

# CorrectCare<sup>®</sup>

The magazine of the National Commission on Correctional Health Care

## Transitions in Health Services

### How to Mitigate Risk and Reduce Disruption to Care

*Patient Lawsuits:  
How NCCHC  
Standards Can Help*

*Successful Juvenile  
Nutrition Strategies*

*Thoughts on Injustice  
and Racism*

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



Real managed care  
makes a *real difference*.

**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.



**centurion**<sup>™</sup>

[CenturionManagedCare.com](http://CenturionManagedCare.com)



# contents



# 8

## Features

- 6** Legal Briefs: Three Takes on Deliberate Indifference
- 8** Transitions in Health Services: How to Mitigate Risk and Reduce Disruption to Care
- 9** Four Keys to a Successful Health Services Transition
- 12** The Best Defense Is a Good Offense: NCCHC Standards in Patient Lawsuits
- 16** Food Fight! Winning Nutrition Strategies for Juveniles

## Departments

- 2** NCCHC News
- 3** Chair Notes: Confronting Injustice: Don't Let Fear Get You Down
- 5** Guest Editorial: Addressing Racism in Correctional Health Care
- 19** Journal Preview: Can Family Therapy Reduce Recidivism?
- 21** CCHP Page: Top 10 Reasons to Become a CCHP-RN
- 22** Exhibitor Opportunity
- 23** Classified Ads and Ad Index
- 24** Standards Q&A

## BOARD OF DIRECTORS

- Robert E. Morris, MD, CCHP-P (Chair)**  
Society for Adolescent Health and Medicine
- Joseph V. Penn, MD, CCHP-MH (Chair-Elect)**  
American Academy of Psychiatry and the Law
- Thomas J. Fagan, PhD, CCHP-MH (Immediate Past Chair)**  
American Psychological Association
- Nancy B. White, MA, LPC (Treasurer)**  
American Counseling Association
- Carolyn Sufrin, MD, PhD (Secretary)**  
American College of Obstetricians and Gynecologists
- Jeffrey J. Alvarez, MD, CCHP-P, CCHP-A**  
American Academy of Family Physicians
- Oscar Aviles, CJM, CCE, CCHP**  
American Jail Association
- Patricia Blair, JD, PhD, CCHP-RN, CCHP-A**  
American Bar Association
- Paula Braverman, MD**  
American Academy of Pediatrics
- Carol Cramer Brooks, MPA**  
National Partnership for Juvenile Services
- Jennifer Clifton, DNP, FNP-BC, CCHP**  
American Association of Nurse Practitioners
- Eileen Couture, DO, RN, CCHP-P**  
American College of Emergency Physicians
- Wendi R. Wills El-Amin, MD**  
National Medical Association
- Kevin Fiscella, MD, MPH, CCHP**  
American Society of Addiction Medicine
- Robert L. Hilton, RPh, CCHP**  
American Pharmacists Association
- Alison O. Jordan, MSW, LCSW**  
American Public Health Association
- Ilse R. Levin, DO, MPH, CCHP-P**  
American Medical Association
- Elizabeth A. Lowenhaupt, MD, CCHP**  
American Academy of Child and Adolescent Psychiatry
- Nicholas S. Makrides, DMD, MPH**  
American Dental Association
- Pauline Marcussen, DHA, RHIA, CCHP**  
American Health Information Management Association
- Edwin I. Megargee, PhD, CCHP-MH**  
International Association for Correctional and Forensic Psychology
- Mary Muse, MSN, RN, CCHP-RN, CCHP-A**  
American Nurses Association
- Peter C. Ober, JD, PA-C, CCHP**  
American Academy of PAs
- Debra Pinals, MD**  
American Psychiatric Association
- George J. Pramstaller, DO, CCHP**  
American Osteopathic Association
- Sheriff B. J. Roberts**  
National Sheriffs' Association
- Christopher T. Rodgers, MPA, MBA**  
National Association of Counties
- Jayne Russell, MEd, CCHP-A**  
Academy of Correctional Health Professionals
- Steven Shelton, MD, CCHP-P, CCHP-A**  
American College of Correctional Physicians
- Samuel Soltis, PhD, MHA, CCHP**  
American College of Healthcare Executives
- Sylvie R. Stacy, MD, MPH, CCHP**  
American College of Preventive Medicine
- Barbara A. Wakeen, MA, RDN, CCHP**  
Academy of Nutrition and Dietetics
- Melvin H. Wilson, MBA, LCSW**  
National Association of Social Workers
- Liaison Pending**  
American College of Physicians

Cover design by Jill Cooper; cover image © Gorodenkoff/Shutterstock

## Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification, or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased, expert, and dedicated only to recognizing and fostering improvements in the field of correctional health care.

Copyright 2020 National Commission on Correctional Health Care. Statements of fact and opinion are the responsibility of the authors alone and do not necessarily reflect the opinions of this publication, NCCHC or its supporting organizations. NCCHC assumes no responsibility for products or services advertised. We invite letters of support or criticism or correction of facts, which will be printed as space allows. Articles without designated authorship may be reprinted in whole or in part provided attribution is given to NCCHC.

Send correspondence to Barbara Granner, CCHP, Editor  
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614  
Phone 773-880-1460; Fax 773-880-2424  
info@ncchc.org; www.ncchc.org  
For advertising, contact sales@ncchc.org.

## NCCHC Launches Correctional Health Foundation

To meet the increasingly complex needs of today's incarcerated populations, NCCHC has launched the NCCHC Correctional Health Foundation, a bold new initiative that will accelerate the organization's important work.

The Foundation's mission is to champion the correctional health care field and serve the public by supporting research, professional education, scholarships, and patient reentry.

"Over 95% of incarcerated individuals will eventually return to their communities, and their health problems and needs will often continue," says Jennifer Riskind, Foundation director. "Supporting their health with interventions, care, and education makes the entire community healthier."

Led by Riskind and board chair Thomas Fagan, PhD, CCHP-MH, the Foundation seeks to support clinical research that identifies best practices and leads to better outcomes in correctional settings; gather, analyze, and disseminate data to support high-quality correctional health

care; encourage health care efficacy and efficiency through support for evidence-based medicine; mentor the next generation of correctional health professionals and support their continuing education needs; and provide resources to incarcerated individuals on supporting their own health.

"For over 40 years, our organization has been at the forefront of leading dramatic improvements in patient care in corrections," says NCCHC CEO Deborah Ross, CCHP. "Despite much progress, our constituents face complex challenges. Limited health care budgets, greater acuity of mental health needs, the opioid crisis, and the rise of infectious diseases like COVID-19 are just a few of the significant problems the Foundation will address."

Initial funding priorities include clinical research to further the correctional health field and scholarships for students and young professionals to attend NCCHC events

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



### Position Statements Reaffirmed, Updated

Recently revised NCCHC position statements reflect updates to women's health care in correctional settings, administrative management for people with HIV, optimizing postrelease insurance coverage, and STI testing for adolescents and adults upon admission.

Find them at [ncchc.org/position-statements](https://ncchc.org/position-statements).

### CCHP-P Study Guide Now Available

Physicians considering taking the CCHP-P specialty exam can find a handy test overview guide on the NCCHC website. It provides details about what physicians preparing for the exam are expected to know, suggestions for study sources, and the percentage range of questions for each section.

Available at [ncchc.org/cchp-p](https://ncchc.org/cchp-p).

## Calendar of events

<b>August 26</b>	CCHP exams, Galveston, TX
<b>August 29</b>	CCHP exams, Phoenix, AZ
<b>Sept. 3</b>	Last day of access to Correctional Mental Health Care Conference educational content
<b>Oct. 3</b>	CCHP exams, Boise, ID
<b>Oct. 14</b>	CCHP exams, Canandaigua, NY CCHP exams, Topeka, KS
<b>Oct. 31-Nov. 4</b>	National Conference on Correctional Health Care, Las Vegas
<b>Nov. 1-2</b>	CCHP exams, Las Vegas
<b>Nov. 18</b>	CCHP exams, Dallas, TX

## Virtual Surveys During Coronavirus, and Beyond

NCCHC's accreditation team has begun conducting virtual surveys, having pioneered a safe and effective plan to continue the vital mission of accreditation while also protecting the health of correctional employees, surveyors, and the incarcerated.

Protocols to ensure that the survey's rigor is not compromised include a HIPAA-compliant videoconferencing platform, prereview of electronic patient records, live inspections using phones and laptops, and secured phones or tablets for patient interviews.

For facilities facing accreditation or reaccreditation, NCCHC Vice President of Accreditation Amy Panagopoulos, MBA, BSN, says that electronic health records, connectivity throughout the facility, and leadership support are key factors for a successful virtual survey. She sees tremendous benefits in accomplishing a virtual survey, even after COVID-19 restrictions are relaxed. "While we don't foresee moving completely to virtual surveying, we want to continue certain aspects to streamline the on-site visits. Plus, it's good to know we can still conduct a survey if there's a snowstorm or other emergency that affects our surveyors' travel."

For more information, contact Panagopoulos at [accreditation@ncchc.org](mailto:accreditation@ncchc.org).

## Confronting Injustice: Don't Let Fear Get You Down

by Robert E. Morris, MD, CCHP-P

**R**ecent events in the United States have generated a lot of conversations about racism, a plea for ongoing discussions, and calls for change.

Fear can be a powerful impediment to dialogue about racism. Fear of saying the wrong thing, fear of being challenged, fear of losing a friend or a job – those fears are real. Saying nothing is so much easier: “No one else seems to mind. Why stick out my neck? We’ve always done it this way. I’m sure ‘they’ know better.” Speaking out can be lonely and risky.



### Corrections Connection?

I observe that same fear and reticence in many areas of corrections. The fear of negative consequences and the need for courage to speak up are the same, whether the issue is blatant racism, more subtle bias, an unfair policy, or some other sort of behavior or injustice.

The question is: How do we react when we see wrongs being perpetrated? What do we do when we witness racism, poor policies, or plain old rudeness? Do we speak up and make an effort to correct wrongs?

