



Spring 2021 | Volume 35 | Issue 1

CorrectCare®

The magazine of the National Commission on Correctional Health Care



LEADING IN DIFFICULT TIMES

**COVID-19 Vaccines: Be
Prepared for Questions**

**Autism Spectrum
Disorder in Corrections**

**Akathisia:
A Medication-Induced
Movement Disorder**

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



HEALTH CARE BEHIND THE BARS

Facilities needed for a research study on health care in jails

The National Commission on Correctional Health Care has partnered with researchers at Harvard University to learn about the effects of health care accreditation in jails.

We all know that health care problems don't disappear behind bars.

Even in the best of times, providing health care to inmates is challenging despite having a disproportionate number of people with serious chronic health issues.

NCCHC's accreditation program is dedicated to improving the quality of correctional health care services and helping jails provide effective and efficient care.

This study will assess the impact of accreditation on jails' health care systems and how accreditation affects the care of the incarcerated. The NCCHC *Standards for Health Services in Jails* will be utilized as the basis for assessing proper management of care services.



NCCHC and researchers at Harvard University are working with jails that have an ADP of 500-3,000 inmates.

Participation involves:

- Commitment to complete surveys about facility characteristics and effects of accreditation process on health care system
- 2-3 virtual and/or on-site visits by the study team

Facilities receive:

- \$500 award for each on-site visit
- Reduced fee if become accredited during study
- Confidential facility assessment of health care delivery system

Benefits of participating:

- Become accredited at a reduced fee
- Improve health care processes
- Improve inmate health
- Limit occurrence of adverse events
- Reduce lawsuits related to inmate health care

For more information, contact
[**accredstudy@hks.harvard.edu**](mailto:accredstudy@hks.harvard.edu)



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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 representatives. 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.

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NCCHC Foundation Receives Federal Grant To Address Substance Use Disorder in Jails

The Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program has selected the NCCHC Foundation as the lead organization in the creation of clinical guidelines for opioid withdrawal management in jails.

Supported by a \$300,000 grant, NCCHC, tapping into the expertise of the American Society for Addiction Medicine, will create an evidence-based set of clinical guidelines, policies, procedures, and protocols to assist clinicians as they treat patients with opioid, alcohol, and other substance use disorder withdrawal.

"This work is critical for saving lives," says Foundation Director Jennifer Riskind. "Jails are reporting that the opioid crisis is worse than ever due to the impact of COVID-19. Supporting medically managed withdrawal is an ethical and medical responsibility."

The project will begin by convening an expert advisory committee representing key stakeholders from correctional health care, addiction medicine, and jail administration. The guidelines are expected to be completed in late 2021.

More Foundation News

Two of the largest providers of correctional health services, Centurion Health and Corizon Health, have made generous



donations to the NCCHC Foundation, making them Gold Partners in the foundation's Partners in Correctional Health Annual Giving Society.

Both gifts will establish scholarship funds for attendance at NCCHC conferences during 2021.

Centurion's gift will allow deserving students interested in the correctional health field, correctional health professionals, and especially early-career nurses and mental health professionals to participate.

Corizon's gift is earmarked specifically for students attending historically Black colleges and universities who are interested in correctional health care.

Additionally, the NCCHC Foundation Board of Trustees elected a new chair, Sharen Barboza, PhD, CCHP-MH, correctional consultant, Barboza Consulting.

Several new board members also were appointed: Brenda Fields, RN, RHIA, CCHP, clinical operations specialist, Centurion Health; Sheriff Peter J. Koutoujian, MA, Middlesex (MA) Sheriff's Office; and Joseph Penn, MD, CCHP-MH, director of mental health services, UTMB Correctional Managed Care, and chair of the NCCHC Governance Board. ●



Enjoy CorrectCare's New Look!

Same great information, same expert authors, same thought-provoking articles, but with a refreshed look and feel to reflect NCCHC's exciting future. Suggestions? Comments? Contact editor@ncchc.org.

Upcoming Events

APRIL 9	CCHP EXAMS, PHOENIX, AZ
APRIL 27-28	VIRTUAL SPRING CONFERENCE ON CORRECTIONAL HEALTH CARE - FREE!
MAY 4	CCHP EXAMS, HANOVER, MD (DEAD-LINE TO APPLY: APRIL 6)
MAY 31	LAST DAY TO ACCESS ONLINE SPRING CONFERENCE CONTENT
JULY 17-18	CORRECTIONAL MENTAL HEALTH CARE CONFERENCE
OCT 30-NOV 1	NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE, CHICAGO

NCCHC Board Welcomes New Members to Its Ranks

These new members were elected at the most recent meeting of the board:

Dionne Hart, MD, adjunct assistant professor of psychiatry, Mayo Clinic School of Medicine and Science, liaison of the American Medical Association

Keith Ivens, MD, chief medical officer, CoreCivic and president, Correctional Medicine Associates, liaison of the American College of Correctional Physicians

Capt. Michael W. Johnson, DDS, MPH, U.S. Public Health Service dentist, Federal Bureau of Prisons national chief dentist, liaison of the American Dental Association

Newton E. Kendig, MD, clinical professor of medicine, George Washington University School of Medicine and Health Sciences, liaison of the American College of Physicians Sheriff Heath Taylor, Russell County, AL, liaison of the National Sheriffs' Association

Coping with COVID-19 as We Enter Year Two: Emotional Wellness Strategies

by Joseph V. Penn, MD, CCHP-MH

While the COVID-19 vaccine promises to be a game-changer, coronavirus is still very much with us and continues to take a toll on our emotional and mental health. Here, I present some practical ideas on how to take care of yourself during this long and ongoing challenge.

There is growing evidence that prolonged and excessive stress leads to burnout. We all know that feeling. When you're burned out, you're less empathetic and less efficient; you feel less joy in your everyday activities at work and at home. You might have trouble concentrating, trouble sleeping, trouble remembering why you chose this career in the first place. You might be self-medicating with alcohol, engaging in overeating or other destructive behaviors.

At times like these, doing even small things to regain a sense of control can be extremely helpful and reduce feelings of helplessness.

Positively Practical

For starters, take care of your physical health; it's strongly connected to your overall well-being.

Find a way to move your body every day. I know this is not a challenge for those in direct patient care, but due to computers and EMRs, it is way too easy to become and remain sedentary.

Watch how much you eat and drink. Indulging feels good... until it doesn't.

If you're anxious or worried, turn that restless energy around and point it toward something useful, productive, and practical.

Eliminate some minor but irritating matters in your life, such as organizing your living space so you're no longer searching for your keys every day. Choose a small but persistent source of frustration in your life – one you do have control over – and take care of it.

Think specifically about your day-to-day habits and pain points. What might make you feel good?

Ask yourself if you really need to respond to every text or email immediately. We need down time to disconnect from screens and get off the grid.

The lack of in-person social connectivity and isolation has caused severe distress for many people. We humans are

social animals. Social connections are integral and critical to our emotional well-being.

I've noticed that people have stopped making as much effort to connect, even virtually, as they did at the beginning of the quarantine. I strongly encourage you to reconnect with friends and get back to Zoom visits, write someone a letter, call an old friend or relative. The longer we remain isolated, the greater the risk of depression.

Change the channel! Music is always available to make you feel better. A lot of people have been making and sharing playlists, which I think is a great idea.

And don't forget to laugh every day. A sense of humor can keep us going. If there is a show that makes you laugh, binge-watch it, and don't feel guilty about it!

This Too Shall Pass

My intention is not to imply that everyone is depressed, but to give you some emotional wellness strategies to help you get through this marathon... and you will. Even when it doesn't feel like it, this is temporary.

In the meantime, remember that we are all experiencing this difficult and challenging time, and some do not cope well. You may notice that those around you are more edgy, irritable, or angry than usual, more nervous and anxious, more depressed, sad, or hopeless.

Cut them some slack. And while you're at it, cut yourself some slack too. Don't be too hard on yourself. In fact, pat yourself on the back!

