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CorrectCare®

The magazine of the National Commission on Correctional Health Care

The background of the cover is a vibrant, abstract painting. It features a hand in the foreground, rendered in white and blue, with fingers slightly curled. The hand is positioned behind a grid of vertical bars in various colors (red, yellow, blue, black). The background is a complex pattern of overlapping geometric shapes and colors, creating a sense of depth and movement.

DEAF AND INCARCERATED

Access, Accommodations, and Care

**Alone: Suicide Prevention
in the Pennsylvania DOC**

**COVID Testing in Jails:
NCCHC Study Results**

**Maintaining Mental
Health During COVID-19**

National Commission on Correctional Health Care
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Foundation Partner Publication Highlights Critical Role of MOUD in Jail Population

A new NCCHC Foundation white paper highlights the critical role jails play in providing medications to treat opioid use disorder for at-risk and high-need populations.

“From the General Public to America’s Jails: MAT Saves Lives” was funded by the pharmaceutical company Indivior through its membership as a Gold Partner in the NCCHC Foundation’s Partners in Correctional Health Annual Giving Society.

The publication summarizes the effectiveness of jail-based MOUD on treatment retention, reduced illicit opioid use, improved criminal justice outcomes, and lower health care



costs. It also discusses the numerous barriers that limit access to medication-based treatment, despite the strong evidence for MOUD’s effectiveness in improving and saving lives.

If policy makers and health care providers are truly interested in reducing recidivism, enhancing public safety, and promoting public health, the paper concludes, more deliberate movement needs to be made in expanding MOUD treatment to people in jail and those being released.

To read the white paper, visit NCCHCfoundation.com or indivior.com.

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2021 was a roller coaster of a year. Learn how NCCHC supported the field with a balance of live and virtual programs, guidance about the pandemic, and continued attention to ongoing critical issues.

ncchc.org/annual-report-2021

Upcoming Events

APRIL 9-12	SPRING CONFERENCE ON CORRECTIONAL HEALTH CARE, ATLANTA
MAY 4-5	VIRTUAL SPRING CONFERENCE
MAY 5	CCHP EXAMS, GREEN BAY, WI
JULY 30	CCHP EXAMS, DENVER
JULY 31-AUG 1	CORRECTIONAL MENTAL HEALTH CARE CONFERENCE, DENVER
AUGUST 26	CCHP EXAMS, PHOENIX
OCT. 22-26	NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE, LAS VEGAS
OCT. 23	CCHP EXAMS, LAS VEGAS

NCCHC Board Elects New Chair and Board Members

Former South Carolina Department of Corrections health services deputy director Samuel Soltis, PhD, MHA, CCHP, is the new chair of the NCCHC Governance Board. Dr. Soltis recently retired after a 34-year career in health care administration. He joined the board in 2015 as liaison for the American College of Healthcare Executives (see next page for a message from Dr. Soltis).

Two new members also were elected at the most recent board meeting:

Joel Andrade, PhD, LICSW, CCHP-MH, a nationally recognized correctional mental health expert and senior director of behavioral health services for Centurion Health, is the newly appointed liaison for the National Association of Social Workers.

Capt. Tami Rodriguez, PharmD, is the new American Pharmacists Association liaison. She is a United States Public Health Service pharmacist and the Federal Bureau of Prisons’ chief pharmacist for the Southeast region.

Priorities for 2022 ... and Beyond

By Samuel Soltis, PhD, MHA, CCHP

It is my privilege to serve as the new chair of NCCHC's Governance Board. It has been an amazing six years as the American College of Healthcare Executives liaison, and I am excited and honored to be serving as the chair for 2022.

During my career, I have held leadership roles in hospital and nursing home administration, consulting, strategic planning, mergers, and outpatient dialysis. Correctional health was never on my radar. When I stumbled into juvenile and adult correctional health care, I found it fascinating, challenging, discouraging at times, but always very rewarding.

I see many opportunities for NCCHC and the correctional health care field moving forward. I'd like to highlight some of the most important here.

Priority 1: Attract talent to the profession.

We need young professionals in correctional health care but often, as was the case for me, this career is not on a graduate's radar coming into the job market. We can all play a role in promoting correctional health as a career choice in our communities, colleges, and professional organizations. There is significant talent out there, and I believe many exceptional people would find correctional health as rewarding as we do if they were knowledgeable about this career path.

Priority 2: Develop collaborations and joint ventures to integrate specialty care with public health facilities and universities.

Given correctional health care's limited financial resources and the widespread locations of correctional facilities, developing joint ventures with local university medical schools and hospitals provides a viable option for specialty services such as infectious disease. State medical universities are also a resource for telemedicine and telepsychiatry, creating access to virtual treatment for incarcerated patients.

Priority 3: Bridge the gaps for incarcerated people returning to the community.

Upon release, incarcerated individuals are faced with many new challenges, and also present challenges to our local communities' public health systems. Developing relationships with community organizations and leaders provides opportunities for continuity of care and integration of the incarcerated population transitioning into the community, particularly in this unprecedented time of employee shortages.

Priority 4: Address the needs of an aging population.

We face a unique challenge with our aging population. Implementing hospice programs in place and creating a peaceful and comfortable environment, along with training health care and custody staff on dealing with dying patients, is essential. Expanding programs for dementia and geriatric care is also critical.

There are numerous other challenges as well, among them the ripple effects from immigration and language barriers, increased civil instability, racial tensions, and political unrest. One constant we can be sure of is that there will always be more changes, challenges, and opportunities to come.

I'd like to encourage everyone to attend NCCHC conferences. As you get to know people, I think you will find, as I have, that it's like having an extended family. The NCCHC conferences are a great place to learn, network, and build lasting friendships with others who understand the challenges – and joys – of working in this unique field and have discovered that one truly can make a difference. ●



Samuel Soltis, PhD, MHA, CCHP, is the 2022 chair of NCCHC's Governance Board and board liaison of the American College of Healthcare Executives.

At a Glance: Meet Sam Soltis

Career Highlights

- South Carolina Department of Corrections, deputy director, health services, 2013-2018
- Adjunct professor, Arnold School of Public Health, University of South Carolina, 2016-2018
- South Carolina Department of Juvenile Justice, director, health services, 2002-2013

NCCHC Positions

- NCCHC Resources Board of Directors, 2019-present
- NCCHC Board of Representatives, 2015-present
- Education, Finance, Young Professionals committee member

Education

- PhD, Public Health, University of South Carolina
- Master of Science, Finance, King's College
- Master of Health Care Administration, The Ohio State University



DEAF AND INCARCERATED

Access, Accommodations, and Care

By M. Elizabeth Bowman, PhD, LCSW-C, and Jaemi Hagen, MSW

Being incarcerated is a difficult, frightening experience for anyone. For individuals who are Deaf, communication barriers can make the experience additionally isolating and distressing.