As Beverly Daniel Tatum, PhD, points out in “Why Are All the Black Kids Sitting Together in the Cafeteria?” silence has a price. When we fail to speak up – about racism, inappropriate cultural biases, prejudiced behavior, poor or negative policies – the result is a loss of human potential, lowered productivity, and a danger of increasing tides of fear and possibly violence. Failure to speak up can alienate us from others, especially our patients, and ironically can lead to burnout: “Things are awful here. I hate working in this dysfunctional organization. I am powerless to make needed changes.”

That pattern can happen to anyone – staff members, managers, supervisors, and other leaders.

### Action and Reaction

How can we begin to think about addressing needed changes? Here are my suggestions:

Form alliances with like-minded coworkers, as well as others inside and outside your organization, to discuss mutual concerns and possible solutions for improvement. Don’t condemn yourself to isolation. Change work is tiring so look to your community and create a network of support. You only need a few people to keep you going.

Participate in NCCHC events. Communicate with others through NCCHC’s online community, Connect. Join the Academy of Correctional Health Professionals or the American College of Correctional Physicians. Identify a mentor. Look for champions who have been successful.

Turn to the NCCHC standards and position statements for guidance.

Build on momentum. Success in making even small changes results in an improved sense of empowerment, confidence, and self-worth. Success is a stimulus for continuing to work for improvements and a connection to others who share the same values.

Identify your strengths and use them. It can feel like there are too many problems to address and you can’t fix everything. Concentrate instead on one or a few problems that are important to you and have the potential for change. Do the right thing by responding to your inner truth.

### Discomfort Leads to Progress

If you are in a supervisory or management position, suggestions for change and interventions might make you uncomfortable. But that is the only way progress can happen. If you are challenged, try to avoid defensiveness. If you can welcome criticism, suggestions, and input from employees, you will find that a collaborative organization functions more effectively and smoothly. For example, an improved procedure or policy may cost more upfront but can prevent larger expenses in the future.

If you make a mistake or a wrong decision or inadvertently offend someone, apologize and move on.

Working for change takes hard work and energy, but not as much as the energy it takes to maintain a sense of resignation and defeat. And the results are much more rewarding.

---

*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.*



ONLINE COMMUNITY FOR  
CORRECTIONAL HEALTH PROFESSIONALS

[connect.ncchc.org](http://connect.ncchc.org)   [connect@ncchc.org](mailto:connect@ncchc.org)





One Team.  
One Goal.  
Working to help put lives back together.

No matter what obstacles arise, Wexford Health employees rise to the challenge. Together, we adapt. Together, we work to help underserved populations. Together, we revolutionize correctional health care.

If you are looking for a fast-paced, challenging environment that empowers you to use all of your skills, join Wexford Health's supportive, multidisciplinary clinical team and make a real difference in patients' lives.

To learn about careers at Wexford Health, or to apply, please visit [jobs.wexfordhealth.com](https://jobs.wexfordhealth.com) or contact us at 1-800-903-3616.



## Addressing Racism in Correctional Health Care

by Wendi Wills El-Amin, MD, and Carolyn Sufrin, MD, PhD

In eight minutes and 46 seconds, the world witnessed a profound tragedy. That duration, the time a white police officer's knee was on the neck of George Floyd, an unarmed Black man, has sparked a resurgence of racial reckoning in the United States, one in which we believe correctional health providers must engage.

Our work, after all, is at the intersection of individual patients' health, public health, law enforcement, and racialized social structures, in ways that are different from the work of community health care practitioners. What happens to our incarcerated patients mirrors what is happening in broader U.S. society. We have a unique opportunity to understand how racial inequity shapes our work, allowing us to better care for our patients and, in turn, help undo some of the unjust realities of our society.

We are correctional health care physicians. One of us is Black, and one of us is white; one of us has experienced racial discrimination in subtle and overt ways throughout her life, and one of us has benefited from the societal structures that make it easier for white people to be safe and successful. We write this together because we believe that it is a collective response, one that acknowledges those different experiences, that will carry us forward.

History matters. When we understand how correctional health fits within our nation's larger history we understand how we can best care and advocate for incarcerated patients. History teaches us that police forces have origins in 17th-19th century slave patrols, when armed white men would capture escaped slaves to return them to their owners. After slavery ended, many states passed laws that criminalized minor behaviors so that former slaves could be arrested and forced to labor on plantations as punishment. As a result, Black Americans are incarcerated at 5 times the rate of white Americans, a disproportion that has not been shown to correspond to actual crime rates.

### Racism, Not Race

But it's not just the undeniable ways that Black communities are disproportionately overpoliced and overincarcerated that we need to be aware of. Black individuals enter custody with a higher burden of chronic diseases than white individuals – a downstream manifestation of adverse social and structural determinants of health. Research has shown that incarceration overall exacerbates racial disparities in health outcomes.

One of the most chilling illustrations of the dynamics of incarceration, health, and racism is the disparities in COVID rates in correctional facilities, which mirror the disparities seen in the community. According to data collected by the

NCCHC–Harvard COVID study, rates of infection are over 3 times higher among Black incarcerated individuals than white incarcerated individuals. This matches COVID racial disparities in the general population, as well.

We should examine this troubling trend in COVID rates in the same ways we understand police brutality and mass incarceration. As outlined by physician and epidemiologist Camara Phyllis Jones, MD, PhD, MPH, because of the effects of structural racism, Black individuals are more likely to be exposed to the virus via less protected, essential jobs and incarceration. They are more likely to die from COVID because of preexisting chronic illness (again, related to determinants of health) and poorer access to health care.

NCCHC's mission is to improve the quality of health care in jails, prisons, and juvenile confinement facilities. We believe that mission should include commitments to justice, equity, and undoing racism, as these goals affect our incarcerated patients, our Black and other minority colleagues, and all of society. We join many of our supporting organizations in declaring that racism is a public health threat.

To move toward healing, we must navigate this enduring American tragedy with a posture of courageous humility and accountability to humanity. While statements of solidarity and editorials like this one are important in shared recognition of the problem of racism in correctional health care, we must move beyond words and commit to action. This is hard work and brings up trauma for everyone involved – the health care team, the other staff at institutions of incarceration, and our patients. We know our trauma response is to fight, flee, or freeze. With racialized and stressful moments, we may experience a combination of outrage, paralysis, and fear. We hope NCCHC leadership will elevate its commitment and action toward equity, diversity, inclusion, and antiracist work, both within the organization and in its collaboration with our partners in the field.

### Moving Forward

What could this look like for correctional health providers? We must recognize our own unconscious biases to examine how as individuals we may have been conditioned in subtle ways to treat patients of color inequitably – not easy to admit. Evidence-based implicit bias training tools, which



Photo: Barbara S. Granner

*Continued on page 14*



## Three Takes on Deliberate Indifference

by Fred Cohen, LLM

In this new column, CorrectCare contributor Fred Cohen presents brief summaries of several cases.

### Case #1: The Experts Have Spoken (But the State's Physicians Were Not Listening)

Washington State inmate Etienne Choquette was awarded \$549,000 in punitive and compensatory damages by a jury where nontreating prison clinicians ignored the treatment recommendations of outside experts.

Prior to incarceration, Choquette was diagnosed with MS accompanied by painful neuropathy. Gabapentin had relieved the pain, and two outside experts not only recommended its continuance but also sought to increase the dosage.

A prison review committee refused the increase and, in fact, acted to discontinue the medication. A reasonable factfinder, finds the magistrate judge, could find deliberate indifference in the five-month withholding of gabapentin and the consequential needless suffering during that period.

This is not a mere disagreement as to treatment. It is the ignoring of two medical experts and following the contrary advice of inhouse, nontreating, nonexpert health care providers in an area of serious medical need. The magistrate judge's report was followed with acceptance by the district court leading to the verdict.

**Comment:** This report bolsters the premise that substituting observation for treatment with an effective drug prescribed by two expert physicians just may constitute deliberate indifference. See *Choquette v. Duvall* (W.D. Wash. 2018).

### Case #2: Continuing Ineffective Care

In *Gonzalez v. Maurer* (D. Conn. 2020), a Connecticut inmate complained about the ineffective treatment he had received for a painful skin condition that emerged after he had surgery for a facial injury suffered while in prison.

The doctor accepts that plaintiff's painful and itchy scalp was a serious condition. He disputes whether he was deliberately indifferent.

Over time the doctor prescribed various ointments to be applied to Gonzalez's scalp and head. That course of treatment did not work but was continued. The doctor had knowledge of the condition and the failure of topical care but continued it rather than refer the plaintiff to a specialist.

Further diagnosis, testing, or treatment would have challenged the finding that there is cause to deny the defendant's motion for summary judgment.

**Comment:** Always consider alternative care when early choices appear not to be working. A rationale for continuance or alteration of treatment is also very prudent.

### Case #3: It Might Be Deliberate Indifference!

Inmate Goodloe began complaining of pain from rectal bleeding immediately upon entering the Illinois DOC system. He thought it was a flareup of hemorrhoids. The doctor prescribed hemorrhoid medication. The pain persisted, Goodloe kept reporting it, and the doctor continued the ineffective treatment. An examination revealed anal warts and an acid treatment was given, which only exacerbated the pain. After many months, an outside expert diagnosed an anal fissure – a small tear in the anal lining. Surgery was performed and the previously unrelenting pain disappeared.

The district court initially granted summary judgment for the defendants.

Goodloe's condition was serious. Was the doctor's care evidence of deliberate indifference? The court states that a jury could so find. The reviewing court reversed and remanded the earlier decision.

The persistence of a course of treatment known to be ineffective in this case is itself evidence of deliberate indifference. An inexplicable delay in responding to this serious condition also supports a finding deliberate indifference.

**Comment:** Plaintiff was a persistent *pro se* litigant here – that is, he represented himself – and finally got the required attention.

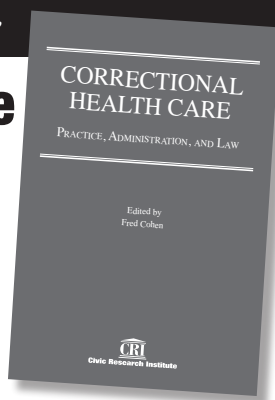
"Insight into the most significant issues in correctional health."