We all deserve care and compassion. Show and model empathy; smile at others, as your smile shows through and beyond the mask; and don't forget to flash that beautiful smile at yourself in the mirror.

Finally, give yourself permission to daydream about the future and what is on the horizon. Things will return to "normal." And possibly better, with some welcome improvements. This too shall pass. ●



Joseph V. Penn, MD, CCHP-MH, is the 2021 chair of NCCHC's Governance Board and board liaison of the American Academy of Psychiatry and the Law.

Delayed Surgery = Deliberate Indifference?

By Fred Cohen, LLM

Case #1

Mr. Morris was booked into an Arkansas jail in 2013 and remained there several months. The principal issue in this case is whether Morris presented sufficient evidence of deliberate indifference against either the county sheriff or his nurse.

When Morris was detained, he complained of pain and swelling in his testicles. He was taken to a local hospital where a doctor diagnosed a cyst or tumor and prescribed ibuprofen.

About a month later Morris was referred to a specialist in urology, who diagnosed inflammation of a testicular tube. He prescribed an antibiotic and pain medication but did not schedule surgery.

Apparently, the urologist refused to go forward with needed surgery because he was concerned that he wouldn't be paid, even after the nurse called him several times and told him she had secured a promise of payment by the sheriff.

The nurse then retained the services of the only other nearby urologist, who subsequently performed the surgery. The plaintiff's pain continued, and a second surgery was performed to remove the testicle. This doctor stated that any delay in the final surgery did not in any way impact the second, and finally satisfactory, surgery.

The district court granted summary judgment to the defendants (the sheriff and nurse) and the circuit court upholds that ruling.

Morris claimed the nurse was deliberately indifferent, causing needless pain and suffering from her delay in

scheduling outside treatment. The court rejoins that she was virtually tireless in her calls to the urologist and it was he who delayed, concerned about his fee.

The sheriff was completely hands-off in this matter; he had no policy and took no action to delay the surgery. If the nurse is not culpable, the court notes, the sheriff cannot be deliberately indifferent. Lower court is upheld.

Comment: There is a money issue lurking here but it is not attributable to the sheriff or the nurse, but to the community urologist.

Case #2

When he was incarcerated, Mr. Miller had already undergone several surgeries for gunshot wounds to his abdomen, necessitating the use of a feeding tube placed into his stomach. When the feeding tube was removed after two years, he was diagnosed with a gastrocutaneous fistula (an abnormal connection between the stomach and skin), which his surgeons expected to close on its own. He also had a ventral hernia (an opening in the abdominal wall muscles). When it did not heal, a trauma surgeon evaluated Miller and recommended that the fistula be surgically repaired.

It was three years before the patient received fistula surgery. He did, however, receive antibiotics, antifungals, and bandage changes during that time.

Nothing in the record suggests this conservative care shows "a complete abandonment of medical judgment." Miller's hernia was neither incarcerated (meaning the tissue was

not trapped and thus did not require prompt medical attention) nor symptomatic, and the fact that one prison doctor recommended surgery while others were opposed does not equal deliberate indifference.

Comment: The opinion does not mention whether additional pain and suffering would have been ameliorated with more timely fistula surgery, but with deliberate indifference so harshly applied here, Miller did not stand a chance of prevailing. ●

Fred Cohen, LLM, is editor of the Correctional Law Reporter. This article is reprinted (with minor modifications) with permission of the publisher. All rights reserved. For subscription information, contact the Civic Research Institute: 609-683-4450; civicresearchinstitute.com.

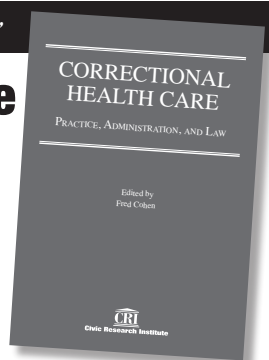
"Insight into the most significant issues in correctional health."

Correctional Health Care Practice, Administration & Law

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

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

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



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LEADING IN DIFFICULT TIMES

A conversation with Esmaeil Porsa, MD, MPH, MBA, CCHP-P, CCHP-A, president and chief executive officer, Harris Health Systems; Ron Charpentier, MBA, vice president of health services, CoreCivic; and Kevin Counihan, senior vice president of products, Centene Corporation, moderated by Brent Gibson, MD, MPH, CCHP-P, chief health officer, NCCHC

Issue #1: Funding Challenges and Partnerships

Dr. Gibson: We face a lot of uncertainty regarding state and local government funding. Correctional health care is not always at the top of the list of things to fund. How do we meet this challenge?

Mr. Charpentier: When economics are an issue in the corrections industry, or in any health care setting, reducing appropriate patient care is not an option. During lean times, we as health care leaders need to figure out how to be good partners while participating in what likely will be facility-wide cost reduction efforts. We need to find ways to reduce health care spending while still meeting our mission of quality care. Too often we have tunnel vision, over-focusing on contract compliance and corrective action plans. When we limit ourselves in this way, we become overly reactive. To innovate, we need to become much more proactive, and that means going outside of our comfort zone.

Let me share three examples that have the potential to improve quality of care while also providing cost savings.

First is emergent technology to better identify suicidal behavior and improve the effectiveness of suicide watch. Second is the use of telehealth for subspecialty medicine to improve chronic disease management within our facilities and eliminate the cost of security and transport. And third is finding new ways to better manage hospital stays.

Mr. Counihan: It is of course important to learn from the challenges we are presented with to plan for the future. In many ways, the coronavirus presents an opportunity to reexamine the appropriateness of how correctional care is funded. Is doing so on a state-by-state basis the best way? Is it the most efficient, the most equitable? These are important questions.

Dr. Porsa: I absolutely believe that in every crisis, there's an opportunity. And it really does fall on us as leaders to identify those opportunities and take advantage of them. This is a great time for us to get rid of our blind spots and identify where we can develop partnerships – both within our organizations and externally, with the county health department, the city health department, and community-

based organizations. We don't have to do everything alone. What are some opportunities we can collaborate on? A few examples that come to mind are lab testing for sexually transmitted diseases, as well as more complex things like training and education.

Another innovation in the age of COVID is telehealth – virtual care inside correctional health settings – for both primary care and specialty care, which reduces costs in terms of transportation and custody. One thing we are excited about is the possibility of conducting shared medical appointments. Instead of one patient per physician, you have a physician and five or six or 10 patients with like diseases who agree to participate in a shared visit.

Issue #2: Is Perception Reality?

Dr. Gibson: We are always under scrutiny as leaders in public health care. Public attitudes toward the field of corrections and correctional health care can be challenging and at times unflattering. How do we manage these perceptions while keeping our teams focused and motivated?

Mr. Counihan: I believe that fundamentally people go into corrections for the mission. If the people at the top are mission-driven, that is going to permeate down to the other leaders and staff. When people understand that they are doing important work to make sure that individuals, irrespective of their status, have access to quality health care, then the way people view their jobs and their commitment to patients will mirror that. The correctional environment is complicated. If it were simple, we wouldn't be having this conversation. Can things be improved? Absolutely, and the industry has an obligation to improvement. When we keep raising the bar, we will be in greater accord with policymakers and legislators. We shouldn't kid ourselves. The incarcerated population is not the one that's going to get the greatest attention of legislators. But it's a critically underserved, vulnerable population. And when leadership makes that clear to their staff, that's the best way to keep their motivation up.

