty have launched research projects in an effort to provide high-quality care for incarcerated youth. In 2014, faculty scholars implemented health literacy assessment in five JJS facilities. The study increased awareness of health literacy in certain populations and provided an opportunity to modify patient and provider communication.

Student Exposure to Correctional Care as a Career Option

Although most students will not choose a career in correctional health, a correctional clinic experience broadens their understanding and may change preconceived ideas of correctional health care and incarcerated individuals. A clinical rotation also helps students to see the connection between incarceration settings and practice in the community at large. Students learn that inmates are a vulnerable population who will reenter society and require health care. Exposing medical and nursing trainees to incarcerated patients and helping them to understand incarceration as a social determinant of health will ultimately result in patients receiving more coordinated care in the community after discharge.

This exposure and experience will benefit the incarcerated population indirectly. More directly, those students who do choose corrections as a career path will be equipped with a thorough understanding of the population, setting and the role of the correctional nurse or provider.

Advocacy, Collaboration and Scholarly Dissemination by University Faculty

The faculty role often includes expectations of advocacy, interdisciplinary collaboration and dissemination of scholarly knowledge. These activities can improve work conditions and patient care and can occur on many levels. For example, in both Utah and Colorado, faculty have advocated and developed programming for inmates to take part in gardening to provide fresh food for meals.

University of Utah college of nursing faculty partnered with the Utah Department of Health and wrote a grant for STI testing and treatment funds for both adult and juvenile correctional populations. When the program proved successful, the NP faculty members sought—and received—STI testing and treatment funding from the state legislature. With a small amount of initial funding, the program gained traction and the NPs were able to implement this quality improvement project across the state.

Through the STI program, faculty also collaborated with the statewide Trafficking in Persons Task Force to provide a safe avenue for youth to disclose gender identity, sexual exploitation, assault and/or trafficking. This project has been presented at several NCCHC and regional conferences and webinars by university faculty, and has been published in peer-reviewed journals.

Reduced Burden of Medical Oversight for Facility Directors

Nurse-managed clinics have existed in this country since the 1960s, with rapid growth in the past 20 years. According to the Institute of Medicine's 2010 Future of Nursing report, nurse-managed clinics reported that their clients make 15% fewer emergency department visits than the general population, have 35% to 40% fewer nonmaternity hospital days and spend 25% less on prescriptions. Again using Utah as an example, the academic–corrections collaboration has meant less duplication of services, improved interfacility communication, less transport and outside referral, and cost savings, according to the facility director.

Youth may be poor historians regarding their health. Fortunately, qualified health care professionals can determine the legitimacy of a health claim more accurately than our correctional colleagues due to their medical training. Qualified health care professionals can better determine the need for health care services like specialty referrals or advanced diagnostic tests. Their knowledge of utilization review can help facility administrators keep transfers and use of health care services at an appropriate level and cost.

Nurses Leading the Way

In this three-part series on nurse practitioners, we have discussed the role of NPs and presented information on their extensive training to assess, diagnose, treat and manage health conditions autonomously and in collaboration with other health professionals. We reviewed the value that nurse practitioners can bring to correctional settings when comparing their quality and service to the cost of other health care providers. Finally, in this article we have

described how academic faculty and correctional administrators have an opportunity to provide quality care, educate students, advocate and implement policies that promote the health of incarcerated individuals.

The authors are affiliated with the University of Utah College of Nursing. Leissa Roberts, DNP, CNM, is a professor and associate dean of faculty practice; Jennifer Clifton, DNP, FNP-BC, CCHP, is a clinical director and associate professor; Tom Rowley, DNP, FNP-BC, is an assistant professor; and Chase Roberts, MBA, CCHP, is outpatient clinic manager/juvenile justice services contract. Clifton also serves on the NCCHC board of directors as liaison of the American Association of Nurse Practitioners.

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CDC Asks for Corrections' Help in Preventing Hepatitis A

With outbreaks of hepatitis A occurring nationwide, the Centers for Disease Control and Prevention is requesting

assistance from correctional health providers to control the spread of HAV.