## 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.



Format: Casebound Book  
Leather, Gold Foil Stamp  
© MMXVII 416 pp.  
ISBN 978-1-939083-07-4  
List Price: \$135.95  
Title Code: CHCPAL  
<http://www.civicrosearchinstitute.com/chcpal.html>

**CIVIC Research Institute**  
P.O. Box 585 • Kingston, NJ 08528  
Tel: 609-683-4450 • Fax: 609-683-7291

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.

For subscription information, contact the Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; [civicrosearchinstitute.com](http://civicrosearchinstitute.com).



# CALIFORNIA

## CAREERS | LOCATIONS | LIFESTYLES



### Mental Health

#### Psychiatrists

\$266,844 - \$320,640

(Board Certified)

\$260,004 - \$311,592

(Board Eligible)

#### Psychologists

\$116,304 - \$129,840

(Licensed)

### Primary Care

#### Physicians

\$282,216 - \$296,328

(Time-Limited Board Certified)

#### Physicians

\$268,080 - \$281,496

(Lifetime Board Certified)

#### Physicians\*

\$324,540 - \$340,776

(Time-Limited Board Certified)

#### Physicians\*

\$308,292 - \$323,712

(Lifetime Board Certified)

#### Supervising Registered Nurses II

\$113,256 - \$141,780

(Non-Bay Area)

#### Supervising Registered Nurses II

\$124,848 - \$156,264

(Bay Area: Correctional Training Facility, Salinas Valley State Prison, and San Quentin State Prison)

Salaries as of 6/30/20. Subject to change upon approval of bargaining unit agreement.

**\*Doctors at select institutions receive additional 15% pay.**

## As a correctional health care professional,

you're already well-versed in the skills needed to provide care for this diverse and unique patient population. Now imagine taking your skills to the California State Prison System!

Together, the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) provide medical, dental, and mental health care to patients in our State-operated correctional facilities. Here, you'll find robust multidisciplinary teams with like-minded professionals dedicated to providing patient-centered primary care. And with locations throughout California, you're sure to find your perfect fit.

You'll also experience more of the California lifestyle with the positive work-life balance found with CDCR/CCHCS. This lifestyle is supported by great State of California benefits, including:

- Generous yearly paid time off and holiday schedule
- Robust 401(k) and 457 retirement plans (tax defer up to \$39k-\$52k per year)
- Comprehensive medical, dental, and vision insurance plans
- State of California retirement that vests in 5 years (visit [www.CalPERS.ca.gov](http://www.CalPERS.ca.gov) for retirement formulas)
- And much more

#### Physicians:

Danny Richardson at (916) 691-3155 or [CentralizedHiringUnit@cdcr.ca.gov](mailto:CentralizedHiringUnit@cdcr.ca.gov)

#### Psychiatrists:

LaTrece Phillips at (916) 691-4818 or [CentralizedHiringUnit@cdcr.ca.gov](mailto:CentralizedHiringUnit@cdcr.ca.gov)

#### Psychologists:

Tim Koch at (916) 691-2874 or [MedCareers@cdcr.ca.gov](mailto:MedCareers@cdcr.ca.gov)

#### Nurses:

Danielle Sawtelle at (916) 691-3036 or [MedCareers@cdcr.ca.gov](mailto:MedCareers@cdcr.ca.gov)

To apply online, please visit [www.cchcs.ca.gov](http://www.cchcs.ca.gov)



**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES**



EOE



# Transitions in Health Services

## How to Mitigate Risk and Reduce Disruption to Care

by Brent Gibson, MD, MPH, CCHP-P

**W**ith more than 20 years of medical experience, I am very familiar with the challenges inherent in any transition of care. I remember the angst I felt as a young medical student and doctor discharging a patient. Whether the patient was discharged to home, to another hospital, or to a skilled nursing facility, the transition created the possibility of disruption to the continuity of care. Any health care-related transition means new providers and caregivers, new medication sources, new routines, and new surroundings, as well as the possibility of new and different formularies, policies and procedures, utilization management processes, and corporate cultures. Another challenge: A large amount of medical information must find its way from one facility or group of caregivers to another.

Many of those same concerns are true in the correctional setting and can be potentially just as challenging for continuity of patient care. In corrections, however, when health services transition from one provider or model to a new provider or model, it isn't the care of one patient that is affected but of many patients, all at the same time. While the four walls of the care environment don't change, many other things can: physicians, nurses, mental health professionals, administrators, processes, policies, and procedures.

A transition can occur for a number of reasons, generally involving some combination of cost considerations, quality concerns, and the local political climate. Sometimes a county or state chooses to self-operate after a period of using a health services vendor; sometimes the reverse is true, when a sheriff or other local leader no longer wants to be in the business of providing health services and decides to contract with a vendor. Another common scenario is

for a county or state to change vendors from one (usually private) entity to another. That may occur when the incumbent fails to win a competitive bid or, less frequently, when the correctional facility or sheriff's office chooses to leave a current relationship and seek a partnership with a local public, private, or academic health system.

### Mitigation Strategies

This high-risk period can be mitigated in several ways.

- ▶ Retain quality health care staff if possible. A change of vendor does not necessarily mean that staff will change. In many cases, the health care staff remains largely intact, simply changing employers. Vendors who take this approach may do so because of local labor market conditions, or they may have an eye on reducing disruption to patients and other staff.
- ▶ Maintain the same health record. While some vendors use a proprietary record that goes with them when they leave, arrangements can be made at the beginning of a contract (or under a separate contract) for the facility to acquire its own enduring health record. While there are clear advantages to having an independent contract for a health record, choices may be limited. A corrections-oriented health record is a specialized product, and many of the more well-known records in use at hospitals and clinics may not be readily adaptable to a correctional environment. Health care in a jail or prison is integrated into correctional processes and may include numerous patient encounters, not only at intake and discharge but also at many points in between where care must be documented, such as nonemergent health requests, emergencies, chronic care clinics, and any time care is provided in a restricted environment

such as segregation. There are also specific illnesses and related situations that merit special attention in the health record, including behavioral health, suicide prevention, substance use disorder, and infectious disease. A high-quality correctional health record will make it easier for providers to document and trace a patient's care and assess its quality, through a correctional lens, without having to go on a scavenger hunt to find critical data.

- ▶ Ensure continuity of policies and procedures. As correctional health services companies provide care in an increasing number of facilities nationwide, it's important that policies, procedures, and protocols reflect local realities such as state law and local practices. Facilities should be able to readily transition locally applicable policies and procedures to operations under a new vendor. While economies of scale can have benefits, there is risk in homogenizing the oversight and attempting a uniform approach to health care. In fact, NCCHC-accredited facilities are expected to demonstrate use of locally tailored policies and procedures rather than a one-size-fits-all boilerplate across multiple facilities with a single parent vendor.
- ▶ Maintain successful aspects of an outgoing vendor's business relationships. That could include administrative or clinical features. Even the largest correctional health care companies cannot provide all needed services. That is usually remedied by establishing relationships with community providers such as individual practices, hospitals, health systems, or other resources. Patients may be transported to subcontracted practices, allowing specialist providers access to patients, or remote care options like telehealth may be employed. Efforts can be made during a transition to keep those important relationships intact. For example, if obstetrical services are provided by a local practice, it may not be necessary to make a change when a new vendor comes in. Arrangements for diagnostic services, such

as imaging and laboratory services, may be allowed to remain intact, providing important continuity.

### Maintain Patient Care Focus

Most importantly, be the consummate professional throughout the transition process. If an outgoing vendor is disgruntled or otherwise dissatisfied with the transition, that will almost certainly create problems and potentially degrade the quality of care before, during, and after the change. Because changes often occur when a client is not satisfied with their current service, great pains must be taken to exhibit the highest level of professionalism and focus on patient care throughout the transition. The outgoing vendor should not express "sour grapes" from having lost a contract, and it is equally important that the incoming vendor not gloat at having been awarded the contract. While a vendor may turn over services in one county to another vendor, sooner or later, perhaps at another location, the situation will be reversed. Maintaining good working relationships, even among competitors, is good both for patient care and for business.

As a mentor of mine always reminds me, when the situation is muddled, always focus on patient care and you won't go wrong. Her advice has never failed me. It starts from the top with executive emphasis on a smooth transition and flows down to frontline providers who can ensure that documentation is intact, supplies are stocked, equipment is in good working order, and patients are aware of the impending change.

Change happens and, as always in corrections, we must expect the unexpected. Preparation, professionalism, communication, collaboration, and transparency are the keys to continuity of quality patient care, even – or especially – during a transition.

---

*Brent Gibson, MD, MPH, CCHP-P, is chief health officer of NCCHC and managing director of NCCHC Resources, Inc.*

## Four Keys to a Successful Health Services Transition

by Jim Voisard, CCHP-A

**H**aving personally experienced and assisted with several transitions in correctional health services during my career, I have identified four critical, on-the-ground areas that must be addressed by leaders on site in order to have a smooth and successful outcome: comprehensive transition planning, leadership, ongoing communication, and training.

### Transition Planning

Often-cited reasons for the decision to make a change in health services include lack of adequate on-site and/or corporate leadership, inadequate staffing levels, alleged performance issues, budgetary concerns, an

increase in off-site transports and hospitalizations, and legal requirements imposed by the jurisdiction, a lawsuit, or court intervention. I have observed that there is often a combination of variables contributing to poor performance (or perceived poor performance), which may or may not be in the health services provider's control. I have also witnessed situations wherein a change of provider was clearly indicated.

Regardless of the reason precipitating the change in health care services, putting the necessary time and effort into a well-researched, customized, and flexible transition plan is crucial. All too often a cookie-cutter approach is taken to what is in fact a major operational

*Continued on page 10*



changeover. Every aspect of the current operation that can be reviewed and understood must be a central component of the planning process.

A comprehensive transition plan includes a detailed approach to staff retention and recruitment, health record maintenance/integration, pharmaceutical services, training, medical equipment and supplies, and a realistic time frame for the implementation to take place without disrupting patients' access to care. I have witnessed a number of transitions that were unorganized and poorly managed, resulting in a reduced level of care and a higher degree of liability exposure for both the providers of health care services and the agency for which those services were provided.