In the correctional setting, as in most environments, every-thing from fire alarms to subtle social norms operates on the expectation of spoken language. That expectation negatively impacts Deaf individuals who, when incarcerated, are often cut off from human ties; left out of education, treatment groups, and other programs; and potentially misdiagnosed or inadequately treated by health care professionals.

Authors' note: The term Deaf, when capitalized, is used to describe individuals who use American Sign Language to communicate and identify as culturally Deaf. The lowercase term, deaf, refers to the medical or audiological designation of hearing loss. While the terms can mean different things in terms of communication and cultural identities, this article will use Deaf throughout for ease in reading. Most of the concepts presented apply to both groups.

Correctional leadership, custody, and health care staff need to know the Deaf population's rights, how to support those rights, and special considerations to keep in mind when working with people who are Deaf.

The number of Deaf adults in the correctional system is difficult to specify, as some estimates include individuals who are mildly to moderately hard-of-hearing while others do not. HEARD, an organization that provides support and advocacy to incarcerated Deaf individuals, estimates the number to be in the tens of thousands.

Rights and the ADA

People who are incarcerated have a constitutional right to health care – and those who are Deaf are no exception. The first of NCCHC's *Standards for Health Services* in jails, prisons, and juvenile facilities, Standard A-01 Access to Care, reiterates that right: "Inmates have access to care for their serious medical, dental, and mental health needs."

The Rehabilitation Act of 1973 and the Americans with Disabilities Act, which became law in 1990, protect the basic civil rights for disabled people, including those who are Deaf – and those who are incarcerated. ADA law requires that "reasonable accommodations" and "reasonable modifications" be made to ensure equal access to the same services, resources, and information that are provided to hearing individuals.

While in practice the word “reasonable” can be and has been widely interpreted, all incarcerated individuals, regardless of hearing status, are legally entitled to access to correctional programming including health, mental health, and certain other services, depending upon a variety of factors including funding sources.

With some exceptions, American Sign Language is required for effective communication with this population. That means that without qualified sign language interpreters, things like health care encounters, educational and vocational programs, library services, 12-step meetings, anger management classes, religious services, and prerelease programs are all rendered useless.

Depending on the person’s needs, interpretation services may include a team of two or more interpreters: a Registry of Interpreters for the Deaf Certified Interpreter teamed with a Certified Deaf Interpreter. The Registry of Interpreters for the Deaf is the only nationally recognized certification for interpreters. RID provides an independent verification of an interpreter’s knowledge and abilities and protects against unqualified people who claim to be qualified interpreters.

Ideally, the appropriate interpreter or team should be scheduled for all health and mental health appointments. Interpreters also should be present for all meetings, education and occupational programs, and substance abuse assessments and treatment. Arranging for interpretation services is the responsibility of the facility staff, not the individual.

Resources should be adapted so that people who are Deaf can use them, such as visual daily schedules; accessible notifications regarding meals, showers, yard time, and appointments; and closed captioning on televisions.

Health Care, from Intake ...

Information about health services is fundamental to the provision of care in correctional settings. NCCHC Standard E-01 Information on Health Services states that “Upon arrival at the facility, inmates are informed of the availability of health care services and how to access them” and specifies that arrangements should be made for an interpreter or assistive device “whenever effective communication is compromised due to speech, hearing, or language deficits.”

Proper intake and needs assessments on the front end can help reduce some of the risks for an individual who is Deaf. NCCHC Standard E-02 Receiving Screening requires that screening be “performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met.” Specifically, the person completing the screening needs to inquire about “current and past illnesses, health conditions, or special health requirements (e.g., hearing impairment ...).”

The standard also states that receiving screening “should

be conducted using a form and language fully understood by the individual, who may not speak English or may have a physical (e.g., speech, hearing, sight) or mental disability.”

For people who are Deaf, proper interpretation, provided by a certified interpreter, is critical for a thorough intake screening to identify health and/or mental health needs. In some cases, the facility will be informed in advance that a Deaf person is arriving so that an interpreter can be secured. If the hearing status of a new arrival is unknown and the individual displays signs of hearing loss – if they are unresponsive to sounds or spoken language or use signs or gestures to communicate – formal audiology testing should be scheduled immediately to determine the degree of hearing loss and the appropriate accommodations.

A comprehensive communication assessment may also be needed to determine the individual’s linguistic ability. Studies estimate that as many as 50% of Deaf people who are incarcerated have linguistic incompetence, a condition in which the individual is unable to comprehend any language, signed or spoken. The condition is often accompanied by cognitive and social deficits resulting from early childhood isolation or abuse, which, sadly, often goes hand in hand with language deprivation in Deaf children.

Obviously, the inability to understand any communication makes it almost impossible to engage in assessments, health care, programming, and socialization while incarcerated.

If linguistic incompetence is identified, interpreters who are trained to work with that population, including a Certified Deaf Interpreter, should be retained.

... To Discharge Planning

The ability to communicate is as essential at discharge as it is at intake and throughout incarceration; the lack of proper accommodations can affect prospects for future success.

Discharge planning generally includes a review of behavior and attendance at therapy, substance abuse support groups, educational classes, and other programs. If individuals have not been provided interpretation services and access to such programs, their release may be delayed.

Furthermore, when justice-involved Deaf people return to the community, they face unique barriers to obtaining postrelease support, housing, and employment. Mental health and other community services have frequently been shown to be inaccessible, and few halfway houses are equipped to provide appropriate support. That lack of supportive services can lead to homelessness, untreated mental health and substance abuse issues, and re-arrest.

Parole also requires that returning citizens engage in specific activities to remain in the community. Even with interpretation, people who are Deaf are not always clear on parole expectations, which can lead to parole violations and recidivism.

Continued on next page

Other Considerations

Many individuals who are Deaf experience prolonged communication deprivation and social isolation while incarcerated. Such isolation not only creates challenges in terms of navigating the correctional environment, it has

also been shown to increase risk of suicide, mental health issues, and substance use.

In addition to sign language interpreters, the facility should have videophones available to enable communication with loved ones or attorneys and to reduce the risk of isolation. Whenever possible, Deaf individuals should be housed in units together to allow for social connection and support.

Facilities should be equipped with a

means to alert people who are Deaf in the event of fire, lockdown, or other emergency to prevent confusion, panic, injury, and even death. All alert systems should provide visual messaging such as digital displays for bed checks and fire alarms with flashing lights.

In addition, leadership should consider including a unit on engaging with Deaf individuals in custody staff training. Staff members who lack training in Deaf culture and language are at risk of misinterpreting gestures, touch, and facial expressions as aggressive, possibly leading to punitive consequences. Understanding their needs can help to ensure they are provided access to specialized equipment and services as well as help to keep them safe.