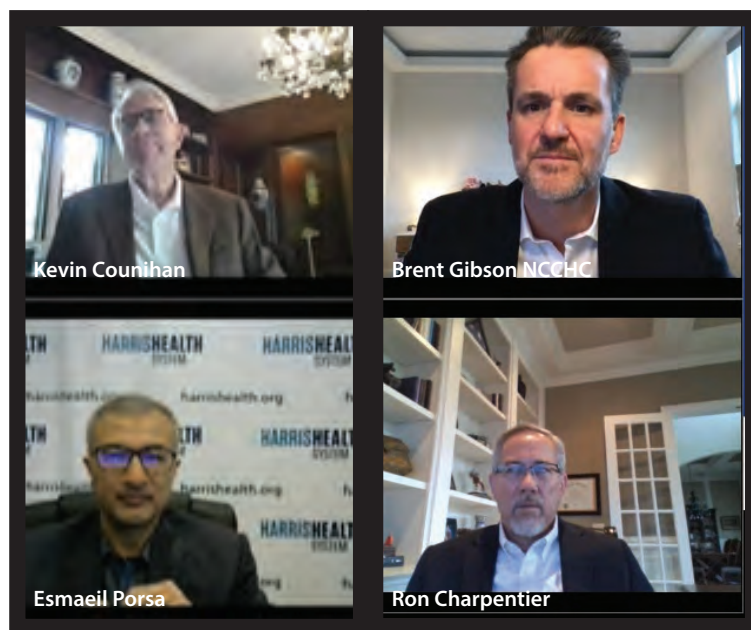
Mr. Charpentier: I think about this a lot, having spent nearly 30 years in "free world" health care and only two years in corrections. I have to say that, at least in my experience, the perception of the poor quality of care in correctional facilities is not accurate and is often unfair. I believe that providers and nurses want to deliver good, high-quality care. If someone doesn't, in our organization, we either coach them up or coach them out. We focus on creating a culture of excellence that brings this new level of meaning, passion, and pride to the work we do. And then we have a path to high performance; we have a path to attracting and retaining quality health staff to our facilities.

We have several key work streams in our operational playbook: One, we focus on hiring effective leaders, qualified medical providers, and competent team-oriented nurses. If we make a hiring mistake, we make a change. Two, we provide ample training around best practices, standardized processes, and clinical protocols. It's about

"Correctional health is not where you go when you run out of options, it's where you go to build a career in public health... Working in correctional health is a source of pride."

Esmaeil Porsa, MD, MPH, MBA, CCHP-P, CCHP-A, president and CEO, Harris Health Systems

more than just policies. We have a saying in our company: "Policy tells us what to do, but it doesn't tell us *how* to do it." We need to look at processes to understand how best to do our work. Three, we monitor standardized processes and protocols to root out any variation that makes us inefficient or leads to poor outcomes. Four, we ensure that health care teams have the resources they need to deliver excellent care, as well as resources like adequate administrative, security, and technology support. And finally, we treat our patients and our colleagues with respect and dignity. Doing so gives meaning to our work. If we're doing the right thing and that's how we're treating our patients and teammates, it's a lot easier to tolerate the scrutiny and negative attitudes, and to eventually change them.



Dr. Porsa: As a second-year resident, my first moonlighting job was at the Harris County Jail. I saw patients in the clinic as they were coming in, and I fell in love with it. I was already a physician, assisting patients in the hospital and

Continued on next page

the clinic, but there was something very special about dealing with the inmates. One thing was the gratitude they had for simply a handshake, a hand on the shoulder, someone to listen. I was one of the chief medical residents, and people would ask me: why would a chief medical resident decide to go into correctional health? I always said that to me, it was the last frontier of medicine, where I used all I learned in medical school, and what I imagined

everybody gets invited to the dance; inclusion is when everybody gets to dance. I thought that was such a simple and effective way of looking at it. It all starts with a commitment to wanting to be a part of the solution, a commitment to diversity and inclusion, and that means being self-reflective and answering this question: Are we representing our communities? Inside the jails, are our providers, our nurses, and our custody staff representative of our communities? Are we able not only to have the conversation but also to listen to what we are hearing? If you treat people like human beings, they will behave like human beings. And if you don't, they won't. There is no reason we cannot carry on that conversation inside our

correctional settings. It may sound controversial or crazy but, you know, a few years ago direct-observation housing inside the jails was a crazy idea. Suddenly, some of the jails started doing it and now all the jails want to get into it because there's great outcomes from it.

Mr. Counihan: I agree that we need to lead by example. We must make sure that our own organizations are following these principles. There may be more that we could do to raise the bar with our clients and make more explicit our expectations about how we want to work

as constructive partners. I also agree there are tangible things that we can do as organizations with respect to making sure our workforce represents the demographic makeup of our clients. We have to consciously make sure that we are interceding at the

right time to develop people and promote people. I know we hope that meritocracy always wins out, but if we look at our society, historically, that has not been the case. And so sometimes we need to intercede more consciously and deliberately to make sure that our organizations reflect our values.

Mr. Charpentier: The first thing to do is to recognize there's a problem and then commit to making meaningful changes in our organizations. Then we need to listen to our employees, our customers, and our patients to learn how they're being impacted. At that point, we can focus on the adjustments we need to make to ensure equity across our organization. We do this, first, because it's the right thing to do. But I also believe that diversity and inclusion are essential to team and organizational

"To innovate, we need to become much more proactive, and that means going outside of our comfort zone."

Ron Charpentier, MBA, vice president of health services, CoreCivic

medicine would be: patient-physician interaction, using diagnostic skills and listening skills to help patients.

As leaders, we need to be committed and we need to be able to show, through example and through our words, that correctional health is not where you go when you run out of options, it's where you go to build a career in public health. The more we can reflect that, the more successful we're going to be at recruiting and retaining very high-caliber people. Working in correctional health is a source of pride.

"It feels to me like we're at a crossroads... We can do nothing and perpetuate the status quo, or we can use this as an opportunity to raise the bar for ourselves and for our clients."

Kevin Counihan, senior vice president of products, Centene Corporation

Issue #3: Confronting Racism and Inequity

Dr. Gibson: Now more than ever, we are aware of the challenges stemming from systemic racism. What issues have emerged among your clients and within your own companies? What have you done? What do you plan to do?

Dr. Porsa: At its core, this is a social justice question. What COVID-19 did, for corrections and for the entire nation, is to shed light on the social injustice that exists in this country in terms of access – not only access to care, but also access to education and economic opportunities. The segments of the population that are most negatively impacted by COVID-19 are racial minorities, the indigent, uninsured and underinsured. And guess what? When you look at the correctional population, for the most part, it's the same population.

The best description of diversity and inclusion that I've heard recently is that it's like a dance. Diversity is when

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(visit CalPERS.ca.gov for retirement formulas)
- And much more

Clinical Executives:

Magdalena Kilmer at (916) 691-5876 or Magdalena.Kilmer@cdcr.ca.gov

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Blair Eversley at (916) 538-3948 or CentralizedHiringUnit@cdcr.ca.gov

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

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Top 10 Questions About the COVID-19 Vaccine

By Michael Teasdale, RN, CCHP

Like most health care providers, I couldn't wait to start vaccinating my patients against COVID-19. I was also very curious to see how many would accept the vaccine and what their reaction would be.

We received our first shipments of vials in early January and began vaccinating staff and very high-risk patients. We then offered the vaccine to anyone interested in receiving it, working closely with custody staff and administration to coordinate vaccine clinics. Dedicated staff were trained in vaccine administration, which was scheduled for eight to nine hours, five days a week.

I was pleased to find that, overall, there was a lot of interest in being vaccinated, much more than for any other mass vaccination I have initiated in a correctional setting. In facilities where I have worked, for instance, we generally saw a 20% to 25% acceptance rate for yearly flu shots. As of late January, we had nearly doubled those numbers for the COVID vaccine.

My staff and I have given the vaccine to more than 1,800 people. I have been amazed at how informed some of them are... while others are extremely misinformed.

As you administer vaccines in your facilities, be prepared for a lot of questions. I've listed my Top 10 below, along with ideas for how to respond. Knowing the answers to your patient's questions and answering them confidently will foster trust in both the vaccine and in your medical department.

1. Did you get the shot?

Not surprisingly, this was the most frequently asked question. Out of the dozens of groups that I have given the vaccine to, someone in every group asked me this. Be sure your answer is yes! I told my patients that not only did I get the vaccine, I received the same vaccine I was giving to them. Hearing me proudly answer yes to this question reassured them. They seemed to relax knowing I was fine after receiving the vaccine, did not experience any major side effects – just some mild soreness – and was now encouraging others to do the same.