## Leadership

When health care services are moving from a self-operation model to a contract operation, it is crucial that the transition be managed by representatives of both the correctional agency and the new health care provider. Both must be actively involved in the transition

and remain engaged throughout the course of the contract. The designated representatives must be empowered with the authority to manage the transition, troubleshoot issues, and act in a decisive and timely manner.

When moving from contracted vendor services to self-operation, the correctional agency must engage health care professionals who have experience in a correctional setting. In corrections there are many business, operational, and health care complexities that must be addressed. For example, large vendors offer economies of scale that can influence pricing and bring with them national relationships for various services that a local operation may not know about or have access to.

## Communication

Open and ongoing communication is the catalyst that will generate a practical approach to accomplishing stated transition goals and objectives. Communication must be multifaceted and include both frontline health care and corrections staff. All too often, staff members are worried about losing their jobs, a reduction in pay and benefits, and possible mandatory shift changes while at the same time being tasked with changing procedures, protocols, and operational directives. They can feel as if their concerns are not understood or appreciated. When not given good guidance on the transition objectives, timelines, and impact on their professional or personal lives, staff may struggle to see potential benefits to new arrangements. However, if kept informed, shown appreciation, and have concerns acknowledged, health staff are more likely to understand that their efforts are integral to the overall success of the transition, tend to be less critical and more

productive, and cultivate a positive work environment.

Ensuring that the corrections staff is kept posted on the transition plan, especially in areas that directly affect their workload such as medication pass times and non-emergent health request processes, is very important when it comes to building and maintaining teamwork.

It is equally important to convey pertinent information to the patients who will experience various degrees of change in health care providers, processes, and medication formulary and administration. The lack of basic informative communication with the patients will lead to misunderstandings, unwarranted concern, and an increase in grievances, and complaints to the courts. Patients will be more tolerant of the transition and complain less when they feel they are not overlooked. Some correctional settings have inmate liaisons who can assist with the dissemination of basic health service-related information.

## Training

Training is a critical component of the transition that is all too often poorly planned due to short transition timelines, staffing shortages, and financial prioritization. Sufficient resources must be made available for training retained employees on new policies, procedures, and protocols, as well as more comprehensive training for all new staff. Agency and part-time staff should receive the same level of training as full-time staff if they are expected to carry out the same duties and have the same responsibilities.

Educating staff on the use of the electronic health record is often inadequate and problematic. Most vendors have proprietary health record software that does not remain at the facility when they are no longer contracted for services there. Even if an electronic health record was in place before the transition, sufficient time must be allotted to train staff on the new system, which inevitably contains vastly different processes, forms, and navigational pathways. All too often, the brief introduction to the new electronic record is inadequate and leads to staff frustration, major disruption in sick call processes, and insufficient patient information being entered into the record. Inadequate health record documentation is often cited in lawsuits that allege access to care issues and deliberate indifference.

If the transition entails moving from hard copy to electronic health records, training resources should be quadrupled.

## Opportunity for Improvement

Managed correctly, those four critical hands-on areas can ease the pain of a health services transition. Change is always difficult, but it doesn't have to be so disruptive as to interfere with high-quality health care. Looked at another day, change also brings with it opportunities for everyone involved. In fact, the very point of a transition is to make improvement. Well-planned and organized transitions can do exactly that.

---

*Jim Voisard, CCHP-A, is a correctional health care consultant with NCCHC Resources, Inc.*



NCCHC Resources team members Brent Gibson, MD, MPH, CCHP-P, managing director; Jim Voisard, CCHP-A, consultant, and Loretta Reed, PMP, ACP, project management office director

# NCCHCResources

Solutions From the Most Trusted Name in Correctional Health Care

## NCCHC Resources provides expert consulting services for correctional health care systems nationwide.

Our parent company, the National Commission on Correctional Health Care, is widely known and respected for its pioneering *Standards for Health Services*, national accreditation and certification programs, and premier correctional health care education.

With roots in NCCHC – the nation's leader in promoting correctional health care quality – NCCHC Resources offers **unparalleled breadth, depth, experience and perspective.**

**NRI will put together a team of correctional health care experts to address any sized project or challenge.**

- Specialized technical assistance
- Accreditation readiness
- Training & education
- RFP/RFQ support
- Health system assessments
- Health services monitoring

As jails, prisons and juvenile detention facilities strive to deliver constitutional health care, improve quality and reduce liability, NCCHC Resources offers **unique expertise** from the nation's foremost leaders in correctional health care.

A **nonprofit** organization, NCCHC Resources works to strengthen NCCHC's mission: to improve the quality of health care in jails, prisons and juvenile detention and confinement facilities.

Consulting services **FOR**  
correctional health care systems  
**BY** correctional health care experts



Photo: Maricopa County (AZ) Jail Systems

# The Best Defense Is a Good Offense (and a Good Set of Standards)



by Daniel Griffith, JD

Imagine yourself in the witness chair of a federal courtroom during a trial. You are confident that the health care treatment provided to the patient was appropriate, but the patient's attorney seems to be setting you up for a trap, so you are being careful with your answers. The attorney asks you: "Would you agree that the treatment you provide to patients must be to a certain standard?"

That's an easy one, you think to yourself. "Yes."

"And that standard is referred to as the standard of care?"

"Yes, that's my understanding." (Where is this going?)

"So if you are required to comply with those standards, you must know what the standards say, right?"

What do you say? "Yes, I know what those standards say," knowing you are about to get grilled about the precise language of some obscure standard and look foolish when it appears you really don't know the standards? Or say "No," implying that you comply with the standards but don't know what they say, and look even more foolish?

Correctional health care litigation has become a multi-billion dollar-per-year industry, and for a health care provider, the court's decision in a patient lawsuit can mean the difference between losing and not losing millions of dollars. The above scenario illustrates the important role that standards play in the outcome of health care-related lawsuits.

## Standards: 'Recommendations' or 'Requirements'?

Correctional health care lawsuits typically involve two separate types of claims: a medical negligence claim (wherein the issue is whether the health care treatment provided to the patient deviated from the appropriate standard of care) and a civil rights claim under the Eighth or 14th Amendment to the U.S. Constitution (wherein the issue is whether the treatment amounted to "deliberate indifference" to the patient's "serious medical needs").

In other words, those lawsuits generally turn on the

answers to two fundamental questions: What standard of care applies to the correctional health professional's conduct, and did the professional's conduct meet that standard? Both questions require a court (or a jury) to identify the standard that applies to a provider's conduct before making a determination as to whether the provider's conduct met that standard.

It is that critical first inquiry – What standard of care applies to the correctional health provider's treatment? – to which the NCCHC standards apply.

While most correctional health providers are familiar with the NCCHC standards, many don't know that compliance with those standards can often mean the difference between winning and losing a patient lawsuit. To appreciate the importance of the standards in that context, it's necessary to consider whether the courts regard them as "recommendations" or "requirements."

The Preface to the Standards manuals says they are "recommended requirements." That language may seem confusing – how can they be both recommendations and requirements? But the manner in which the standards are implemented makes clear that they are recommendations that become requirements.

If the standards are merely "recommendations," they are analogous to an outside specialist's suggestions to a correctional health care provider upon returning a patient to the correctional facility: "My recommended treatment should be implemented if practicable, but there are no real-world consequences if it can't be implemented." In the same way, if courts consider the standards to be merely recommendations, noncompliance would have no real impact on the outcome of patient lawsuits.

But they aren't truly requirements either. NCCHC cannot require states and counties to comply with the standards. States and counties do, however, typically incorporate compliance with the standards into their policies and require private correctional health care providers to comply with the standards. In that way, the standards become requirements.



## Experts and General Acceptance

The degree of care and skill required of a health care professional is typically beyond the understanding and knowledge of someone who is not a such a professional. Most correctional health care lawsuits, therefore, involve testimony by a medical expert who can identify, with specificity, the standard of care to which the providers should be held under the circumstances of that case. The expert then renders an opinion concerning whether the professional's conduct met that standard.

Expert witnesses are not free to impose their own standard of care upon health care professionals. Lawsuits would be virtually impossible to defend if a patient's expert were free to testify that, for instance, only physicians who are board-certified in emergency medicine should perform intake screenings or that all correctional facilities should include on-site physical therapy. Correctional lawsuits would devolve into a free-for-all, in which providers are held to some personal standard adopted by a patient's expert.

To avoid that confusion, courts apply a number of factors in deciding whether an expert's opinion will be allowed. One important consideration, the "general acceptance" factor, is critical to the role of the NCCHC standards in patient lawsuits. The general acceptance factor, as determined in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), is "whether the opinion has attracted widespread acceptance within a relevant scientific community." In other words, experts in correctional cases are required to identify the standard of care applicable to the provider's conduct, and that standard must be generally accepted in the professional community.

Clearly, NCCHC standards are generally accepted in the correctional community. Because of this general acceptance, experts who rely on the standards as the basis for their opinions are typically insulated from challenges to the admissibility of those opinions. Conversely, experts who attempt to hold correctional professionals to different standards are subject to challenge on the basis that such an opinion is not generally accepted in the correctional community.

Because the NCCHC standards are generally accepted in the correctional community – through the accreditation process and through incorporation into policies and procedures – experts frequently cite them as the standard of care. Since the central inquiry in any patient lawsuit is usually whether the health care treatment complied with the applicable standard of care, the issue essentially becomes whether the treatment was in compliance with the NCCHC standards.

To offer some sense of the prevalence of the NCCHC standards, they have been referenced in no fewer than 191 published opinions, and specific standards have been referenced in 129 published opinions. In fact, the standards have been described by the courts as "benchmark standards" for correctional health care (*Cole v. Epps*, 2007).

Just a few months ago, a federal court succinctly described the approach courts have taken in analyzing the importance of the NCCHC standards in patient lawsuits: "In the case of the NCCHC, its standards are the most demanding of the various standards in evidence and are likely more stringent than what is necessary to provide

constitutionally adequate mental health care in most cases." (*CPX v. Garcia*, 2020)

The federal court's language, albeit in the context of mental health and in comparison to other standards, suggests that compliance with the NCCHC standards is tantamount to proof that the health care met constitutional standards. The passage is as close as a court has gotten to saying outright what correctional litigators have been arguing for years: The NCCHC standards represent the standard of care in correctional litigation.