Since the outbreaks were first identified in 2016, 32 states have publicly reported the following as of February 15:

31,220 HAV

cases, 19,074 (61%) hospitalizations and 314 deaths. While hepatitis A infection is typically self-limited, morbidity and mortality in the current outbreaks are elevated compared to what is normally reported.

The cases are primarily person-to-person and seen among people with risk factors common in incarcerated populations, as well as contacts of people infected with the virus. At-risk populations include the following:

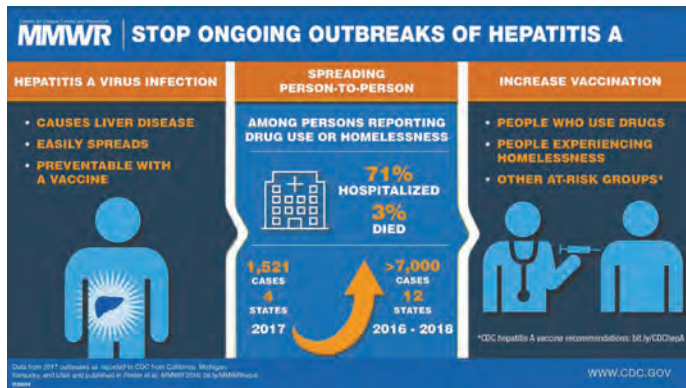
- People who are, or were recently, incarcerated
- People who use drugs (injection or noninjection)
- People experiencing unstable housing or homelessness
- Men who have sex with men
- People with chronic liver disease, including cirrhosis, hepatitis B or hepatitis C

Initial health assessments and clinic visits are key times to screen for risk factors and document their presence or absence in the medical record. Incarceration also presents critical opportunities for vaccination.

CDC is asking the correctional health field to vaccinate people at high risk of infection. Vaccinations should not be postponed if vaccination history cannot be obtained or records are unavailable. One dose of single-antigen hepatitis A vaccine has been shown to control outbreaks of HAV and provides up to 95% seroprotection in healthy individuals for up to 11 years. Prevacination serologic testing is not required to administer the vaccine.

CDC recommends considering hepatitis A as a diagnosis in anyone with jaundice and clinically compatible symptoms. If no alternative diagnoses are likely, serologic testing for acute viral hepatitis (including anti-HAV IgM) and liver function tests should be ordered. Do not test people without signs of acute hepatitis for hepatitis A. It is important that all people diagnosed with hepatitis A be reported to the health department in a timely manner.

- www.cdc.gov/hepatitis/hepAoutbreak.



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Tuesday, May 5 • 2:45 - 3:45 p.m. • Session 143

Person-to-Person Outbreaks of Hepatitis A, Multiple States, 2016–2020

Person-to-person outbreaks of hepatitis A virus have been ongoing since 2016. Correctional facilities commonly house people at risk. In this session representatives from the CDC's Division of Viral Hepatitis will present results from a CDC survey that examined the proportion of outbreak cases who were incarcerated during their exposure or infectious period, their risk factors for HAV and the proportion who may have contracted HAV while incarcerated. They also will discuss the importance of hepatitis A vaccination in correctional facilities.

Educational objectives

- Describe the prevalence of incarceration among HAV cases identified during the ongoing outbreaks
- Identify risk factors for infection in the incarcerated population
- Discuss the role of correctional facilities in community-wide efforts to control HAV transmission

Find information about the conference on page 4, or visit ncchc.org/spring-conference.

What Do Correctional Staff Think About Inmate Medical Care—and Does It Matter?

Correctional staff are essential to the effective, safe operation of any correctional facility, so it's important to understand the work environment variables that affect their job involvement and organizational commitment. In the January issue of the *Journal of Correctional Health Care*, three academic researchers present results of a study aimed at determining the effects of views concerning several inmate health care topics: (1) proper handling of infectious diseases, (2) quality of medical care provided, (3) officers' timeliness of responses to medical needs, (4) turnover of medical staff and (5) medical privacy rights.

In the article's introduction, Eric Lambert and colleagues explain that job involvement and organizational commitment among correctional staff are important work attitudes and key factors that affect the quality of individual and organizational outcomes. They propose that correctional staff views of inmate medical care could affect these important work attitudes. To date, little if any research has addressed this issue.