2. When do I get my second shot?

Some of the more informed inmates knew that the available vaccines require two shots and they were very interested in knowing when they would be scheduled to receive their next doses. Know which vaccine you are giving, the appropriate time between doses, and how scheduling second doses will work in your facility. Will the second shots be scheduled in the same manner as the first? Is there a required time frame for getting the second dose? There is a lot of misinformation in the media about this, so make sure you know what the CDC recommends

for the vaccine you are administering. What I have done is keep a running spreadsheet of everyone who received the first dose and when, and then used the spreadsheet to schedule the second doses in the appropriate time frame.

3. What if I am released before my second shot?

The issue is particularly important to people in short-term settings, such as pretrial detention. Discuss the plan for continuation of care with your administration and executive leadership. The answer will vary greatly from state to state and facility to facility. I have several inmates who hope to be released into the community before their second dose. When scheduling your patients, pay attention to this information and inform your classification department and discharge planners. Discuss with your medical director and leadership whether pending releases should be considered when prioritizing your vaccines.

4. What are the side effects?

Know all of the side effects of the particular vaccine you are giving and speak to the most common: pain at the injection site and feeling run down and achy for 24 to 48 hours. Having had direct experience receiving the vaccine will be helpful here. Let your patients know that while some people experience more severe side effects, that is unusual – and possible with any vaccine.

5. Will getting the shot make me test positive for COVID-19?

In my facilities, we test regularly for COVID so this was a big concern for my population, and it may be for yours. Assuming you are doing PCR testing to determine if an individual currently has the disease, then the answer is no.

6. Now that I've gotten my shot, can I stop wearing my mask?

The answer is no, but that seemed to surprise many of my patients. I had to do some serious education about the importance of receiving both parts of the vaccine, the fact that they will not have immunity until two weeks after receiving the second dose, that no vaccine is 100% effective, and that there is still a lot to learn and understand before people can confidently (and permanently) remove their masks.

7. Is this shot going to make me sick?

This is another common concern, as it always is with the flu vaccine. Remind your patients that they are not receiving a live vaccine, and even if they feel a bit under the weather for up to 48 hours post-vaccine, that is a side effect and does not mean that the vaccine gave them COVID or made them sick.

8. Can I still get COVID even though I got the shot?

While the answer is yes, I don't think giving that one-word answer is advisable; the next question inevitably will be, "So why bother getting the shot?" When I received this question (several times), I told my patients, "It is technically possible, but being vaccinated is by far the most effective precaution you can take – more effective, even, than the flu shot is against the flu. Not only does the vaccine protect you against getting COVID-19, it protects you from getting seriously ill, being hospitalized, or dying if you do. This is a pandemic. Your chance of being exposed to the virus at some time is almost 100%. The important question is how protected you will be at that time."

9. I have (diabetes, hypertension, asthma, HIV, fill in the blank). Can I still get the vaccine?

I tell my patients with preexisting conditions, "Not only can you get the vaccine, you need it more than others!" I know of several facilities in my state that are prioritizing patients with risk factors to receive the vaccine. While there are no contraindications related to specific diagnoses, the CDC recommends delaying the vaccine in some instances, for example, if the patient received plasma treatment within the past 90 days or received another vaccine within the past 14 days. Before administering the vaccine, be aware of any other instances in which it is contraindicated or should be delayed. Be sure to include questions about contraindications in your consent paperwork so you can discuss those issues with your patients.

10. How do you feel about inmates getting the shot before the general public?

Surprisingly, I got this question several times. I feel that inmates are very deserving of being among the first

populations to receive the vaccine due to their increased risk, so I answered truthfully: "I am darned happy to be able to give you this vaccine. I wish there was enough out there to vaccinate everyone right now!"

As I reflect on the last question, I can't help but wonder where it comes from. Are the patients concerned that I resent them receiving the vaccine? Or is this idea coming from the media or from people they know? Everyone seems to agree that medical professionals, first responders, and nursing home residents should be among the first to be offered the vaccine; those groups are at high risk, so naturally they should have priority. I have never heard anyone from any of those groups question whether they are worthy of receiving the vaccine or wonder what others think about them being prioritized.

Yet despite all the risk factors incarcerated populations face and the good reasons for them to be vaccinated before they return to their communities, the idea of vaccinating them is somehow controversial. For now, I take solace in the fact that my patients are able to receive a lifesaving vaccine.

I sincerely hope we will continue to see the numbers of patients being vaccinated grow as we move through the vaccination phases, supply increases, and the fact that it is a good idea spreads. As I am giving the vaccine, I encourage inmates to share the news. "Tell a friend, tell a cellmate, talk about it in the yard and during meals. Let your peers know that the vaccine is good for everyone." ●

Michael Teasdale, RN, CCHP, is regional nurse manager with Rutgers University Correctional Health Care in New Jersey.



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Caution: Oxcarbazepine and Carbamazepine Interact With Many HIV Medications

By Rebecca Scharf, Katlyn Grossman, PharmD, and Alysse Wurcel, MD, MS

Since HIV and serious mental illness are both common in the incarcerated population, it is important to understand a dangerous interaction between many HIV medications and two antiepileptic medications, oxcarbazepine and carbamazepine, that are sometimes used to treat psychiatric disorders.

HIV is a common chronic illness in prisons and jails. According to the Bureau of Justice Statistics, at the end of 2015, 1.3% of individuals in the custody of state and federal

correctional authorities had been diagnosed with HIV — many times higher than the percent of nonincarcerated people in the United States living with HIV.

People with HIV also have higher rates of serious mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and obsessive-compulsive disorder, than the general public. The American Psychiatric Association reports that rates of HIV infection and transmission among people with serious mental illness are as much as 76 times higher than the general population.

Potential Interactions Between ART and Common Antiepileptics

	Carbamazepine	Oxcarbazepine
NNRTIs (nucleoside reverse transcriptase inhibitors)		
Abacavir	No interaction expected	No interaction expected
Emtricitabine ("FTC")	No interaction expected	No interaction expected
Lamivudine ("3TC")	No interaction expected	No interaction expected
Tenofovir alafenamide	Do not coadminister	Do not coadminister
Tenofovir disoproxil fumarate	No interaction expected	No interaction expected
NNRTIs (non-nucleoside reverse transcriptase inhibitors)		
Doravirine	Do not coadminister	Do not coadminister
Efavirenz*	Consider alternative	Consider use with close monitoring
Etravirine	Do not coadminister	Consider alternative
Nevirapine	Consider alternative	Consider alternative
Rilpivirine	Do not coadminister	Do not coadminister
PIs (protease inhibitors)		
Atazanavir	Do not coadminister	Consider alternative
Darunavir + cobicistat + ritonavir	Do not coadminister Consider alternative or increase dose to twice daily darunavir 600 mg + ritonavir 100 mg	Consider alternative Consider alternative
Lopinavir	Do not coadminister	Do not coadminister
INSTIs (integrase strand transfer inhibitors)		
Bictegravir	Do not coadminister	Do not coadminister
Elvitegravir/cobicistat	Do not coadminister	Consider alternative
Dolutegravir **	Increase dolutegravir dose to 50 mg twice daily	Consider dolutegravir dose increase to 50 mg twice daily
Raltegravir***	Do not coadminister	No interaction expected Avoid once daily raltegravir HD

*Although there is an expected interaction between oxcarbazepine and efavirenz, a case report written by Goicoechea et al. describes an individual with HIV on efavirenz, and also prescribed oxcarbazepine, who had no effect of oxcarbazepine on his blood levels of efavirenz. This suggests that efavirenz may also be a preferred HIV medication for patients on these antiepileptics. However, further studies are needed to confirm there is no true effect of oxcarbazepine on efavirenz concentrations.