## NCCHC Standards Most Commonly Referenced in Correctional Health Litigation

Although there are 59 standards for health services in jails and 60 for prisons, certain standards are recurring themes in correctional health care lawsuits.

### Standard E-02 Receiving Screening

The standard provides that "screening is performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met." The receiving screening form is often the first document in the individual's chart, the first contact between the patient and a health care professional, and the launching point for many lawsuits. Receiving screening-related lawsuits often involve efforts by the patient's expert to expand the scope of the screening beyond what the actual standard requires by, for instance, calling for a more comprehensive physical examination, contending that the patient's prior health records should be obtained as part of the screening, or challenging the credentials of the screener. An effective defense in such lawsuits requires that the correctional professional involved recognizes the limited scope and purpose of the screening and not allow the standard to be expanded beyond its terms.

### Standard E-04 Initial Health Assessment

This standard requires that "inmates receive initial health assessments," including a physical exam, conducted by a "qualified health care professional," no later than seven calendar days after admission for prisons or 14 days for jails. Correctional lawsuits are rife with disputes concerning whether the patient's initial health assessment should have identified risks of conditions that were ultimately diagnosed later. If a 55-year-old patient is diagnosed with Stage IV colon cancer two years into his incarceration, you can be assured that the scope of the initial health assessment will be challenged by the patient's expert.

I believe the best protection against patient lawsuits

In May, a U.S. District Court judge ordered an end to a class action case after nearly 40 years of litigation, finding no constitutional violation in the health care provided to incarcerated individuals at the Idaho State Correctional Institution. The judge wrote, "The NCCHC accreditation and MCP [Modified Compliance Plans tied to NCCHC standards] compliance, while not determinative, constitute substantial evidence of adequate medical care." The judge highlighted that compliance with NCCHC standards is "powerful evidence" of compliance with Eighth Amendment requirements.

*Continued on page 14*

concerning the initial health assessment is adherence to national clinical protocols, particularly those related to the patient's age and risk factors. If a test was performed or not performed during the initial health assessment, the correctional provider should be able to identify at a deposition a national protocol which justifies the decision.

#### **Standard F-01 Patients With Chronic Disease and Other Special Needs and Standard A-08 Health Records**

Virtually every correctional facility has a chronic care program. The existence of such a program is integral to NCCHC accreditation. Consequently, correctional lawsuits seldom challenge the existence of a chronic care program under standard F-01, but they frequently challenge the operation of the program.

Chronic care programs usually designate the frequency with which patients in the program are to be seen by a provider (for instance, every 90 days). Lawsuits by patients in chronic care programs are exponentially more difficult to defend if the chart does not reflect the requirements of the program. The patient's treatment could be otherwise defensible and within the standard of care, but the easiest path to success for a patient's attorney is a scenario in which the chart reflects that the patient wasn't seen according to the schedule required by the program. No correctional professional wants to be under oath at a deposition explaining why there are no records in the chart reflecting compliance with the chronic care program's requirements.

#### **B-05 Suicide Prevention and Intervention**

The loss of a loved one by suicide is tragic for any family, and when suicide occurs in a correctional facility, those family members often pursue litigation. When that happens, virtually every aspect of the patient's treatment preceding the suicide can be fodder for criticism. Experts representing the patient's family often contend that the suicide was caused by the mental health professional's inadequate qualifications to assess suicidal ideation; failure to identify the patient's suicidal ideation upon intake and screening; misclassification of the patient, resulting in an inadequate level of supervision; and inadequate mental health treatment following intake. Most suicide cases involve judgment calls by the mental health professional and, whenever judgment calls are involved and the outcome is death, patient's experts have plenty of opportunities for second-guessing with 20/20 hindsight.

Although patient lawsuits involving suicides require an examination of each decision (and the cases generally rise and fall on these decisions), it helps immeasurably when the mental health professional can point to the facility's implementation of a suicide prevention program that meets the criteria in the NCCHC standard and the professional's adherence to the standard. Judgment calls are defensible. Noncompliance with the standard is much less defensible.

---

*Daniel Griffith, JD, is partner with Whiteford, Taylor, Preston LLC and managing attorney of the firm's Delaware office.*

### **Racism** *Continued from page 5*

are widely available online, can help this process. While bias training will not change the larger structural problems in society, like racial discrimination in arrests and sentencing, it is nonetheless important work to address the unconscious ways we treat certain patients differently.

As part of continuous quality improvement, correctional health services must track more facility-level health outcomes and treatment data according to race and ethnicity to help elucidate whether subtle bias or other race-based factors may play a role. Such race-aware CQI measurements are just as important as hemoglobin A1Cs.

We must individually commit to speak up, not be bystanders but upstanders. We must audit our sphere of influence and develop clear lines of accountability. Silence about this American tragedy does not recognize that this trauma is collective; we must all share in this immense pain. When humanity witnesses the injustice of racism, people respond to this trauma in different ways. This may show up at work in correctional settings in different ways. We must also recognize that many people who work in corrections are people of color and that working in a setting characterized by racial injustice may present a distinctive challenge.

NCCHC has stated its support for "all who seek to make our justice system more just, more fair, and more inclusive" and for working with individuals and organizations to do

such work that improves the health of incarcerated patients and their communities.

Racism, in all of its subtle and overt forms, is debilitating and a threat to public health. But it can be undone. *Estelle v. Gamble* transformed the landscape of correctional health over 40 years ago. We are now at another moment when we can transform correctional health care and make it more just. This critical time in history marks an opportunity for us to enhance the quality of our organizational cultures and interactions with colleagues, staff, patients, and community partners through an awareness of the need to address the structural injustices of racism in the daily work of correctional health care.

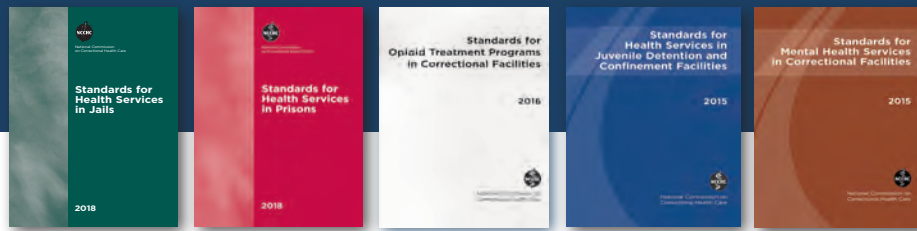
As Kareem Abdul-Jabbar wrote in the Los Angeles Times, "Racism in America is like dust in the air. It seems invisible – even if you're choking on it – until you let the sun in. Then you see it's everywhere. As long as we keep shining that light, we have a chance of cleaning it wherever it lands. But we have to stay vigilant, because it's always still in the air."

---

*Wendi Wills El-Amin, MD, is the NCCHC board liaison for the National Medical Association; Carolyn Sufrin, MD, PhD, is the NCCHC board liaison for the American College of Obstetricians and Gynecologists.*

# NCCHC STANDARDS

For authoritative guidance on correctional health care, turn to the organization that “wrote the books.”



With five *Standards* manuals, we've got you covered!

| JAIL | PRISON | OPIOID TREATMENT | JUVENILE | MENTAL HEALTH |



NCCHC *Standards* are widely recognized as the most rigorous and highly respected guidelines for quality, efficiency and safety. Continually updated, they reflect the evolution of health care, mental health, corrections and the law.



National Commission on  
Correctional Health Care

Order yours at [ncchc.org/standards](https://ncchc.org/standards).



# Food Fight! Winning Nutrition Strategies for Juveniles in Detention

by Sarah Magaziner, MD

Eating a healthy, nutritious diet during childhood and adolescence can have long-term positive effects on physical and emotional development, helping to prevent several chronic diseases including obesity, coronary heart disease, cancer, stroke, and type 2 diabetes.

Daily nutrition choices influence sleep, mood, cognition, and behavior, particularly during the critical period of adolescence. Among young Americans, however, common defi-



ciencies can compromise energy levels, bone health, and cognitive function. Those deficiencies and imbalances are often exacerbated among underresourced and detained youth.

Encouraging healthy nutrition and exercise habits among juveniles is an important part of the rehabilitation process, and I believe it also is an ethical issue, as failure to do so can perpetuate poor health outcomes that last a lifetime. An improvement in practices at juvenile facilities can have life-long effects on the health and well-being of the residents.

## Obesity Challenges

The prevalence of obesity among American youth has doubled in the past three decades, with the most recent data confirming that 1 in 3 children in the United States is clinically overweight or obese, and obese youth are likely to remain obese as adults. Obesity is considered easier to prevent than it is to treat.

Obesity is linked with serious immediate and long-term health consequences and is a leading cause of premature death in this country. Adolescents with weight difficulties and inadequate nutritional intake also are more likely to experience psychological and behavioral problems including depression, hyperactivity, difficulty focusing, and a reduced ability to learn new tasks and skills.

The most common cause of obesity is a daily caloric intake that exceeds expenditure, combined with a genetic predisposition for weight gain. Significant socioeconomic factors, such as lack of access to health care services, also contribute to the problem, as do inadequate nutrition education, unavailability of healthy foods, convenience, and youthful taste preferences. According to data from the 2011 National Health and Nutrition Examination Survey, solid fat and added sugars account for nearly 40% of children's caloric intake; added sugar in soda and fruit drinks alone provides nearly 10% of many juveniles' total calories, often without significant added nutritional value. Just drinking one extra can of soda per day without altering activity levels can produce a weight gain of 15 pounds in a year, and the caffeine found in soda and energy drinks can increase anxiety in those with preexisting anxiety disorders and can alter adrenal hormone production into adulthood.

Data confirm that many juveniles experience a dramatic increase in weight during time spent in detention. A 2011-2012 quality improvement project based on 61 youths at one juvenile facility revealed a 7% increase in obesity and a 12% increase in overweight from the time of admission to the study's conclusion 13 months later. Ten percent of the residents who were overweight on admission became obese and 20% of those with normal BMIs on admission became overweight. Reports from medical staff confirmed that the majority of adolescents gain weight during their stay: The health charts of 23 males showed that over the course of three months, 69% had gained weight. A study of 159 males from a different long-term juvenile correctional facility showed that the percentage who were overweight or obese increased from 38% to 66% after only three months.