To that end, ongoing communication between custody and health staff about special needs, accommodations, and other considerations is essential and will help ensure the patient's health and safety.

Despite legal protections, Deaf incarcerated individuals face unique challenges in accessing health care, mental health services, educational programming, and other services. Health care professionals and custody staff who interact with the Deaf population can help by being aware of their needs and struggles as well as the rights afforded to them. Increased awareness will help improve access to correctional health care, services, and resources that are every disabled individual's right. ●

FOR MORE INFORMATION

Hearing Loss Association of America: HearingLoss.org

National Association for the Deaf: NAD.org

HEARD: BeHeardDC.org

"Deaf People in the Criminal Justice System: Selected Topics on Advocacy, Incarceration, and Social Justice," Debra Guthmann, Gabriel I. Lomas, Damara Goff Paris, and Gabriel A. "Tony" Martin, Editors: gupress.gallaudet.edu

M. Elizabeth Bowman, PhD, LCSW-C, is an assistant professor in the social work department at Gallaudet University and works with reentry services in Washington, DC. Jaemi Hagen, MSW, is a social worker and social justice advocate in Washington, DC.

About the artist: *Nancy Rourke is an internationally known Deaf artist and activist. In addition to her work as a professional artist, she conducts artist-in-residencies at Deaf schools and promotes De'VIA (Deaf View/Image Art), art that examines and expresses the Deaf experience from a cultural, linguistic, and intersectional point of view. She has taught De'VIA art in Poland, Russia, France, Canada, and the U.S. Three of her paintings hang in the Silesian Museum in Katowice, Poland. Her work was featured in the September 2018 issue of Harper's Magazine. Ms. Rourke graduated from Rochester Institute of Technology with a Masters of Fine Arts and lives in Loveland, Colo. Learn more at nancyrouke.com.*

Suggested Accommodations

Regular medical assessments related to comorbid physical or mental health conditions

American Sign Language interpreters

Auditory equipment (e.g., hearing aids and cochlear implants)

Fire alarms and other alert systems with flashing lights and visual messaging

Accessible housing reserved for Deaf individuals

Captioned televisions and visual schedules posted in common areas for entertainment and notification

Videophone – TTY/TTD devices are no longer usable communication technology.



Painting © Nancy Rourke, nancyrouke.com

How Do Disability Laws Apply to Deaf People Who Are Incarcerated? It's Complicated

By Deana Johnson, JD

Both the Americans with Disabilities Act and the Rehabilitation Act protect individuals with disabilities, including those who are incarcerated. Both laws use the same legal standards and offer the same range of remedies.

The major protections are the right to participate in or gain the benefits of services, programs, or activities of a public entity (called a participation claim); and freedom from discrimination based on the disability (called a discrimination claim).

Interestingly, neither one allows the plaintiff to recover money damages unless there is discriminatory intent. For that reason, many plaintiffs add constitutional claims of deliberate indifference as a way to prove discriminatory intent.

To prove a participation claim, the plaintiff must show:

- A disability as defined by these laws
- Otherwise qualified to receive the service or benefit
- Denied the benefit solely by reason of the disability
- The program/benefit receives federal money.

To prove a discrimination claim, the plaintiff must show:

- A qualified individual with a disability as defined by these laws
- Subject to discrimination by the agency due to the disability

In deliberate indifference cases, the plaintiff must prove:

- The agency knew of the need for accommodation either because the plaintiff notified it or the need was obvious.
- The agency's failure to act was deliberate.

Applications in the Correctional Setting

Hearing impairments qualify as disabilities if they substantially limit hearing, speaking, and communicating. The incarcerating agency must take steps to make communications as effective as they are with others. However, the type of auxiliary aid or service needed to ensure effective communication varies depending on the person's specific medical and lingual history and the complexity and nature of the communication.

The ADA requires that deference be given to the requests of the disabled individual for specific aids. In addition, the incarcerating agency has a duty to gather sufficient

information from the person and, if needed, qualified experts, to determine what accommodations are necessary. Failure of the agency to perform any inquiry can result in an award of money damages.

Aids for Medical Appointments

Do Deaf individuals have a right to American Sign Language interpretative services for medical visits during incarceration?

The courts' answer often turns on the specifics of the health care exchange itself: the more complex the subject matter, the longer the visit, and the more chaotic the environment, the higher likelihood that the court will side with the patient's claim that an ASL interpreter was required. Especially with today's technology, which allows for web-enabled interpretative services with little advance notice, plaintiffs have stronger arguments to support these types of claims.

Telephone Aids

When it comes to specific technology to aid in telephone communication, case law on rights is far from settled. For instance, a Michigan federal court decision found an ADA violation for offering only teletypewriters, while a Louisiana federal court held the exact opposite and deferred to the correctional agency's choice of TTY over video technology.

Other cases have required ASL interpreters during routine phone calls only if the person's hearing loss and language skills render interpretation services the only option for effective communication.

Takeaways

As is so often the case when hundreds of different judges throughout the country hear similar legal challenges, the results are not nearly as uniform as the legislation tries to make them. However, as technological advancements make connectivity cheaper and easier and as internet access, even in limited capacities, increases in jails and prisons, it is logical to expect that claims seeking interpretative services for incarcerated individuals who are Deaf will continue to be pursued, both on individual and class action bases. ●

Deana Johnson, JD, is general counsel for Centurion Health and the recipient of the 2021 B. Jaye Anno Award for Excellence in Communication.

ALONE

Suicide Prevention in the Pennsylvania DOC



Photo © Lightfield Studios/Shutterstock

By Lucas D. Malishchak, DBA

A cluster of suicides within Pennsylvania Department of Corrections facilities led to a review of suicide data, identification of an inadvertent error in the data collection process, and several transformative revisions to PDOC's suicide prevention efforts.

Background

A few years ago, the Pennsylvania Department of Corrections experienced a cluster of suicides within a short period of time. After each suicide, PDOC adhered to our standard suicide clinical review process in an effort to identify areas of improvement or needed remediation. Our psychology office also reviewed the cluster of suicides together as a whole to identify any broader systemic concerns that may have occurred.

In this cluster review, we identified that the percentage of individuals categorized as “double celled” at the time of their death – meaning they had a cellmate assigned to their cell – appeared high based on our previous experience reviewing and understanding suicides. Consequently, we re-reviewed each suicide within the cluster and discovered that in fact only one of them was technically double celled at the time of the suicide; that is, in only one instance was the cellmate present in the cell when the decedent was discovered.

In the other four cases, although the individuals were categorized as double celled, they did not initiate the suicide until their cellmate was away or had exited the cell. The individuals were actually alone in the cell by themselves at the time they initiated their suicide.