**Note that dolutegravir can still be considered when given at a twice daily dose despite its interaction with carbamazepine.

***To our knowledge, while raltegravir has not been studied in combination with oxcarbazepine, it is the only INSTI not metabolized by the enzyme that oxcarbazepine is known to induce, and thus will theoretically have minimal drug interactions. However, carbamazepine is also known to induce the enzyme that raltegravir is metabolized by, and therefore the combination should be avoided.

Background © Vectorsun/Shutterstock

When people are incarcerated, their medications are sometimes changed due to expense or availability. Unfortunately, that creates the possibility for a potentially devastating drug interaction for people with HIV who are being treated with antiretroviral therapy, as many are.

Oxcarbazepine, dispensed under the brand names Trileptal and Oxtellar XR, is an antiepileptic medication that works in the brain to prevent and control seizures; it is sometimes, though rarely, used for mood and/or psychiatric disorders in the nonincarcerated population. We have seen it prescribed in jails as a mood stabilizer, despite Department of Health and Human Services recommendations against its use for people with HIV who are on ART.

Oxcarbazepine has a substantial risk of drug interactions; for people taking HIV medication, the interaction can be significant – reducing the levels of HIV medications and risking breakthrough HIV levels, HIV viral resistance, and treatment failure.

Carbamazepine, sold under the brand names Tegretol XR, Equetro, Tegretol, Eptol, and Carbatrol, is another antiepileptic that is used more commonly than oxcarbazepine outside the correctional system. It has a similar mechanism of action and similar high potential for drug interactions, and also leads to decreasing concentrations of ART during coadministration.

Bottom line: Avoid both oxcarbazepine and carbamazepine in patients on ART. ●

Rebecca Scharf is a student at Tufts University School of Medicine; Katlyn Grossman, PharmD, is clinical pharmacy specialist at Tufts Medical Center; Alysse Wurcel, MD, MS, is assistant professor at Tufts University School of Medicine.

All About Akathisia, the Mysterious Medication-Induced Movement Disorder

By Lenny Gallo, LCSW

A patient once told me, “If it was a choice between cancer and this, I would take cancer.”

What is this condition that could be perceived as being worse than cancer? My patient was referring to akathisia, a medication-induced movement disorder characterized by restlessness, fidgeting, rocking, pacing, and the inability to sit or stand still. Akathisia occurs when certain medications, specifically antipsychotics, are started, stopped, increased, or decreased in dosage.

For patients who experience this condition, “restlessness” and “fidgeting” are putting it mildly, as akathisia is often described as one of the most terrifying experiences of a person’s life. “I wanted to constantly jump out of my skin” and “I can’t stop moving” are common phrases heard among sufferers. Others have described it as “pure torture.”

That tortured feeling is due in part to less noticeable characteristics of the condition, referred to as “inner akathisia,” which have little to do with movement. Sufferers of inner akathisia experience an abstract feeling of terror that can be hard to describe or define. They may experience feelings of unreality, anxiety, agitation, and even self-harming, violent, or homicidal behavior.

Correctional health professionals need to understand just how severe the condition can be, since many incarcerated individuals with mental illness are prescribed the antipsychotic medications, also known as neuroleptics, most commonly associated with akathisia. Neuroleptic medications are prescribed to treat and manage symptoms of many psychiatric disorders, including schizophrenia, depression, anxiety, and bipolar disorder.

Recent data also links akathisia to other medications, including SSRIs and MAOIs used to treat depression, fluoroquinolone antibiotics such as ciprofloxacin (Cipro), steroids, calcium channel blockers, and some illicit drugs (specifically amphetamine and cocaine). Additionally, case reports suggest that akathisia can be seen in individuals who are trying to stop, or have developed tolerance to, benzodiazepines.



There is no clear evidence on the incidence rates of akathisia; studies on the data are mixed. According to a 2001 study, an estimated 20-45% of individuals taking antipsychotics will experience some form of akathisia. A 2017 study reported incidence rates for individuals with bipolar disorder taking antidepressants of somewhere between 10 and 18%.

Aka-What? The Need for Education

With rates that high, one would think that most medical and mental health professionals would recognize the condition. Sadly, that’s not the case. While many psychiatrists are trained to recognize the disorder, many medical and mental health professionals are unaware of it or have only read about it in a textbook. Even the DSM-5, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, merely touches on the condition.

As a result, akathisia often goes undiagnosed or misdiagnosed as a psychiatric problem. Patients who do not present with the classic motor symptoms and experience only the subjective feelings of terror or agitation

Continued on next page

Graphic © agsandre/Shutterstock

are often misdiagnosed as having anxiety. Sufferers themselves are sometimes unable to differentiate between anxiety and the agitation associated with akathisia. A misdiagnosis can lead to prescribing more medications that can further exacerbate the problem.

Akathisia awareness is especially important for correctional health professionals and custody staff because many individuals with the disorder are susceptible to suicide. They may look to suicide not because they want to kill themselves but as a way of ending the torture and pain

of this traumatizing condition. Case reports suggest that people with akathisia can become suicidal after being given neuroleptics without any previous suicide history.

Homicidal behavior also has been documented in individuals who have akathisia. Incarcerated patients on potentially offending medications should be closely monitored and, if indicated, a correlation between their behavior and their medications should be investigated.

Five Types of Akathisia

1. Acute akathisia occurs within a few days to weeks of a medication change or addition.
2. Chronic akathisia is defined as lasting for more than three months.
3. Withdrawal akathisia occurs when a medication is taken away and is usually self-limited to six weeks.
4. Tardive akathisia refers to an onset that occurs one to three months after the discontinuation of a medication.
5. Pseudoakathisia refers to a later-stage chronic or tardive version where motor symptoms are present but there is no awareness of them on the patient's part.

Diagnosis and Treatment

In addition to the restlessness, fidgeting, rocking, pacing, and inability to sit or stand still most closely associated with akathisia, staff also should be on the lookout for some of the less common features, since not everyone experiences the motor symptoms. Other signs include:

- General feelings of terror
- Depersonalization – feelings of detachment or being an outside observer or watching yourself
- Derealization – feelings of unreality or detachment from surroundings
- Agitation and/or subjective feelings of agitation
- Sleep disruptions

Patients who are not medication-compliant often cite side effects as the number-one reason for not staying on a medication. Noncompliant patients should be thoroughly assessed and asked about side effects to determine if akathisia is a potential cause.

Treatment options for akathisia are limited. Discontinuing the offending medication is generally considered the first treatment option, but it must be done slowly, often at a snail's pace, to prevent further exacerbation of symptoms. Even after the offending medication is removed, symptoms can linger for months or years, although most cases do subside with time and treatment.

If eliminating or reducing the offending medication proves to be too difficult or ineffective, other medications can be tried, among them benzodiazepines, anticholinergics, clonidine, propranolol, mirtazapine, and antiparkinsonian agents. Most studies suggest that medication management for akathisia is still not completely effective and can vary greatly from patient to patient.

Ideally, patients should be referred to a neurologist who specializes in movement disorders and psychiatry. Finding someone with that specialty can be very difficult in a correctional environment, making it all the more important for psychiatrists and other providers to be able to recognize the condition and put a proper treatment protocol in place.

Prevention is always the best option, as there is no way of knowing who will experience akathisia and to what degree. Patients who do not regularly take medication need to be informed of the risk – and all potential side effects – in advance. Education may even help prevent med-seeking behavior as the potential cost of taking meds is weighed against the benefits.

Fortunately, educating staff about akathisia can be simple and need not cost a dime. A quick search on YouTube will give hundreds of results. Nonprofit organizations such as MISSD, the Akathisia Alliance, and the Benzodiazepine Information Coalition all offer informational videos, first-hand accounts, and information from those who have experienced the condition.