## A Matter of Taste (and Other Barriers to Maintaining Best Practices)

The 2015 Standards for Health Services in Juvenile Detention and Confinement Facilities states that the food served to juveniles in detention facilities should foster good health and help support different phases of growth and development, while also addressing the dietary needs of individuals with health conditions. That can prove to be very challenging.

During my third year of medical school, I worked on an independent nutrition study at the Rhode Island Training School, a secure correctional facility for detained and sentenced youth located in Warwick, RI. Working closely with a registered dietitian who was hired to review menus and work with juveniles experiencing weight difficulties, I investigated the challenges involved in providing adequate and optimal nutrition to youth under an institution's care. And there are many challenges.

One barrier is the lack of nutritional guidelines specific to the correctional setting that fully capture the nuances of the environment. For instance, while RITS abides by federal pub-

lic school nutritional guidelines, those guidelines emphasize the nutritional content of breakfast and lunch, the meals typically provided in public schools, but not dinner.

Funding can also be a challenge, since eating healthily is notoriously expensive. To realistically address this barrier, institutions need to obtain a recent comprehensive budget and work with it to devise better dietary options, with involvement from kitchen staff and clinicians. It would also be helpful to gain a better understanding of where the food comes from to ensure that goals for improvement are realistic and attainable.

As every parent knows, healthy options are often not as inherently palatable to less mature palates as foods that contain more fat, sugar, and salt. At RITS, diet trays prescribed to residents who were struggling with their weight were often not as appealing as the other food options, creating opportunities for trading, bartering, and general noncompliance. Water is an essential part of a healthy diet and contributes to feelings of satiety that can prevent overeating. Depending on what the residents are permitted to have on their person, however, it can be difficult to provide easy access to water, and juveniles often express preference for sugary beverages.

An added challenge is that caloric requirements vary substantially according to age and sex. Given the varied population in many juvenile facilities, it can be difficult for staff to distribute calorically appropriate meals, resulting in many residents eating more than is recommended during mealtimes. Snacks and other between-meal food also contribute to an unhealthy cycle in which caloric intake severely exceeds expenditure.

As part of culinary vocational training at RITS, for example, students are given the opportunity to prepare and eat foods of their choice, including mozzarella sticks, chicken wings, french fries, and onion rings – not very healthy, but very popular. There is also a snack bar with items the juveniles can purchase with points have earned for good behavior, as well as a nightly snack. Furthermore, staff members bring in food, either as a reward, as an incentive to participate in extracurricular groups, or as a nurturing gesture. They describe this as a way to bring the adolescents comfort and stimulation, as well as to give them an element of control in an environment where they often feel its absence. However, all those extra food opportunities result in young people consuming up to twice their recommended caloric intake on a daily basis during incarceration. What can be done?

### Suggestions for the Kitchen ...

How can facilities provide the necessary calories and micronutrients to support healthy growth in a way that realistically balances caloric intake and expenditure? There is no secret recipe, but here are some suggestions:

Incorporate healthier, more nutrient-dense snack options such as fresh fruit, vegetables and dip, low-sugar yogurt, and granola bars into the canteen and culinary programs, while reducing the

portion size offered at meals.

To make healthy meal options more palatable, explore the use of citrus and spices to reduce the use of salt and add more vegetables to soups and stews. Freshness and storage limitations are often considered barriers to increasing fruit and vegetable consumption, but canned and frozen vegetables work well due to their longer shelf life, lower cost, and higher content of phytonutrients.

Look into seasonally available fruits and vegetables by forging partnerships with food pantries or local farms.

Replace grains with at least 50% whole grain options that contain 7 or fewer grams of sugar per ounce. There is concern about the reduced shelf life of these options as compared to processed white bread, so be sure to serve items with shorter shelf lives more quickly.

Since many juveniles mention missing the food they're accustomed to, serve foods similar to what they are used to eating at home. This approach might also help to involve the residents in their own nutritional choices and could provide comfort and familiarity without relying on sweets and fried foods. Staples like rice and beans are filling, cheap, and protein-rich, and easily lend themselves to the addition of more vegetables. There is room for creativity in this idea, as well, since it would be feasible to incentivize good behavior or healthy eating by allowing the juveniles to bring in recipes from home. A sense of ownership over their nutritional choices could be further cultivated in medical appointments, in health class, and in extracurricular activities, all of which might contribute to an increased feeling of control.

Pull ideas from the HealthierUS School Challenge or utilize teaching tools from [choosemyplate.gov](http://choosemyplate.gov) to introduce a fun sense of competition and empowerment surrounding good nutritional practices.

Create institutional guidelines as to what kinds of foods staff can provide to the residents.

Complete elimination of sweets and junk food would certainly not be a popular option, but a few slight modifications could go a long way, like offering pizza parties and fried foods instead of (rather than in addition to) other meals, limiting the frequency with which those options



*continued on page 18*

are offered, or finding ways to encourage participation and good behavior that doesn't involve food as a reward.

Reduce availability of sugary juices, sodas, and whole milk while making the water supply more appealing through filtration. Ensure that all milk is skim or low-fat, that flavored milks are offered only on special occasions, and that the juices provided are 100% fruit juice and free of added sweeteners or flavoring.

Overall, decreasing portion sizes and more carefully monitoring snacks while encouraging physical activity can help decrease weight gain among detained youth. There should also be well-established guidelines for the diets offered to those with other health conditions or allergies.

### ... And the Clinic

Health care staff have an important role to play in the care for overweight or obese juveniles.

Provide monthly dietary counseling and weight monitoring. Obtain fasting lipid panels and glucose levels every three

months, and draw vitamin D levels and liver function tests for those meeting criteria for obesity.

Remember that certain commonly prescribed antipsychotic medications, antidepressants, and lithium have been shown to increase appetite and weight. Since many youth begin taking medication for psychiatric conditions while they are detained, consider that possibility when looking at barriers to weight management.

Consider that some micronutrient deficiencies might be exacerbated in a correctional facility. These include vitamin D, a common deficiency that is likely exaggerated due to limited time outdoors, and iron, especially in menstruating girls. Provide supplementation as necessary.

Make all overweight and obese patients aware of their weight status so they can play a role in its improvement. Research shows that overweight youth are counseled about their weight at a much lower rate than those who are obese. Any nutritional interventions that take place can easily be assessed by looking at before and after BMI numbers.

Provide health education and instruction in self-care in topics including nutrition, as recommended by NCHC. Use techniques that have been shown to be effective with juveniles such as motivational interviewing, peer education, integration into their course curricula, and creative arts. Offering individuals diet logs or books to keep track of calories could help them to identify areas where changes could be made and those in which they've improved, and also could provide health care providers with more information on which to base their advice.

Encourage or lead physical activity and stress its role in proper body development. Engaging in high-energy activities can help alleviate stress and control anxiety, nervousness, manic episodes, and depression. Adolescents should exercise for at least one hour a day, seven days a week. It's important that exercise take place outside of the resident's room, and outdoor exercise is recommended when possible.

Detained youth deserve to enjoy the long-term health implications of maintaining good nutrition and a healthy weight in adolescence. By cultivating healthy habits and self-care among residents, staff can contribute to their rehabilitation rather than playing a role in predisposing them to severe health challenges. While there are many barriers to creating ideal circumstances for healthy weight maintenance among detained youth, through education and small adjustments, it can be done.

*Sarah Magaziner, MD, is a resident physician in pediatrics at MedStar Georgetown University Hospital, Washington, D.C.*

*Photos © Shutterstock: p.16 Dean Drobot, p.17 Schnapps2012, p.18 Josep Curto*



## Medi-Dose<sup>®</sup> EPS<sup>®</sup>

# Tamper Evident Products

**Unit Dose,  
Bar Coding,  
Pharmacy &  
Nursing Supply  
Experts!**

**Featuring:**

- ShrinkSafe ID Bands
- Labels & Tapes
- IV & Oral Syringe Caps
- Security Envelopes
- Control Sets & Seals

Scan Me!

**MediDose.com • 800.523.8966**



## Family Therapy: Can It Curb Recidivism?

The causes of criminal reoffending are many, but one challenge for those returning to society is the inability to deal with family conflict, psychopathology, substance abuse, and antisocial behaviors. In the July *Journal of Correctional Health Care*, prison psychologist Micaela Garofalo examines therapeutic interventions for couples and families of incarcerated individuals aimed at addressing these challenges. In short, family members are employed as resources and allies in the effort to better prepare the individual for reentry and, ultimately, to change behavior.

Garofalo outlines evolving trends in therapeutic programming in prisons over the past 50 years, and how the emergence of program evaluation led to evidence-based practice. She describes the risk-need-responsivity model, which is effective in reducing criminal behavior. The model helps to determine who should receive services (risk); the risk factors, criminogenic or dynamic, that interventions should address (need); and how best to match treatment to the patient's individual characteristics (responsivity).

### Varieties of Family Therapy

Garofalo briefly describes a range of programs targeting different patient populations. The juvenile justice system has been the subject of most research on family therapy in corrections, with several interventions found to meet the criteria of best practice. One example is Function Family Therapy, which focuses on reducing juvenile delinquency and aggressive behavior. Other programs vary in therapeutic goals, e.g., addressing substance abuse, solving specific problems, and family integration.

For incarcerated women, gender-responsive treatment that address trauma-related problems is needed. Sources of trauma include the mental health impact of separation from minor children, histories of violent interpersonal relationships, and associated substance abuse problems. Programs noted include Trauma-Informed Family Therapy and Emotion-Focused Family Therapy.

Research is lacking on family-focused intervention with adult criminal populations, but Garofalo cites several community-based interventions that may be adaptable, such as cognitive-behavioral family therapy and systemic couple therapy.

### Building Stronger Families

A key benefit of family therapy is reduced recidivism as strong family bonds are correlated with low reoffending. It can also reduce rule violations in the facility. Therapeutic goals are to reduce family conflict, identify and manage emotional disorders, and reduce behavioral problems through the effects of family and peer influences.