Upon discovering this inadvertent data collection error, we initiated a larger retrospective review of all suicides that had occurred within PDOC since 2000 in an effort to clarify the precise housing status of each decedent at the time of their discovery. Looked at through the lens of our new understanding of the concept of being double celled versus being alone, our review of this larger dataset revealed the

same error in our understanding and categorization of housing status. The result was staggering: in 95% of all suicides that have occurred within the PDOC since 2000 – 174 of 184 – the individual was alone in a cell at the time of the suicide.

The pie chart on the next page tells the entire story. For reference, a Z-code indicates the person is assigned to a single cell (they are not assigned a cellmate).

Once we discovered the “alone” issue, we wanted to further examine the data beyond our categorization error. We thought it would be helpful to know which specific PDOC prisons had experienced the most suicides during the past 50 years, so that we could strategically focus planned corrective interventions. We plotted exactly where – at which state correctional institution – each of 342 suicides had occurred since 1971.

Asking the Right Question

The 50 years of data revealed that certain prisons had experienced significantly more suicides than others. We asked ourselves, “What are those institutions doing so wrong?” It seemed obvious that we would find what we needed to know in the answer to that question.

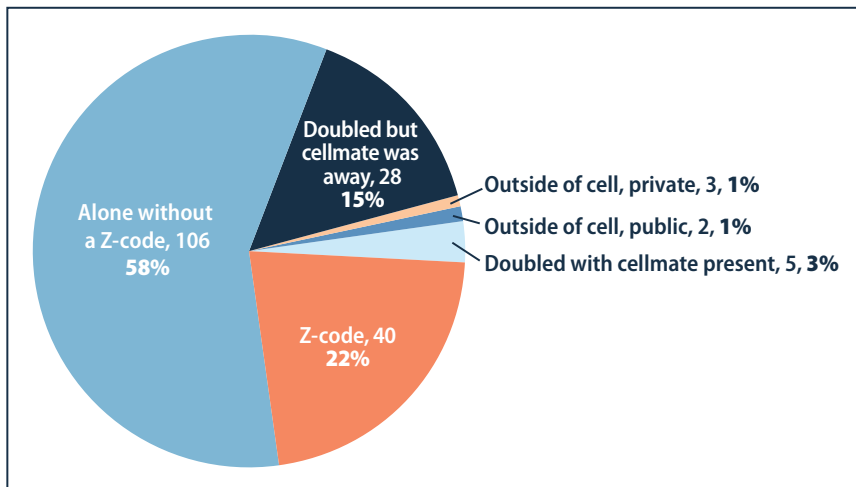
After some deliberation, we realized at least two reasons those prisons had had the most suicides: they have been open the longest, and they are some of our largest prisons. It immediately became clear that we were asking the wrong question.

The better question was, “Which prisons have had the fewest suicides and why?” We identified four prisons that were at least 30 years old and had very low numbers of suicides: Quehanna Boot Camp, SCI-Cambridge Springs, SCI-Laurel Highlands, and SCI-Waymart.

We were surprised to find that all four facilities house populations known to be at increased risk of suicide: Quehanna Bootcamp houses and treats predominantly

younger (under 40) people with drug and alcohol treatment needs. SCI-Cambridge Springs specializes in housing females, who report or experience higher rates of mental illness and serious mental illnesses than men. SCI-Laurel Highlands specializes in delivering the highest level of acute medical care in our system, including care for people who are terminally ill or near end of life. SCI-Waymart is responsible for delivering PDOC's highest level of inpatient mental health care and specializes in housing our most seriously mentally ill male individuals. Despite high-suicide-risk patient populations, those four SCIs, looked at together, had only ever experienced two suicides.

That finding was counterintuitive to what we thought we knew about suicide risk. How were those institutions, which house apparently higher-risk populations, having so much success at preventing suicides?



We informally interviewed staff from each of the prisons and asked, "What are you doing differently?" Their answers were consistent: "We've learned how to work effectively with these populations. We know how to keep them safe. We treat them professionally and humanely; we speak to them and treat them with respect."

That seemed like a plausible explanation, but it didn't quite fit with what the data were telling us. While we agreed that our staff at these institutions were professional, we thought there may be something more going on, and in fact there was.

At each of these four prisons, there are very few cells. Most of their physical plants are essentially open-dorm style settings. Most individuals are housed in large open areas, visible to many other people, which creates infrequent "alone time." In addition to their excellent staff, one potential reason these prisons had so much success in preventing suicides was that the individuals in these settings were rarely housed alone.

Suicide and the Pandemic

The number of suicides recorded in PDOC prisons since the beginning of the COVID-19 pandemic appears to corroborate the psychology office's data findings. Given the significant change, stress, loss, and unpredictability associated with this crisis, one would expect the number of suicides to rise. During COVID, however, the total number of suicides within PDOC prisons decreased by more than 50%, compared to the same amount of time immediately preceding the start of the pandemic.

How do we explain that significant reduction? It might have been our reduced population, a new Suicide Risk Assessment tool, enhanced training, enhanced communication, better levels of supervision, or maybe even something else.

One of the preventative actions PDOC, like other correctional jurisdictions, enacted to mitigate the risk of spreading COVID-19 was to enhance movement restrictions within our population. Many activities that during normal operations take people out of their cells and create an opportunity for those who are double celled to be alone – for instance going to school, work, or even to the day room to play chess – were suspended. In an effort to protect our staff and population from spreading COVID-19, we unintentionally decreased the amount of time alone

experienced by those who were double celled.

We believe this partly explains why PDOC did not have a single suicide categorized as "Doubled but cellmate was away" throughout the entire pandemic, but had experienced at least one of those types of suicides in 16 of the 18 years prior to the pandemic.

Of all suicides that have occurred within PDOC since 2000, in 95% of cases the individual was alone in a cell at the time of the suicide.

After putting all the pieces together, it seemed clear to us that double celling or having a cellmate present is a strong protective factor against suicide.

Our next step was to critically review our operational policies and practices. We began with a review of our Z-code policy, which outlined operational standards and guidelines for single and double celling. We discovered that our Z-code policy indicated that having mental health

Continued on next page

problems or a history of being dangerous toward self, self-mutilative, or unable to care for self were acceptable singular reasons to consider housing someone in a single cell. Our data, however, suggested that those reasons, taken alone, were likely contraindicated for being housed alone.

As a result, we took immediate action and issued a memo to the organization revising the Z-code policy to prohibit assigning Z-codes for those contraindicated reasons. Additionally, we directed that all SCIs commence meaningful reviews of all individuals single celled at that

- Increased emphasis on out-of-cell clinical encounters with individuals housed alone on all Restrictive Housing Units and Special Management Housing Units, by assigning additional psychology staff to these units.
- Developed enhanced psychological evaluations for Z-codes, which now include a suicide risk assessment, violence risk assessment, review of objective testing, review of records, patient interview, and discussion with other staff members who know the patient well.
- Augmented pre-service and annual in-service suicide prevention trainings for all contact staff to include the results of this data review and relevant operational updates.