We know more about what is happening millions of miles away in the vastness of the universe than we do about the organ that sits right inside our heads. Antipsychotics, which are prescribed on a daily basis, are powerful medications that need to be treated with caution and respect. Education, awareness, and proper recognition of the symptoms has never been more important. ●

FOR MORE INFORMATION

MISSD.co
AkathisiaAlliance.org
BenzolInfo.com

Lenny Gallo, LCSW, is a mental health and substance abuse counselor at the Bergen County Jail in Hackensack, NJ, and also a private clinician.

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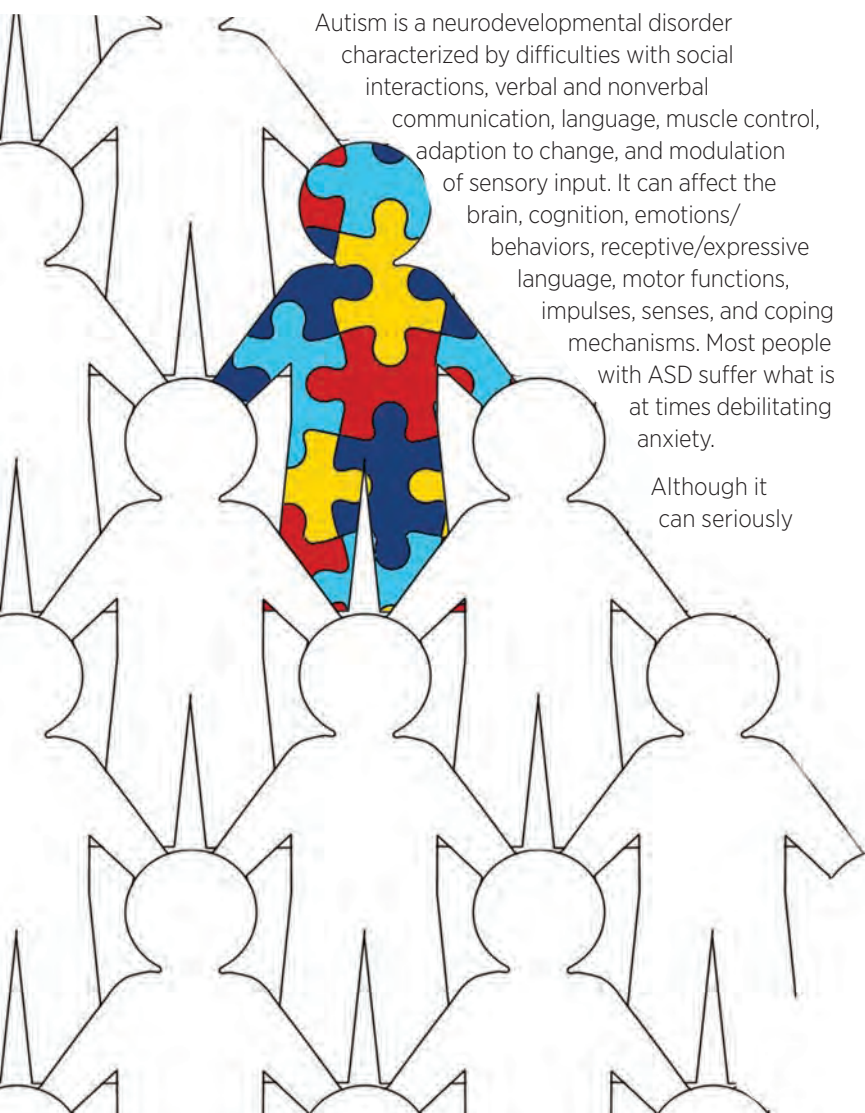
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On the Spectrum and in the System: Understanding Autism

By Joyce J. Benjamin, PA-C (Emeritus), RN, and Michelle A. Grimes, MS, MBA

Autism spectrum disorder is currently diagnosed at a rate of 1 in 54 people, and the number is increasing by approximately 17% each year. That means that in an incarcerated population of 1,000 individuals, 18 or 19 have been diagnosed with ASD – not to mention those who have not been diagnosed. To effectively interact with and care for individuals on the autism spectrum, correctional health professionals need to recognize and understand their characteristics and behavior.

You may have encountered such a person in your work: a man or boy (ASD affects males 5 times more frequently than females) who does not make eye contact, answers questions in a seemingly random way, cannot seem to sit still, and possibly covers his ears. Consider that this person might not be defiant, mentally ill, or high. He might have autism spectrum disorder.



Autism is a neurodevelopmental disorder characterized by difficulties with social interactions, verbal and nonverbal communication, language, muscle control, adaption to change, and modulation of sensory input. It can affect the brain, cognition, emotions/behaviors, receptive/expressive language, motor functions, impulses, senses, and coping mechanisms. Most people with ASD suffer what is at times debilitating anxiety.

Although it can seriously

limit daily activities, ASD is considered an “invisible disability” because many of its symptoms are largely unseen by onlookers, including fatigue, dizziness, learning differences, mental health disorders, hearing and vision impairments, allergies, and gastrointestinal problems. It presents in many ways and with varying degrees of severity, on a spectrum from Asperger’s syndrome (often referred to as “high-functioning autism”) to severe autism.

Recognizing ASD

People on the autism spectrum often seem “off” or “odd” and their behavior can be misconstrued as defiance. It’s important to know the signs and signals so that you can react appropriately – that is, calmly and patiently.

People with ASD generally adopt certain self-regulating behaviors to calm themselves. These adaptive behaviors help them function in a high-anxiety world.

One characteristic self-regulating behavior is known as **stimming**. It involves repetitive movements such as foot or finger tapping, fidgeting, hand flapping, finger flicking, rocking, twirling, and repeating words and sounds.

Acclimating allows an autistic person to adjust to their environment by wandering around the area, looking at and touching things and people. Touching, examining, or smelling things in a new environment is their way of adjusting and is almost always indicative of autism.

Many with autism have **difficulty with eye contact** and may appear to be ignoring you. They are single-track thinkers. It is probable that by not looking at you when you talk, they are concentrating on what is being said.

There are many other characteristics as well. Does this sound like someone you have treated or are currently treating?

- Speaks more loudly than most people or speaks in a monotone
- Is overly talkative and/or does not provide enough information to help you treat them
- Seems to have a delay in processing what is said to them and requires more time to answer; may repeat questions without answering them
- Creates confusion during triage and treatment
- Rearranges things in the waiting room, office, or clinic
- Chews on objects or self, pulls own hair out, or eats inappropriate things like dirt or paper
- Becomes overwhelmed with too many instructions or questions
- May cover ears when overwhelmed

Medications Commonly Used with Autism Spectrum Disorder

Benzodiazepines, such as alprazolam (Xanax), clonazepam (Klonopin), and lorazepam (Ativan), block excessive activity of nerves in the brain and other areas in the central nervous system. They are used to reduce anxiety and panic disorders, to induce relaxation and sleep, to treat or prevent seizures, to treat alcohol withdrawal, and as a muscle relaxant.

Atypical antipsychotics, such as aripiprazole (Abilify), quetiapine (Seroquel), and risperidone (Risperdal), are generally prescribed for schizophrenia, severe depression, agitation, anxiety, and bipolar disorder manic episodes. They are used to relieve delusions, hearing voices, hallucinations, and paranoid or confused thoughts associated with mental illnesses. They are less likely than traditional antipsychotics to cause extrapyramidal

side effects such as akathisia. (For more information on akathisia, see the article on page 13.)

SSRIs (Selective Serotonin Reuptake Inhibitors), such as citalopram (Celexa), escitalopram (Lexapro), and fluoxetine (Prozac), block the reabsorption of serotonin into neurons, making serotonin available to improve transmission of messages between neurons. They are used to treat depression and anxiety.

NSRIs (Norepinephrine-Serotonin Reuptake Inhibitors), such as atomoxetine (Strattera), duloxetine (Cymbalta), and venlafaxine (Effexor XR), block the reabsorption of both serotonin and norepinephrine. They are used to treat depression and anxiety that are resistant to typical SSRIs as well as fibromyalgia.