Patients gain greater awareness of family dynamics and the causes of conflict in their families, and they improve

their skills in problem-solving, coping skills, and communication, among other positive outcomes. Family therapy can also improve parenting skills (thus reducing future incarceration) as well family cohesion.

### JCHC Vol. 26, Issue 3: July 2020

- The Relationship Among Secondary Trauma, Self-Efficacy, and Correctional Nurses – *Ranee' Maree' Wright*
- Anger and Emotion Regulation Associated With Borderline and Antisocial Personality Features Within a Correctional Sample – *Patrick T. McGonigal & Katherine L. Dixon-Gordon*
- Special Needs of and Promising Solutions for Incarcerated Veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn – *Alexandara Pajak*
- Family Therapy in Corrections: Implications for Reentry Into the Community – *Micaela Garofalo*
- Occupational Therapists' Rehabilitation Orientation Toward People Who Are Incarcerated – *Sarah Tucker & Hon K. Yuen*
- Service Provision Study on the Implementation of a Nurse-Led Clinic in the Irish Judicial System – *Jay P. Rosalim*
- An Outcome Study on the Naloxone Education/Dispensing Program for Departure Patients at Cermak Health Services of Cook County – *Tony C. Leung, Stefanie Colyer, & Svetozara Zehireva*
- Fatherhood, Reproductive Health, and Incarcerated Men: A Qualitative Study With Implications for Reentry – *Jessica Laird, Jennifer Clarke, Bradley Brockmann, & L. A. R. Stein*
- Suicides Among Incarcerated Persons in 18 U.S. States: Findings From the National Violent Death Reporting System, 2003-2014: A Qualitative Study With Implications for Reentry – *Kristiana J. Dixon, Allison M. Ertl, Rachel A. Leavitt, Kameron J. Sheats, Katherine A. Fowler, & Shane P. D. Jack*

Academy of Correctional Health Professionals members receive JCHC as a member benefit and Certified Correctional Health Professionals receive a complimentary online subscription.

<https://journals.sagepub.com/home/jcxc>

# CCHP-RN Specialty Certification for Correctional Registered Nurses



- Recognition for registered nurses practicing in the specialized field of correctional health care
- Validation of correctional nurses' expertise and knowledge
- A next step in the most prestigious correctional health care certification program

Specialty certification as a CCHP-RN provides validation of dedication to continuing competence and to providing appropriate high-quality nursing care to incarcerated patients. CCHP-RNs have proven their mastery of specialized content developed by nurse experts in the field of correctional health care.

## THE BEST CCHP-RN EXAM PREPARATION, HANDS DOWN!

Attend a special preconference seminar, The Challenge of Correctional Nursing: Compassion, Care, and Calling, before you take the CCHP-RN exam at the National Conference on Correctional Health Care!

**CCHP Application Deadline:** September 25

**Preconference Seminar and Exam:** November 1

More information is available at [ncchc.org/national-conference](http://ncchc.org/national-conference).



For more information or to obtain an application, visit [ncchc.org/cchp-rn](http://ncchc.org/cchp-rn).  
Or contact us at [cchp@ncchc.org](mailto:cchp@ncchc.org) or 773-880-1460.

## Top 10 Reasons to Become a CCHP-RN

**D**id you know that 2020 is the Year of the Nurse? It is also the 10th anniversary of the CCHP-RN exam for nurses.

"The CCHP-RN program came about because of a desire on the part of correctional nurses for a more focused, discipline-specific certification, like other specialty nursing certifications," says Ned Megargee, PhD, CCHP, vice chair of the CCHP Board of Trustees. "While the 'basic' CCHP exam covers what is in the NCCHC Standards, the CCHP-RN exam is very specific to correctional nursing and looks at best practices in that specialty," explains Pauline Marcussen, DHA, RHIA, CCHP, Board of Trustees chair.

The program has gained momentum since its birth in 2010, so, in honor of its 10th anniversary, we present the Top 10 Reasons to Become a CCHP-RN:

**1. Professional recognition.** "The No. 1 benefit has to be professional recognition in the correctional arena among employers, coworkers, and those I interact with outside our agencies," says Dub Newton, BS, RN, CCHP-RN, regional nurse supervisor with North Carolina Adult Correction and Juvenile Justice. Many CCHP-RNs agree: Certification recognizes the unique skills and abilities that correctional nurses bring to their jobs. "One of the indicators of professionalism in nursing is having certification in your area of specialty," says Mary Muse, MSN, RN, CCHP-RN, CCHP-A, who was part of the task force that created the original CCHP-RN exam and got it off the ground. "Certification says you understand your field."

**2. Personal satisfaction.** The second most-often cited benefit of CCHP-RN certification is a sense of personal pride and accomplishment. For many, those intrinsic rewards are as or more valuable than the external rewards.

**3. Increased knowledge.** "Obtaining CCHP and then CCHP-RN increased my knowledge of correctional health care," says Caleb Meyer, MSN, APRN-CNP, CCHP-RN, commander, U. S. Public Health Service, LSCI Butner, NC. Most nurses are lifelong learners, committed to always educating themselves – especially important in the challenging correctional environment. The experience of studying for the exam, and the continuing education required to remain certified, are built-in opportunities for learning.

**4. Hiring potential.** CCHP-RN certification makes a difference – to the nurses who attain the credential, to the patients they care for, and to employers who want to hire first-rate nurses.

**5. Potential for job advancement.** Want to climb that nursing ladder? Some CCHP-RNs report that the credential helped them earn a promotion or elevate their position.

**6. Elevation of the field.** "What we do is so important, and certification helps legitimize the specialty," says Muse. Earning your CCHP-RN helps advance awareness of correctional health care as a legit specialty. "Certification communicates to my peers and colleagues that I have a certain level of expertise," says one CCHP-RN.

**7. Prestige.** CCHP-RNs are part of an elite group – currently only about 220 nurses have earned the credential.

**8. Professional pride.** "I proudly advertise certification in my email signature and wear my CCHP and CCHP-RN pins," says Newton.

**9. Tenth anniversary activities just for CCHP-RNs** at the National Conference on Correctional Health Care. Stay tuned for details!

**10. A chance to learn from the best** before the exam. The CCHP-RN exam will be offered, along with all CCHP exams, at the National Conference in Las Vegas. Also featured: A special preconference seminar, taught by experienced CCHP-RNs, will provide the perfect pre-exam refresher. See below for details.



### Educational Seminar & Exam

**Seminar: The Challenge of Correctional Nursing: Compassion, Care, and Calling**, Sunday, November 1, 9 am – 12:30 pm

Presenters: Becky Pinney, MSN, RN, CCHP-RN, CCHP-A, Pinney Consulting Company; Denise Rahaman, MBA, BSN, CCHP-RN, CCHP-A, CFG Health Systems; Tracey Titus, RN, CCHP-RN, CCHP-A, Centurion

Review the basics, explore the challenges and rewards, and understand the unique mix of skills needed to be a correctional nurse. This is the perfect for those taking the CCHP-RN exam that afternoon.

#### CCHP-RN Exam

Sunday, November 1, 1 pm – 3 pm

*Applications must be received by September 25.*

CCHP and CCHP-MH exams also will be offered at this time. The CCHP-P exam will be offered on Monday, November 2, at 2:30 pm.





Exhibit at NCCHC's National Conference on Correctional Health Care and connect with correctional health professionals from across the country. This is the largest annual meeting in correctional health care, an opportunity to meet with nearly 2,000 professionals who influence or make purchasing decisions. And they spend significant time browsing the exhibits to learn about products and services including pharmaceuticals, information technology, staffing services, and more. It's the place to be!



## WHERE WILL YOU FIND YOUR NEXT GREAT HIRE?

Find your next lead with the **National Commission on Correctional Health Care mailing list**, a proven tool to reach over 40,000 physicians, nurses, mental health care providers, medical directors, nurses and other allied health professionals and administrators. Pinpoint your audience by job title, work setting and demographics. No other marketing channel allows you such a targeted marketing opportunity.

[www.InfocusLists.com/Datacard/NCCHC](http://www.InfocusLists.com/Datacard/NCCHC)

**Contact *INFOCUS* Today!**

Kerry Tranfa  
[ktranfa@infocuslists.com](mailto:ktranfa@infocuslists.com)  
 800.708.LIST (5478), ext 3247

[www.InfocusLists.com](http://www.InfocusLists.com)

### Draw Qualified Customers to Your Booth

NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and direct outreach.

- Three days of dedicated, expo-only activities
- Three free full conference registrations per 10' x 10' booth
- Electronic attendee lists for pre- and postshow marketing
- 75-word listing in the Final Program and conference app
- Discounts on advertising in the conference program
- Opportunity to participate in raffle drawings
- Exclusive opportunity to become a sponsor

### For Extra Impact

Gain added exposure through sponsorships that support and enhance the conference. Recognition is given through additional signage, sponsor ribbons, and listings in the final program. Ask about advertising, too!

Contact exhibits and advertising manager  
 Stana Manojlovic at 773-880-1460 or  
[sales@ncchc.org](mailto:sales@ncchc.org)

## Academy Career Center

**Looking for a job?** Post your resume online and showcase your skills and experience to prospective employers to find the best job opportunities.

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

Hosted by the Academy of Correctional Health Professionals. For information or to access listings, visit [careers.correctionalhealth.org](http://careers.correctionalhealth.org).

## Still Available! Through September 3

Tune in to recorded educational sessions from the VIRTUAL Correctional Mental Health Care Conference and earn up to 26 continuing education credits:

"This worked surprisingly well. I enjoyed this experience and learned more than I thought I would."

"The digital format allowed a better dissemination of information because you didn't have to select a session and miss out on the others at the same time. Also, the ability to attend all of the sessions makes the CEs very affordable."

"I loved the ability to 'attend' simultaneous talks and to return to a talk a second time if I wanted to pick up even more details."

For information on how to participate, go to [ncchc.org/mental-health-conference](http://ncchc.org/mental-health-conference).



## About CorrectCare®

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

**Subscriptions:** *CorrectCare* is mailed free of charge to Certified Correctional Health Professionals, key personnel at accredited facilities, members of the Academy of Correctional Health Professionals, and other recipients at our discretion. To see if you qualify for a subscription, create an account at [ncchc.org](http://ncchc.org) or email us at [info@ncchc.org](mailto:info@ncchc.org). The magazine is also posted at [ncchc.org](http://ncchc.org).