This topic has salience because "Dealing with the medical needs and conditions of inmates can wear on staff," the authors write. Furthermore, the relatively high incidence of infectious diseases among inmates presents risks to staff. In terms of quality of medical care, a concern is that inadequate care (due to poor response times or staff turnover) makes staff members' jobs more difficult due to inmate demands. Finally, issues related to inmate medical privacy rights may lead staff to worry about workplace safety.

Methods and Findings

The study was conducted at an urban jail in Florida with an average daily population of about 4,000. Based on seven focus group meetings with 48 staff members, a survey was created and given to all available staff members during a five-day period. Of the approximately 1,500 full-time staff members, 71% participated in the voluntary survey. Two-thirds of respondents were correctional officers.

The dependent variables (job involvement and organizational commitment) were measured using six items (four and two, respectively), with answers given on a 5-point Likert scale. The five independent variables (views of inmate medical services, as noted in the first paragraph) were measured using 12 items in total. Demographic characteristics were also measured.

For job involvement, statistically significant correlations were found with the variables of age, position, infectious disease, quality medical care and privacy rights variables. Older staff and those who were correctional officers tended to report higher involvement than did younger staff and noncustody staff, respectively. Staff who viewed infectious diseases as properly handled had higher job involvement, as did staff who felt that quality medical care was provided. Finally, staff who felt inmate privacy rights placed staff at risk reported less job involvement.

For organizational commitment, significant correlations

were found for position, tenure, infectious disease, quality medical care, officers respond timely to medical needs and privacy rights put staff at risk. Correctional officers in general reported higher commitment than did noncustody staff. However, the longer employees had worked at the jail, the lower the bond with the organization. Views that infectious disease issues were properly handled, that there was quality medical care and that officers respond quickly to medical needs were all associated with higher job involvement. Conversely, views that inmate privacy rights threatened staff safety were associated with lower job involvement.

Overall, the authors conclude, views of inmate health care were related to both involvement and commitment. They suggest that correctional researchers and administrators should work to explore and improve views of inmate medical care issues among staff.

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- Geriatric Inmates: Policy and Practice – *Angela Silletti*
- Initial Management of Incarcerated Pregnant Women With Opioid Use Disorder – *Alane O'Connor & Nathaniel Bowling*
- A Senior Management Perspective on the Policy Debate of Needle and Syringe Exchange Program Provision in Irish Prisons – *Jay P. Rosalim*
- Interest and Knowledge of HIV Pre-Exposure Prophylaxis in a Unified Jail and Prison Setting – *Lauren Brinkley-Rubinstein, Christina Crowley, Madeline C. Montgomery, Meghan Peterson, Nickolas Zaller, Rosemarie Martin, Jennifer Clarke, Manisha Dubey & Philip A. Chan*
- Improving Medication Adherence Among Drug-Using HIV-Infected Formerly Incarcerated Individuals: A Pilot Test of Two Interventions – *Tawandra L. Rowell-Cunsolo, Hyun K. Hong, Rahma Mkuu & Amber Britton*
- Gender Differences in Health Care Needs and Service Attainment Among Violent Offenders – *Mary H. Hughes, Molly Smith, Timothy C. Brown & Marc D. Glidden*
- The Effects of Inmate Medical Issues on Correctional Staff Job Involvement and Organizational Commitment – *Eric G. Lambert, Eugene A. Paoline III & Nancy L. Hogan*
- Effect of Yoga on Antiretroviral Adherence Postincarceration in HIV+ Individuals – *Alexandra S. Wimberly, Robert Gross & Molly Layde*

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Seeking a Friend for the CCHP-A Exam

by Barbara S. Granner, CCHP

In 2019, 10 people took the Certified Correctional Health Professional – Advanced exam, the largest number in one year, bringing the total number of CCHP-As to 41.

In addition to having the requisite education, experience, documentation, degrees and diplomas, these 10 had a “secret weapon”: a buddy, or a group of buddies, to share the experience and encourage them along the way.