- Has verbal outbursts, such as loud squeals or shouts
- Becomes combative when touched without permission, such as during lab draws, examinations, splinting, or wrapping

Handle With Care

Corrections is a very anxiety-producing environment for many who are incarcerated. For someone on the spectrum, it can be nearly impossible to manage. Decreasing the patient's anxiety level will make any interaction easier and more productive for all involved.

If the behaviors outlined above are not hurting the individual or others, allow them to continue. Do not force eye contact as that may increase anxiety and cause the patient to withdraw or melt down. Focus on what is most important in the moment: the individual's health.

Upon first meeting the patient, look for alert indicators that may indicate autism – on a wristband, necklace, or the like. Ask if the patient has any special needs you can accommodate.

Remain calm and patient. Speak softly and slowly. Use as few words as possible. You may have to repeat what you say.

Engage respectfully; remember, behavior does not equal intelligence. Whenever possible, explain what you are going to do before you do it. Always ask before touching, and, if possible, avoid getting too close; it could lead to more anxiety or a cause the patient to shut down.

Know how to de-escalate if the patient melts down or becomes combative. Learn the five keys to de-escalation to diffuse the situation.

1. Take their side. Validate their viewpoint; say, "I agree. You're right."
2. Enlist their help. "I need your assistance with..."

3. Bargain with them. "If I will..., will you...?" Choose something appropriate, of course.
4. Distract them. Ask them to tell you about something you know interests them or to solve a simple math equation.
5. Call for a canine, if possible. Animals are very soothing.

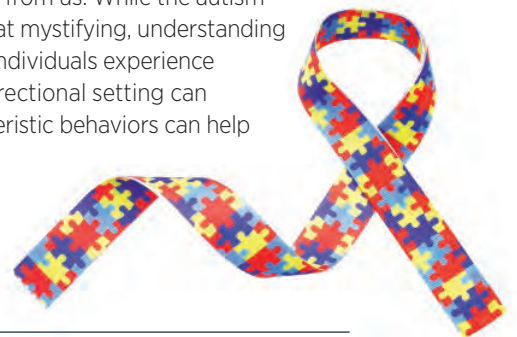
Environmental Accommodations

For a person with autism, the environment inside of a correctional facility can be, at best, challenging, and at worst, horrifying. Certain environmental alterations can help, though it is often difficult to make these impromptu changes.

If possible, install a dimmer switch and turn down the lights, and provide a quiet space. If that's not possible, consider noise-dimming headphones. Create sensory kits that contain items used to calm escalating behavior, such as weighted neck collars or blankets, fidgets, squeeze balls, puzzles, chewy items, and chewing gum or mints.

Everyone is safer when we have a better understanding of those who are "different" from us. While the autism spectrum is still somewhat mystifying, understanding the basics of how these individuals experience the world and how a correctional setting can exacerbate their characteristic behaviors can help soothe any encounter. ●

FOR MORE INFORMATION
Autism-Society.org
AutismFYI.org



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Add Solitary Loss of Taste or Smell to Screening Protocols for COVID-19

This case report highlights findings from a federal prison in which 8 of 10 men who tested positive for SARS-CoV-2 reported no symptoms other than ageusia or anosmia – loss of taste or smell. The report by Capt. Jamal K. Gwathney, MD, MPH, CCHP, appears in the March issue of the *Journal of Correctional Health Care*. Gwathney is clinical director at the Metropolitan Correctional Center in San Diego, an all-male facility that houses approximately 1,100 individuals.

Six days after diagnosis of the prison's first COVID-19 case in April 2020, a nonmedical staff member made rounds on a housing unit (n=125) and asked all inmates about any loss of taste or smell. The 10 who reported this symptom had nasopharyngeal (NP) samples taken the next morning. They were then placed in isolation and the housing unit was placed on quarantine status.

Two of the 10 patients had additional symptoms: body aches and dizziness for one, and subjective fever, shortness of breath, headache, and body aches for the other. Vital signs were normal on initial exam for all except one patient with an oral temperature of 100.5. Evaluations over the next 12 days revealed another patient with three elevated temperatures (max. 102.0). No additional symptoms developed for any of the patients during the subsequent 12-day period.

The NP swab tests were positive for all 10 patients (ages 21-54). All had full recovery of their senses and resolution of other symptoms, most within the 12-day period.

An Important Indicator

The case report notes that when the Centers for Disease Control and Prevention added new loss of taste or smell to its list of symptoms, initially it had to be associated with at least one of six other symptoms. However, the CDC removed this qualifier in May 2020.

Gwathney writes that fever was a poor indicator of infection in this small cohort. However, elevated pulse rate was more sensitive in identifying positive cases as five patients had elevated pulse rates (>100 bpm) and of the 91 pulses taken eight (8.8%) were greater than 100.

Mass testing of the entire prison population found that of 125 patients from that unit, 64 (51.2%) were positive. This is significantly lower than the overall prison infection rate of approximately 65%. Gwathney concludes that using the loss of taste or smell as a solitary indicator of COVID-19 greatly improved the time to identification of infection in this group.

Gwathney reports that the Federal Bureau of Prisons implemented screenings with temperature checks, symptom screens (to include loss/change in taste or smell), and rapid SARS-CoV-2 PCR testing in mid-May 2020. This process is applied to all new intakes, internal/external transfers, and releases when possible. He recommends that this entire process (if testing is available) be implemented at the county and state correctional levels nationwide to help identify cases more rapidly while decreasing the spread, especially from asymptomatic and presymptomatic patients. ●

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- The COVID-19 Epidemic and the Prison System in Italy
- Solitary Anosmia/Ageusia in Prison: Results from a COVID-19 Cluster
- An Outcome Study on Naloxone Education/Dispensing Program for Departure Patients
- Suicide Completion Among Women While They Were Incarcerated
- I Wish I Could Hold Your Hand: Inconsistent Interactions Between Pregnant Women and Prison Officers
- Gender Differences and the Effect of Copayments on the Utilization of Health Care in Prison
- An Ultra-Brief 2-Item Depression Screening Tool for Correctional Populations
- A Qualitative Study of Success in Post-Release Federal Offenders with Mental Health Issues
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New CCHP-A Tells Correctional Health Executives: “The CCHP Program Is for Us Too”

Knowing the NCCHC standards and becoming certified is just as important for correctional health administrators as it is for nurses, physicians, and other health care professionals,” says Brandon De Julius, MBA, CCHP-A, area vice president, Corizon Health. He is one of three individuals to have earned the prestigious CCHP-Advanced certification during 2020.

In his role with Corizon, De Julius is responsible for the delivery of contracted health care services at several locations within the Philadelphia Department of Prisons (which, he explains, is actually a jail). He oversees contracts, compliance, finance, human resources, and legal issues and supervises several health services administrators – a role he himself held when he first joined Corizon 11 years ago.

A Real Eye-Opener

At that time, he was finishing up coursework for a master’s degree in health administration. A colleague suggested the jail as a possible place to work; De Julius was dubious but went for an interview.

“I’m not sure what I expected – we had learned absolutely nothing about corrections in my master’s program. But I can tell you I did not expect to find a clean, fully staffed, well-equipped, comprehensive health clinic. It was a real eye-opener,” he says. He got the job.

The facility was preparing for an NCCHC accreditation survey, and he was encouraged to sit for the CCHP exam as the best way to learn the NCCHC standards. “Earning my CCHP gave me confidence in interacting with clinical and nonclinical colleagues alike,” he says. “I now spoke their language, which I needed to do to be a good leader and make a positive impact.”

Ten years and several promotions later, De Julius was ready to admit that he was all-in on correctional health as a career and really commit to the field. To make it official, he applied to take the CCHP-A exam. He was accepted and passed.



Brandon De Julius, MBA, CCHP-A

Setting the Bar

“CCHP-As set the bar. That’s who I wanted to be associated with,” he says. “It’s one thing to be an expert in the standards. It’s quite another to know how to operationalize them, how to use them to advance a correctional health program. That’s what the CCHP-A test calls for.”