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

**Editorial Submissions:** Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, email [editor@ncchc.org](mailto:editor@ncchc.org) or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

**Advertising:** Contact us at [sales@ncchc.org](mailto:sales@ncchc.org) or call 773-880-1460, ext. 298.

## ADVERTISER INDEX

California Correctional Health Care Services.....	7
CCHP – Registered Nurse.....	20
Centurion .....	Inside front cover
Correctional Health Care: Practice, Administration & Law....	6
InFocus Mail Lists.....	22
Medi-Dose EPS.....	Back cover
Medi-Dose Tamper Evident Products .....	18
Medi-Dose Tamper Evident Syringe Bags.....	24
National Conference.....	Inside back cover
NCCHC Resources, Inc.....	11
NCCHC Standards .....	15
Wexford Health Sources.....	4



## SIMPLIFIND

Tap into the incredible network of the National Commission on Correctional Health Care with the NCCHC Buyers Guide. Powered by MultiView, the Guide is the premier search tool for correctional healthcare practitioners. Find the suppliers and services you need, within the network of the association you trust.

Simplifind your search today at [www.ncchc.org](http://www.ncchc.org).




## Expert Advice on NCCHC Standards

by Amy Panagopoulos, MBA, BSN

### Suicide Training Expectations for COs

**Q** I noticed a discrepancy in the 2018 standards. A compliance indicator for Standard C-04 Health Training for Correctional Officers states, "Correctional officers who work with inmates receive health-related training at least every 2 years," including procedures for suicide prevention. But the discussion section for Standard B-05 Suicide Prevention and Intervention states, "All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide ... Initial and at least annual training is provided." What is the expectation – annually or at least every 2 years?

**A** The answer to your question is "at least every two years," as stated in the compliance indicators for Standard C-04. The standards and compliance indicators are measurable items that are scored during accreditation surveys, while items in the discussion section are not scored but are intended to help clarify the standard's intent. Thank you for pointing out this discrepancy; we will be sure to amend it during our next standards update.

### Is COVID-19 a Mass Disaster?

**Q** Due to our recent experience with the COVID-19 pandemic, we are considering using our efforts to manage the virus in our facilities as compliance with the mass disaster drill requirement. Would this meet the intent of the standard? All our shifts and staff have been affected and play a major role in our daily efforts.

**A** Great question! The answer is yes. This is a perfect example of how facilities can use a real-life event to meet the mass disaster requirement. Standard D-07 Emergency Services and Response Plan addresses planning for disruptions in service during emergencies and requires that mass disaster drills be conducted so that each shift, including satellite facilities, has participated in a drill over a three-year period. The drills must then be critiqued and the results shared with all health staff. NCCHC asks that staff members who are not present during a drill later review and initial the written critiques.

### Service Interruptions During Coronavirus

**Q** We are an intake facility and are quarantining all intakes for 14 days due to coronavirus concerns. Standard P-E-04 Initial Health Assessment states that initial health assessments must be completed within seven days, including a physical examination and a pelvic exam when clinically indicated. However, due to quarantine, our patients are not able to come to the health services unit. How does NCCHC advise that we handle this?

**A** Over the past months, we have received many requests for information about how to handle changes to operations due to COVID-19. While we understand that there may be changes, we ask facilities to do their best to address the needs of their patients, follow the standards, document changes made, and return to normal operations as soon as possible.

Many facilities are struggling with the same issue. In some, intake staff go to the cell or a private area close to the cell to complete the initial health assessment instead of bringing patients to the clinic. Other facilities complete a modified initial health assessment that assesses top comorbid conditions along with a brief mental health screen in the time frame set forth in the standards, with a documented plan to complete any omitted health screen items as soon as possible and schedule the pelvic exam as soon as the inmate can be seen in the clinic.

Whatever you do, be sure your response is thoughtful and well-documented, and includes looking at the risks of postponing assessments or aspects of care. As always, come into compliance with standards as soon as possible.

Amy Panagopoulos, MBA, BSN, is NCCHC's vice president of accreditation.

An advertisement for Medi-Dose EPS Tamper Evident Syringe Bags. The background is blue with a white curved line. In the center, there are several syringe bags: one clear with a red plunger, one clear with a white plunger, and two brown ones. A red circular badge on the right says "Unit Dose, Bar Coding, Pharmacy & Nursing Supply Experts!". At the bottom left, there is a QR code and the text "Scan Me!". Below the QR code, there are three bullet points: "Durable 3 Mil Plastic with Tamper-Evident Closure", "2" x 8" or 3" x 12" Bags Fit Virtually All Syringe Sizes", and "Clear or Amber Ultraviolet Inhibitant". At the bottom, there is a white bar with the text "MediDose.com • 800.523.8966".

**Medi-Dose EPS®**

**Tamper Evident Syringe Bags**

Unit Dose, Bar Coding, Pharmacy & Nursing Supply Experts!

Scan Me!

- Durable 3 Mil Plastic with Tamper-Evident Closure
- 2" x 8" or 3" x 12" Bags Fit Virtually All Syringe Sizes
- Clear or Amber Ultraviolet Inhibitant

**MediDose.com • 800.523.8966**





# National Conference on Correctional Health Care

Oct. 31 - Nov. 4, 2020  
Paris Las Vegas

## Doesn't getting together sound good?

Now more than ever, we all feel the need to come together, discuss what we've been through, share what we've learned, and maybe even have a little fun.

The conference promises the same high-quality educational programming and top-notch speakers, while keeping your health and hygiene the top priority. Hope to see you there!



**NEW**  
Preconference Seminar  
Just for Nurses!  
The Challenge of  
Correctional Nursing

- More than 100 educational presentations
- Hot-topic preconference seminars
- Special COVID-related programming
- Up to 32 CE credits
- CCHP exams
- Camaraderie and networking
- Exhibit hall special events
- Special room rates at the Paris Las Vegas through October 8

**REGISTER BEFORE SEPTEMBER 25 AND SAVE!**

Visit [NCCHC.org/national-conference](https://www.ncchc.org/national-conference)

For more information, contact  
[info@ncchc.org](mailto:info@ncchc.org) or call **773-880-1460**.



**Medi-Dose®  
EPS®**

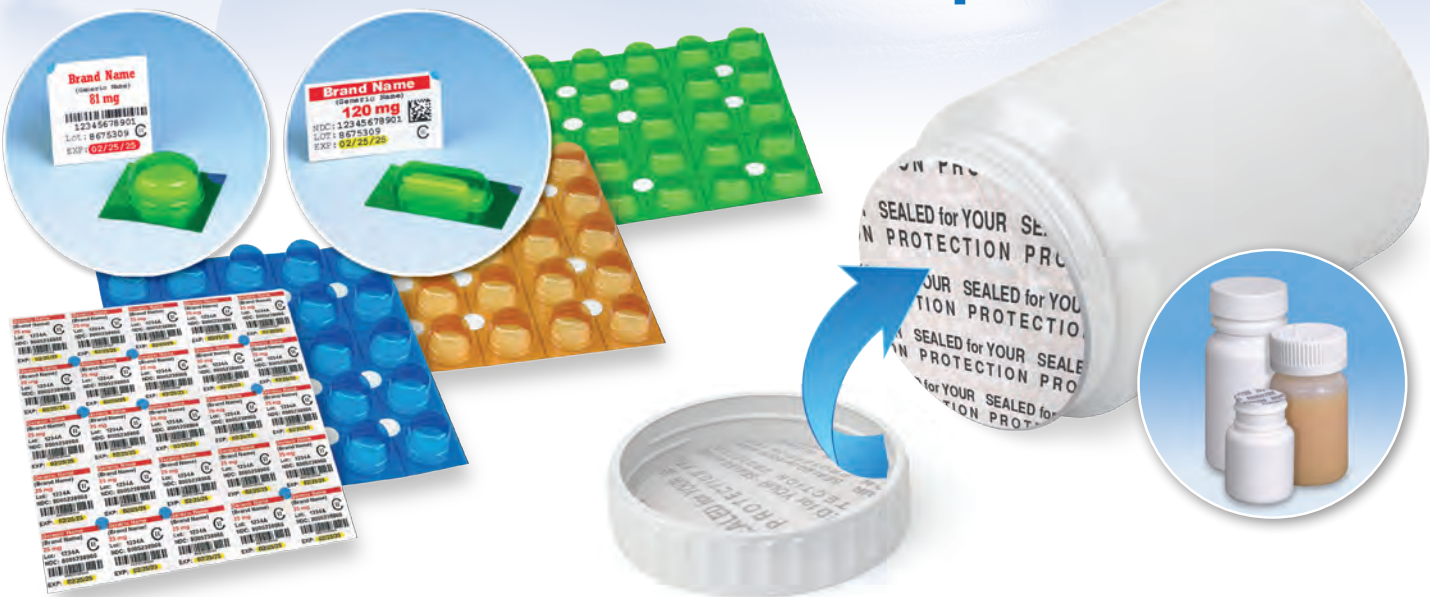
# THE VERDICT IS IN

***Still #1 for tamper-evident unit dose  
in correctional care pharmacies***

**Unit Dose,  
Bar Coding,  
Pharmacy &  
Nursing Supply  
Experts!**

**Medi-Dose®**

**TampAlert®**



***Simple. Safe. Secure. Since 1971, the Medi-Dose® and TampAlert® unit dose packaging systems have continued to meet the specific needs of correctional care pharmacies.***

Medi-Dose® is the economical answer for packaging and dispensing your solid oral medication. Available in 13 styles, with 6 or 12-month beyond-use dating options, it's moisture and light resistant. No in-service training is required and it's barcode ready. Medi-Dose® uses no metal, glass or machinery...so it's safe to use for both your staff and patient population.

TampAlert® is the ideal tamper-evident solution for liquids or powders. It's stocked from 15 to 120 mL, in natural or UV inhibitant polyethylene, with regular or child-resistant screw caps. The TampAlert® seal goes on automatically when you twist on the container cap.

***Call or visit our website for  
samples and more information.***

**800.523.8966**

**MediDose.com**