It was over coffee at an NCCHC conference that Johnnie Lambert, RN, Johnny Wu, MD, and Denise Rahaman, MBA, RN, decided the time had come. “If I hadn’t connected with them I might not have taken the step,” says Lambert. “I had thought about it over the years, but never committed until Denise said, ‘Let’s make a pact to do it this year.’”

Tracey Titus, RN, says she always thought the Advanced designation was out of reach, until she made a pact with Jeffrey Alvarez, MD, that pushed her “over the edge.”

Mari Knight, MSN, RN, teamed up with Josie Mabalay, MA. Says Knight: “If it weren’t for the two of us doing it together, I’m not sure I would have stuck with it. We carried each other and spurred each other on. I thought I could do it on my own ... but I never did.”

Team members supported each other in so many ways: simply touching base and providing a friendly nudge or reminder about deadlines, discussing potential exam questions, encouraging and cheerleading when the going got rough and, on the day of the test, having a friendly face in the exam room. “We both vacillated depending on what was on our plate,” says Mabalay. “When she was busy, I provided her with a list of helpful articles I had read. When I was ready to back out, she lifted me up.”

Acing the Exam ... and the Application

For these CCHP-A testers, completing the exam application was the first and perhaps highest hurdle to jump. Unlike the other CCHP exams, CCHP-A requires an in-depth application that details the individual’s experience and contributions to correctional health care—and the application itself is reviewed for acceptance. That can be daunting for those who doubt their own accomplishments, or their organizational skills. “Getting myself organized was the hardest part: finding references, updating my resume, putting all the documentation in order,” says Lambert.

Having a buddy creates accountability—or friendly competition! Says Mabalay, “Mari got her application completed right away, and being competitive in nature, I had to get mine done, too.”

CCHP-A candidates take an essay test, with four hours to complete it. While that might sound exhausting, last year’s cohort was pleasantly surprised to find themselves feeling well prepared. “On the day of the exam I felt good and confident. All the stress and anxiety were gone,” reports Knight.

“I didn’t think I would have enough to say, but I used every bit of the four hours,” says Titus.

Words used to describe the test include fun, challenging, “not as difficult as I expected” and pertinent. “It was like a typical day at work,” says Wu. “It asked about the type of situations I encounter and have to think through every day.”



Correctional health professionals mingle at the CCHP-A lounge at NCCHC’s 2019 National Conference

The key to success, everyone agrees, is to understand the NCCHC standards, not merely recite them.

“You need to know the standards inside, outside and upside down,” says Lambert. “You don’t need to quote them, but you need to know what they mean and how to apply them.”

Some Friendly Advice

If you are considering applying to take the Advanced exam, consider this advice from 2019’s newly minted CCHP-As:

- Plan ahead – way ahead. Start the application process months in advance.
- Be prepared to describe what you have done to advance correctional health care. That includes publishing, presenting, serving on NCCHC committees and the like.
- Study the NCCHC standards. Think: How do you use this standard to do your job? In the words of Jeff Alvarez, “Get the book. Read the book. Understand the book.”
- And do like they did, with a little help from your friends.

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

Thanks to the CCHP-As interviewed for this article:

Johnnie Lambert, RN, CCHP-A, consultant (in photo above, in red); Denise Rahaman, MBA, RN, CCHP-RN, CCHP-A, executive director for corrections, CFG Health Systems (far right); Tracey Titus, RN, CCHP-RN, CCHP-A, director of policy and accreditation, Centurion (in black and white). Not pictured: Jeffrey Alvarez, MD, CCHP-P, CCHP-A, chief medical officer, Western states, NaphCare; Mari Knight, MSN, RN, CCHP-RN, CCHP-A, director of clinical programs, CFG Health Systems; Josie Mabalay, MA, CCHP-A, medical program director, Cermak Health Services at Cook County Juvenile Temporary Detention Center; Johnny Wu, MD, CCHP-P, CCHP-A, chief of clinical operations, Centurion

For more advice, see “Preparing for the CCHP-A Exam” at www.ncchc.org.