Additionally, we emphasize that all other suicide prevention efforts currently in place must continue.

And that is how a fortuitous error helped advance PDOC's understanding of suicide prevention and led to transformative changes. ●

After putting all the pieces together, it seemed clear that double celling or having a cellmate present is a strong protective factor against suicide.

time to determine whether the individual could be safely double celled.

Other improvements we have implemented, based on this suicide data review:

- Increased the frequency of security rounds on all Restrictive Housing Units and Special Management Housing Units statewide, from once every 30 minutes to unpredictable intervals with no more than 15 minutes between checks, with special emphasis on those individuals housed alone. By increasing the frequency of security rounds, we decrease the amount of time that people who are housed alone are alone.

RELEVANT NCCHC STANDARDS

Standard A-09 Procedure in the Event of an Inmate Death: The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths.

Standard B-05 Suicide Prevention and Intervention: Suicides are prevented when possible by implementing prevention efforts and intervention.

NCCHC Standards for Health Services in Prisons, 2015

Lucas D. Malishchak, DBA, is director of the psychology Office for the Pennsylvania Department of Corrections.

Why? Possible Explanations for the "Alone" Effect

Why do suicides appear to happen so rarely among people who are double celled with the cellmate present? The Pennsylvania Department of Corrections' psychology office believes there are several potential explanations:

- A cellmate, if present, can provide immediate rescue/intervention.
- A cellmate, if present, can call professional custody staff for help.
- A cellmate, if present, may act as a deterrent simply by being present.
- A cellmate, if present, may offer protection against the fluctuating or vacillating nature of suicide risk or inaccurate assessments of suicide risk by custody professionals.
- A cellmate, if present, may offer protection against people who falsely deny suicide intent.
- Having a cellmate might increase the chances of developing one's social network, a known protective factor against suicide.
- We believe there is a strong association between people assessed to be at high risk of violence and increased risk of suicide, given that a primary violence risk mitigation intervention in prison is to cell violent people alone.



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Interventions for Maintaining Mental Health During COVID-19: Good for Everyone

By Talia Parente and Justin Berk, MD, MPH, MBA

The COVID-19 pandemic has disproportionately affected staff and residents of correctional facilities, and the impact goes beyond physical health. Protecting the community has required increased restrictions, decreased visitation, less programming, and some lockdowns. Though necessary, those mitigation efforts can increase feelings of isolation and uncertainty, undermine emotional well-being, and exacerbate mental health issues among facility staff and residents alike.

A significant percentage of incarcerated individuals – as well as some custody staff – have preexisting mental illnesses. Both populations face tremendous stress, especially now during the pandemic. The following summary of recently published evidence-based interventions offers guidance and strategies for maintaining mental health – your own as well as the mental health of the incarcerated individuals you work with.

For the Incarcerated

Early in the pandemic, *The Lancet Psychiatry* published several suggestions for minimizing mental health harm related to the pandemic as identified by Hewson et al.:

- Offer mindfulness exercises; they can help alleviate anxiety and uncertainty caused by the pandemic.
- Increase access to telephones, video calls, and postage stamps for letters to help reduce feelings of isolation.
- Provide education about COVID. Having access to accurate and up-to-date information can combat some of the uncertainty related to mitigation strategies and helps prepare people for the transition back into society. Education that emphasizes the importance of their role in protecting others can also establish a sense of empowerment and belonging.

Other suggested interventions:

Encourage communication between staff and the incarcerated. A scoping literature review on the subject by Johnson et al. found that clear communication regarding any new COVID-19 information or changes in restrictions or protocol within the facility can help prevent the spread of mistrust, fear, and anxiety and improve the overall climate.

Provide distraction materials. According to a recent article by Kothari et al. in *Medicine, Science and the Law*, incarcerated individuals appreciate receiving self-help materials such as puzzles, journals, coloring books, and playing cards, as well as instructions for in-cell exercises, to occupy their time and promote physical and mental health.

Increase yard time. Rebecca Vauter, PsyD, CCHP-MH, chief behavioral health officer for Armor Health, suggests providing more time outside and access to sunlight during times of increased isolation. While the logistics can be challenging given COVID-19 restrictions, outdoor yard time offers positive mental health impact with reduced risk of disease transmission – and it's good for facility staff too.

Look to the NCCHC standards. NCCHC's *Standards for Mental Health Services in Correctional Facilities* includes several strategies for maintaining patients' mental health, which should be emphasized to combat COVID restrictions. The standards suggest the following:

Engage patients in the development of their mental health treatment plans to establish a sense of ownership and increase the likelihood of compliance to care.

Provide education regarding mental health, mental illness, coping mechanisms, medications (if applicable), and self-care activities through classes, brochures, pamphlets, videos, and other materials. Self-care subjects include maintaining good personal hygiene, coping with stress, anger management, conflict negotiation, and relapse prevention. Maintaining good personal hygiene can enhance self-esteem and a sense of well-being.

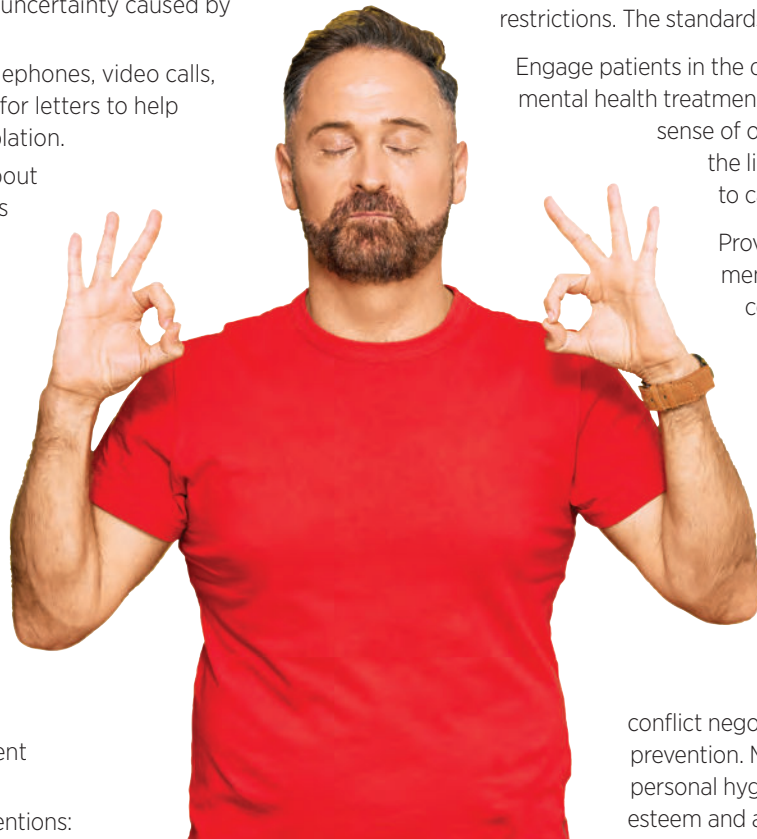


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(Poor hygiene, on the other hand, can be an indicator of mental illness, including depression, intellectual deficits, and severe psychiatric disorders.)