To prepare for the exam, De Julius read all the suggested books, thought through scenarios, analyzed processes, and brainstormed solutions to theoretical problems. Nevertheless, he says, “Ten years of experience was the best preparation. There are some things that only experience can teach.”

He urges anyone in the field, hands-on caregivers, providers, administrators, and executives alike, to learn the NCCHC standards and become a CCHP. “The standards guide everything. If you don’t know the standards, you don’t know your job,” he says.

De Julius loves his chosen field. “There is so much opportunity to do so much for patients who haven’t had a lot of interaction with health care. To get them started on taking ownership of their own health is very satisfying,” he says.

He has a message for his fellow administrators: “Whether you wear scrubs or a suit and tie to work, CCHP certification is for you. And as you transition from having a job or career in correctional health to having a calling, consider applying to become a CCHP-A.” ●

Learn More!

For more information on the CCHP program, go to ncchc.org/CCHP or write to cchp@ncchc.org.

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performance. Research and our own experience validate this principle. To that end, we're revamping our diversity and inclusion training to bring our employees into alignment with our values and to create a culture of respect, inclusion, and opportunity for everyone. These are easy words to recite, but shaping our culture requires very, very hard work. We're not only changing systems and policy; we're also aligning hearts and minds. That's difficult, but we believe it's a worthy effort.

Issue 4: Beyond COVID-19

Dr. Gibson: Looking to the future, what are your thoughts?

Mr. Counihan: It feels to me like we're at a crossroads. I know there are a million reasons why things can't be done. There are a million reasons for institutional resistance to change. But we need to challenge ourselves to somehow overcome that resistance. If we can't figure this out in 2021, I think we're failing to some degree. We can do nothing and perpetuate the status quo, or we can use this as an opportunity to raise the bar for ourselves and for our clients.

Dr. Porsa: During the early months of the pandemic, many jails in this country worked with their local sheriffs' offices and other legal entities to depopulate the jails to a

great extent. In terms of a crisis being an opportunity for innovation and learning, what a great opportunity! How wonderful would it be if we could learn those lessons and keep the number of incarcerated to a minimum? Both because it's the right thing to do, and because it reduces the cost of care inside the correctional setting.

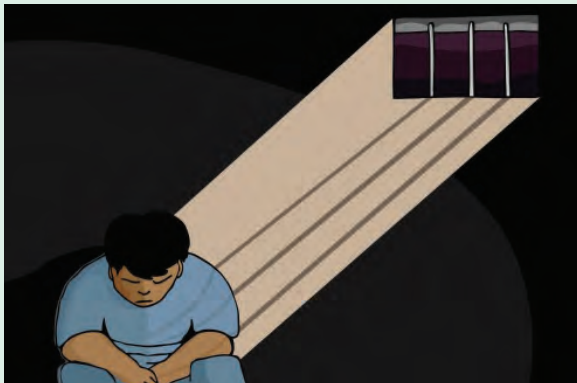
Mr. Charpentier: This pandemic has been really challenging. We've all struggled to try to understand the virus. From an infectious disease control and management perspective, it's very different to battle a virus that is transmitted by air or droplets rather than transmitted sexually or via needles. We've had to work hard to figure out how to protect the people in our facility and our staffs. For our industry, it has mandated we take our game to the next level. We've had to figure out the amount of effort required to do something this complex, for example, the amount of innovation and planning, how we get organized, and how we execute on strategy. Hopefully we are building some muscle memory in terms of being able to execute on solutions that address difficult challenges. Hopefully we've built systems and put processes in place that are going to help us to do well, not only as we finish out this virus, but with the next virus that is sure to come along. ●

NCCHC Adopts New Position Statements

Humane Housing for Youth

Restrictive Housing in Juvenile Correctional Settings addresses the need to reduce or eliminate the use of restrictive housing for youth in detention. Given the widespread use of restrictive housing and the well-understood negative health impacts of these practices, the need for this position statement is urgent.

The statement asserts that "the practice of restrictive housing should not be used in juvenile corrections," either as a disciplinary or punitive measure, as a response to minor infractions, because of staffing shortages, for administrative convenience, or for retaliation. It outlines



Graphic © TheBlackRhino/Shutterstock

measures that should be considered as alternatives to restrictive housing and delineates steps that must be taken to ensure the health and well-being of juveniles in the rare event that restrictive housing is necessary.

Humanizing Language for All

The Use of Humanizing Language in Correctional Health Care position statement supports the use of respectful language to describe individuals who experience incarceration. NCCHC recommends that those who work in correctional facilities or interact with people experiencing incarceration use person-centered language, such as "incarcerated people" instead of "inmates" or "offenders."

Recently revised position statements include:

- Health Services Research in Correctional Settings
- Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths
- Nonuse of Restraints for Pregnant and Postpartum Incarcerated Individuals
- Transgender and Gender Diverse Health Care in Correctional Settings

To read the statements in their entirety, visit ncchc.org/position-statements. ●



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Expert Advice on the NCCHC Standards

By Amy Panagopoulos, MBA, BSN

Pharmacy Inspections

Q How do we handle interruptions to our quarterly pharmacy inspections as required in Standard D-01 Pharmaceutical Operations? In 2020 the pharmacy inspections were missed due to the COVID-19 pandemic.

A Over the past few months, NCCHC has received many questions on how to handle changes to operations due to COVID-19. While we understand that there may be changes to daily operations, we are asking facilities to do their best to address the needs of their patients, follow the standards, document the changes made, and return to normal operations as soon as possible.

Throughout 2020, many facilities operated under their emergency management plan with surges in COVID-19 cases. As facilities return to normal operating procedures, NCCHC requires accredited facilities to work with their consulting pharmacists to conduct quarterly on-site inspections. If COVID-19 cases are surging at a facility, the pharmacist can conduct a virtual consultation. The responsible health authority and the health services administrator can work with the consulting pharmacist to ensure that the facility's pharmaceutical services are operating safely, properly, and according to the law. Given that medication dispensing, administering, and procuring are high-risk endeavors, it is imperative that quarterly pharmacy inspections resume whether on-site or via a virtual consultation.



Staggered Suicide Monitoring

Q During our survey, the surveyors cited Standard B-05 Suicide Prevention and Intervention compliance indicator 2 as noncompliant. We provide nonacute suicide monitoring at precise 15-minute intervals. Is that not the correct practice?

A The compliance indicator specifically states that “nonacutely suicidal inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.” Surveyors review monitoring logs to ensure monitoring times are staggered and unpredictable and that the monitoring does not go

beyond 15 minutes. Your facility is out of compliance because you are monitoring nonacutely suicidal inmates precisely every 15 minutes. Monitoring at precise intervals allows the inmate to understand the pattern of checks, which is why the standard supports unpredictable and staggered times not to exceed 15 minutes. For additional information regarding suicide prevention and intervention, please see the discussion section for B-05 in the jail standards book.

Policy vs. Reality

Q During our recent on-site survey, the surveyors cited noncompliance with standard B-03 Clinical Preventive Services. This is confusing to us since our policy and procedures for B-03 state that we follow nationally recognized standards. Can you provide clarity on how we need to address this?

A Often the compliance issue with this standard has to do with an inconsistency between written policy and practice. Most facilities have policies and procedures in place, but the actual practice does not always reflect the policy or the national guidelines the policy is based on.

For this standard, these inconsistencies are usually discovered during chart reviews. Upon review of the medical records, the physician surveyors may note that actual practice is not in compliance with the written policies. For instance, they may find that screenings being ordered do not follow the facility's policy and/or national guidelines.

While it is important to have clear policies and procedures, it is equally important to conduct periodic chart audits to ensure you are doing what you say you will do for your patients. Trust what you are doing, but periodically verify with a chart audit. ●

Amy Panagopoulos, MBA, BSN, is NCCHC's vice president of accreditation. Send your standards-related questions to accreditation@ncchc.org.

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