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19%
12%
12%
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5%
6%

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Trauma-Informed Care for Youth: It's All About Trust: Thursday, March 26, 1-2 pm CST

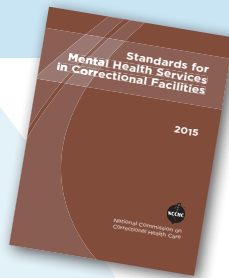
The speaker will give an overview of adverse childhood experiences with a focus on neurodevelopmental science. He will review the effect of secure attachment on brain development, how unresolved traumas alter behavioral patterns and the principles of therapeutic approaches that can help resolve behavior patterns. Practical advice for implementing these principles in a juvenile justice setting will be shared. 1.0 CE hour available. Sign up at www.ncchc.org/events/conferences.

2015 STANDARDS for Mental Health Services in Correctional Facilities

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

This second edition represents the **culmination of hundreds of hours of careful review** by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain **the most authoritative resource for correctional mental health care** services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women's health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.



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Standards Q & A

Expert Advice on NCCHC Standards

by Jim Martin, MPSA, CCHP

Proper Orientation Is Essential

Q My question is about the orientation packet that our company states is mandatory per NCCHC standards. We are told to sign all of the different spots on the packet stating that we have been oriented to these areas of the facility, but the orientation does not actually do this, and in fact it is conducted as quickly as possible without any structure. Is this the intent of the standard?

A Orientation into a correctional health care setting is very important and should not be handled lightly or loosely. Standard C-09 Orientation for Health Staff states that health staff are properly acclimated to work in the correctional environment and understand their roles and responsibilities. A basic orientation should be conducted on or before the first day of on-site service. Within 90 days of employment, all health staff should complete an in-depth orientation. The orientation program should be documented and kept on file. If the orientation for your

new health staff is not living up to this standard, you should consider reevaluating your orientation plan. Your staff deserves it.

Keep Those Patient Encounters Private!

Q Our county jail is accredited by NCCHC. I work in the intake department, usually in an office where there is privacy when doing the medical history. When the jail is short-staffed and there is no deputy available to sit outside my office, I am expected to use an area that is not private at all. The inmate sits in a cubby and the nurse is behind a window. Behind the nurse sits office personnel and they can hear everything that I say and what the inmate says about their medical and mental health history. Does this comply with the standards?

A This is a good question and a situation that we heard described before. Standard A-07 Privacy of Care states that health care encounters and exchanges of information are to remain in private. This includes discussions of protected patient health information and clinical encounters. Privacy should be afforded during physical exams, with special considerations for breast, rectal, pelvic or other genital exams. We understand that extenuating circumstances sometimes prevent this, but it should be the exception and not the norm.

Initial Health Assessments: Who Signs Off?

Q If an RN performs the initial health assessment after documented training, does the MD still need to sign off on the health assessment? I know this was a previous requirement, but I no longer find this in the 2018 standards.

A This was one of the changes to the 2018 edition of the jail standards. Standard E-04 Initial Health Assessment says that a physical examination is to be performed by a qualified health care professional (defined as a physician, physician assistant, nurse practitioner or nurse). There is no compliance indicator that says a physician has to sign off on the assessment. The responsible physician does, however, need to determine the components of the initial health assessment.

Jim Martin, MPSA, CCHP, is NCCHC's vice president of development. 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.

2018 STANDARDS for Health Services in Jails or Prisons

The most authoritative resources for correctional health care services, the NCCHC Standards are continually updated to reflect the latest evidence and best practices in meeting professional, legal and ethical requirements in delivering correctional health care services.