Encourage and provide access to exercise and fitness. Exercise is beneficial in managing anxiety, depression, and manic episodes, and improving cardiovascular performance and self-esteem. Although programming may decrease during COVID, offering exercise in a safe setting – in a small group or outdoors, for instance – should be prioritized.



Photo © Kyle Lee/Shutterstock

COVID-19 has been challenging for everyone in all sorts of environments, but the restrictive and controlled nature of correctional facilities presents unique issues that warrant special attention. Administrators must make efforts to ensure that necessary interventions to address the mental health effects of COVID-19 and associated restrictions are available. ●

RELEVANT NCCHC STANDARDS

Standard MH-F-01 Mental Health Education and Self Care: Mental health education and self-care instructions are given to inmates with mental illness.

Standard MH-F-02 Healthy Lifestyle Education and Promotion: All inmates have access to mental health educational materials that promote disease prevention, wellness, and recovery and are encouraged to participate in programs that encourage healthy lifestyle choices.

NCCHC Standards for Mental Health Services in Correctional Facilities, 2015

For Facility Staff

As essential personnel, correctional staff serve a critical role in society's response to the pandemic. The pressure of having direct daily contact with a high-risk population, on top of the well-documented work-related stress and anxiety among those working in jails and prisons, requires interventions to support correctional facility staff.

Create a “buddy” system. Kothari et al. suggest improving bonds between staff members through buddy systems that give them an opportunity to debrief before and after shifts.

Decrease stigma. Managers should encourage custody and health staff to practice self-care and support them in seeking treatment whenever necessary, particularly during the pandemic.

Use the PIES framework. The PIES system of formal support – Proximity, Immediacy, Expectancy, Simplicity – emphasizes the efficacy of treatment and support that is close to the place of work, immediate and efficient, simple, with the expectation of returning to work. Solomon et al. developed this system to support veterans suffering from post-traumatic stress disorder, and it could be extremely helpful in providing services to those who work in high-stress environments like corrections.

Evaluate and update sick leave policies. The Centers for Disease Control and Prevention offers personnel guidance related to COVID-19 and correctional facilities. Recommendations include ensuring that policies are “flexible, nonpunitive, and actively encourage staff not to report to work when sick.” This helps staff to feel supported and also helps prevent symptomatic transmission at work.

Talia Parente is an AmeriCorps VISTA intern and Justin Berk, MD, MPH, MBA, is director of medical services at the Rhode Island Department of Corrections.

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NCCHC Study Highlights Differences in COVID-19 Testing Rates in Jails Nationwide

By Emma Smyth; Ruben Guardado, MPH; Nick Zaller, PhD; George Pro, PhD; and Alysse Wurcel, MD, MS

At the onset of COVID-19 in March 2020, researchers from Harvard University partnered with the National Commission on Correctional Health Care to assess the pandemic's impact on correctional facilities. Between March and June 2020 NCCHC emailed weekly surveys to jails, prisons, and juvenile facilities across the United States.

Our team of researchers at Tufts Medical Center and the University of Arkansas for Medical Sciences used the data collected in the Harvard – NCCHC survey to compare COVID-19 testing rates in U.S. jails to statewide testing rates during the first wave of COVID-19 to see how the rates compared at that time.

Methods

Participation in the survey was voluntary; survey responses were received from 214 jails in 41 states. Nine states (AK, AR, CT, HI, MS, OK, TN, SD, and WV) did not have a jail respond to the survey. (Data collected from Rhode Island was not included because the state has one unified correctional facility and would therefore be identifiable.)

Using data from the COVID Tracking Project and the Prison Policy Initiative, jail testing rates were calculated for each state by dividing the number of tests performed in the state by the number of people incarcerated in jails in that state.

Using data from the COVID Tracking Project and the United States Census Bureau, state testing rates were calculated for each state by dividing the total number of tests performed in the state by the state's population.

The final rate ratio is the ratio of jail testing rate to state testing rate.

Results

Figure 1 shows our results and incorporates the state COVID-19 positivity rate during the first wave of the pandemic (March-June 2020).

Twenty-three states (57.5%) had a higher testing rate inside the jails than in the community. The testing rates in the other 17 states (42.5%) had lower testing rates inside jails than in the community. There was no clear relationship between the severity of the epidemic in the community and the rate of testing in the jails.

Discussion

Health care decisions in jails are made by facility leadership, clinicians, and vendor medical corporations. During the first wave of the pandemic, many parts of the nation experienced a shortage of COVID-19 tests. Jails in states

with low testing rates likely did not have access to the amount of COVID-19 tests needed, and the federal government did not prioritize giving tests to jails. Therefore, jail administrators had to rely on quarantining potentially positive inmates to stop the spread of COVID-19.

Our research findings offer lessons for the development, implementation, and dissemination of COVID-19 testing policies and protocols in jails.

For instance, we believe that variations in COVID-19 testing protocols and policies can be avoided through more unified guidance from credentialing agencies. A system of disseminating information from the CDC to national jail associations would be very helpful. Collaboration can be facilitated by scheduled meetings of leadership; joint strategizing on effective methods of information dissemination; and linkages to testing supplies and clinical laboratory support.

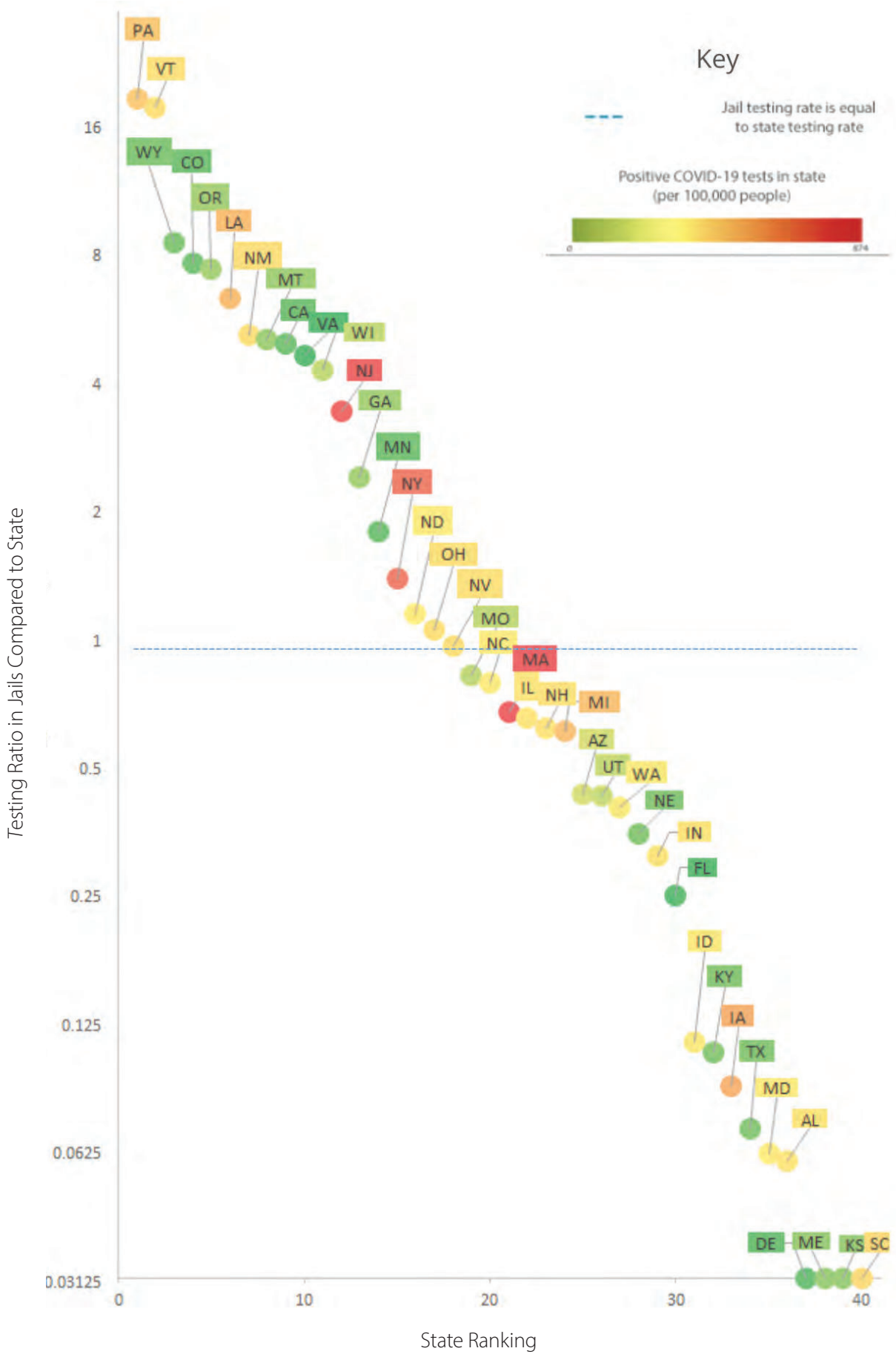
Several limitations to this study should be noted. The most granular geographic information for COVID-19 testing was at the state, not county, level, which meant we were unable to differentiate between urban and rural geographies. It is worth noting that cross-state transfers of incarcerated people are common, especially in smaller states, which might affect results. Jails that responded represented a variable percentage of all the jails in the state; for example, three Indiana jails responded, which represents only 3% of all jails in the state. In comparison, 10 North Dakota jails responded, which is 42% of all jails in the state and therefore more representative of the state as a whole.

Despite these limitations, we feel this research study hints at some important truths that remain relevant as COVID-19 continues to evolve. Aiming for best practices for infectious disease mitigation is key as we deal with the continued waves of COVID-19 and any other pandemics that may arise in the future. ●

Emma Smyth and Ruben Guardado, MPH, are research coordinators in the department of medicine at Tufts Medical Center; Nick Zaller, PhD, and George Pro, PhD, are researchers at the University of Arkansas for Medical Sciences, Fay W. Boozman College of Public Health; Alysse Wurcel, MD, MS, is assistant professor in the department of public health and community medicine at Tufts University School of Medicine and an infectious disease physician at Tufts Medical Center.

Conflict of Interest: AGW, ES, RG were funded through NIH grants: 1KL2TR002545-01; K08HS026008-01A

COVID-19 Testing Rate in Jails by State



Awardees Applauded at National Conference

NCCHC's annual awards pay tribute to leaders and innovators who have enriched the correctional health care field. The 2021 awards were presented during the opening ceremony of the National Conference on Correctional Health Care in Chicago.

Bernard P. Harrison Award of Merit

NCCHC's highest honor, named for the organization's cofounder and first president, is presented to an individual who has demonstrated excellence and service to advance the correctional health care field.

Richard Clarke, MD, CCHP-P



For 20+ years Dr. Clarke oversaw all health care at the Berkshire County Jail and House of Correction in Pittsfield, Mass., guiding that facility to NCCHC accreditation and to a Program of the Year Award for its innovative long-term care and discharge planning program. He remains highly involved with both NCCHC and NCCHC Resources.

A physician surveyor for almost 20 years, Dr. Clarke has been an active member of the surveyor advisory committee since its inception, served on the task forces that revised the 2014 and 2018 editions of the *Standards for Health Services*, and is a regular presenter on the standards.

B. Jaye Anno Award of Excellence in Communication

This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to an individual for a body of work. It is named for NCCHC's cofounder.

Deana Johnson, JD

Ms. Johnson has nearly 30 years of correctional health care legal experience with over 20 years providing legal services for Centurion Health and MHM Services, Inc., Centurion's cofounding company. She is a nationally recognized expert in correctional health law and a frequent and very popular presenter at NCCHC conferences.

Edward A. Harrison Award of Excellence in Correctional Health Care Leadership

This award, presented this year for the first time, honors an individual who leads by example, inspires others, and is

committed to quality improvement in correctional health care. It is named for NCCHC's longtime president.

Joel Andrade, PhD, LICSW, CCHP-MH

Dr. Andrade has over 20 years of correctional and forensic health experience and is a nationally recognized mental health expert in the treatment and management of individuals with personality disorders and gender dysphoria in correctional settings. He is a published author and regular presenter/educator on the delivery of effective treatment for those populations. He is currently the senior director of behavioral health services at Centurion Health.



Dr. Andrade, center, with vice president of program development Jim Martin and 2020 board chair Joseph Penn.

NCCHC Young Professional

The Young Professional Award recognizes new and upcoming leaders in the field of correctional health care.