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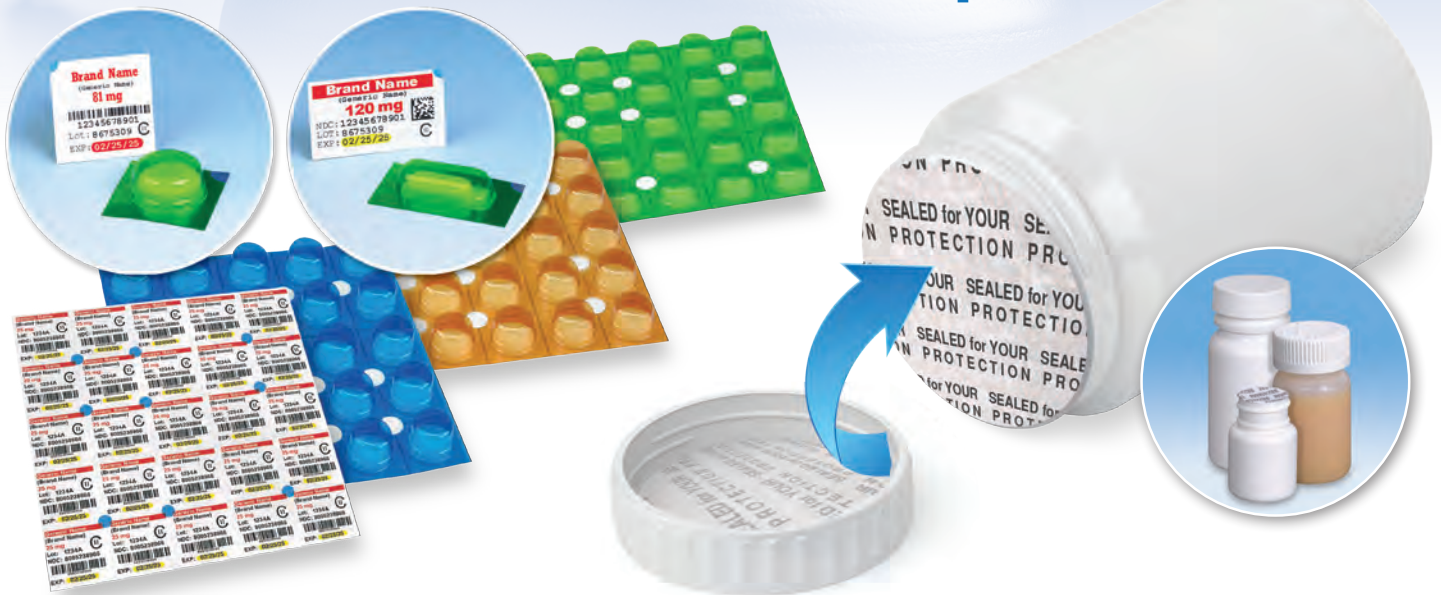
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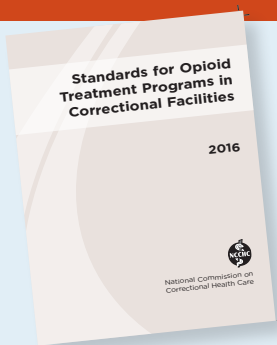
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NCCHC: Support for Opioid Treatment in Correctional Facilities



Bureau of Justice Statistics data show that nearly two-thirds of people in jail meet criteria for substance use or abuse, putting jails on the front line for substance abuse treatment. Jail-based medication-assisted treatment programs for opioid use disorder are desperately needed to stem the cycle of addiction, incarceration, release, relapse and recidivism. Jails across the country are beginning to implement MAT programs. NCCHC can help you make a difference in your facility and community.



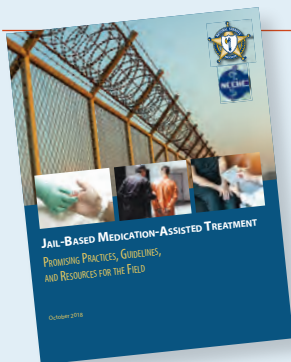
OPIOID TREATMENT PROGRAM STANDARDS

NCCHC's Standards for Opioid Treatment Programs reflect the 2015 revision of the Federal Guidelines for Opioid Treatment Programs, published by the Substance Abuse and Mental Health Services Administration. The standards are linked to specific federal regulations and offer guidance for providing OTP services in a correctional facility.

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JAIL-BASED MEDICATION-ASSISTED TREATMENT: PROMISING PRACTICES, GUIDELINES AND RESOURCES

Co-produced by the National Sheriffs' Association and NCCHC

This free resource supports jail administrators in providing effective treatment for individuals with opioid use disorder. Download the guide at [ncchc.org/jail-based-MAT](https://www.ncchc.org/jail-based-MAT).

For more information, visit [ncchc.org](https://www.ncchc.org).