Nathaniel Morris, MD

Dr. Morris is attending psychiatrist at San Francisco Jail Behavioral Health Service and assistant professor of clinical psychiatry at UCSF Department of Psychiatry and Behavioral Sciences. He became inspired to pursue a career in correctional and forensic psychiatry during



an elective rotation at Bellevue Hospital during medical school at Harvard University. Dr. Morris has published extensively in peer-reviewed journals and popular media. He hopes to help change views and treatment of incarcerated people with mental health issues, while also providing direct patient care.

Surveyor of the Year

The award was created in 2019 to recognize a surveyor who is an exemplary representative of NCCHC and demonstrates extraordinary dedication.

Donna Mayne, RN, CCHP

Ms. Mayne served for nearly two decades as health services administrator for the Fairfax County Adult Detention Center in Virginia. Between supervising more than 20 health professionals, establishing chronic care clinics, developing nursing protocols, and implementing a new medical records system, she also found time to participate in NCCHC accreditation surveys. She became a lead surveyor soon after retiring and has devoted herself to that vocation ever since. When COVID-19 drove surveys to a more high-tech virtual format, Ms. Mayne embraced the new technology and was soon training other surveyors on the process. Throughout the pandemic, she has been a leader in the number of virtual and hybrid surveys completed.



veterans with a supportive and constructive environment to help restore their dignity. In addition to receiving mental health and substance abuse treatment, participating veterans are housed together in a pod decorated with American flags and flags from each branch of the U.S. military. Inspirational imagery painted by inmates covers the walls.

R. Scott Chavez Facility of the Year

The award is presented to one facility selected from among all NCCHC-accredited facilities for outstanding quality, innovation, and dedication. It is named for NCCHC's longtime vice president.

South Woods State Prison, New Jersey

South Woods State Prison is the largest and one of the newest facilities managed by the New Jersey Department of Corrections with a capacity to house more than 3,000 incarcerated individuals, including some of the most critically ill in the state system. Despite its size, NCCHC surveyors noted that close collaboration between custody, health care, and mental health care creates a positive culture focused on high-quality, personalized care, provided by Rutgers University Correctional Health Care. ●

NCCHC Program of the Year

The Program of the Year Award recognizes programs of excellence among the thousands provided by accredited jails, prisons, and juvenile facilities.

Hillsborough County Sheriff's Office, Falkenberg Road Jail, Veterans Resurgence Program

In August 2019, Hillsborough County Sheriff Chad Chronister launched the Veterans Resurgence Program, which focuses on providing incarcerated U.S. military





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To Improve Mental Health, Encourage Strong Social Support Systems

Given the high prevalence of mental illness among those who are incarcerated, it's worthwhile to identify evidence-based ways to mitigate adverse effects of mental health problems. A study described in the February issue of the *Journal of Correctional Health Care* sought to examine the association between social support and improved mental health outcomes.

Authors Lindsay Chassay and Kristen Kremer, PhD, of Kansas State University analyzed data from the 2004 Survey of Inmates in State Correctional Facilities, which yielded a sample of 3,451 people. In that study, participant interviews obtained a wide range of information, including psychological well-being and mental health diagnoses.

Chassay and Kremer examined variables related to mental health and social supports (i.e., calls, visits, mail). The aim was to predict current mental health functioning from frequency of visits and phone calls. Nearly 60% of the sample had a minor child, and the study highlighted the role of communication with the participants' children.

Study Concepts

Discussing the conceptual framework of the study, the authors explain how the "buffering" effects of social support lead to better overall health at baseline and puts them in a better position to combat chronic stressors to both improve recovery from mental illness and decrease the likelihood of onset. However, prison settings undermine strong social support systems, with barriers related to visitation and the cost of phone calls.

Key Findings – And a Caveat

In line with previous research, incarcerated people with higher levels of social support were found to have better mental health outcomes. In particular, those who received more frequent phone calls had better mental health functioning than those who never received phone calls, and those who received more frequent visits had better outcomes than those with less frequent visits. With regard to interactions between parents and their minor children, phone calls and mail were significantly related to higher mental health scores, especially for mothers. However, visits from children had an insignificant effect.

The study authors do note that the cross-sectional data do not allow for causal inferences – in other words, although social support and mental health outcomes are related, it may be that mental illness leads to social isolation.

Policy and Practice Recommendations

The authors say that these findings suggest ways that prison administrators can improve access to incarcerated peoples' social supports, for example by enabling them to earn credit toward phone calls and by ensuring that they are housed within a manageable travel distance from family members. In addition, correctional health professionals may recommend increased contact with family members as a way to improve mental health.

Given that prior research has demonstrated a lower likelihood of recidivism and violence when strong social support systems are present, these policies could be beneficial for the community, as well. ●

JCHC Vol. 28, No. 1: February 2022

- The Importance of Criminal Justice Health Education for Today's Medical Students and Strategies for Integration Into Medical School Curricula
- Patterns of Physical Activity Among Women Incarcerated in Jail
- A Comparison Between Rural and Urban Jail Proximities to Inpatient Mental Health Care in New York State
- Preexposure Prophylaxis for Women Across the Criminal Justice System: Implications for Policy and Practice
- Psychiatric Disorders and HIV Drug Risk Behaviors Among Individuals Under Community Correctional Supervision
- Reducing Medicaid Coverage Gaps for Youth During Reentry
- Association Between Social Support and Mental Health of Incarcerated Individuals
- An Economic Analysis of the Cost of a Regional Crisis Stabilization Unit
- Formerly Incarcerated People With Disabilities: Perceptions of Accessibility and Accommodations in Correctional Programs

Note: The *Journal of Correctional Health Care* is now being published six times a year by Mary Ann Liebert, Inc., up from four times a year. Academy of Correctional Health Professionals members receive a complimentary online subscription and Certified Correctional Health Professionals receive a 30% discount on subscription rates.



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Meet NCCHC Resources' Loretta Reed, CCHP

Project manager, cross-functional team leader, scrum master, problem solver, process improver, and now a Certified Correctional Health Professional ... meet Loretta Reed, MBA, PMP, CCHP, director of the Project Management Office of NCCHC's consulting subsidiary, NCCHC Resources, Inc.

Reed joined NCCHC Resources full-time in 2019 after having served as a consultant to the organization during a rapid growth period over the previous few years. She brought to the role a diversified portfolio of experience spanning management consulting, business analysis, agile project management, business process management, finance and accounting, and more.

About NCCHC Resources

NCCHC Resources was created to manage the increasing demand for correctional health care technical assistance and other consulting work through the provision of high-quality consulting services. 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.

Reed's first order of business upon joining NCCHC Resources was to build a centralized project management structure, which included creating processes and setting standards for the business's projects. As Project Management Office director, she is at the center of operations. She coordinates the growing list of projects; trains and oversees consultants; manages project time lines, resources, and personnel; and tracks compliance.

Like so many people in the field, Reed had had no previous experience with correctional health care. And like thousands of fellow CCHPs, she turned to the NCCHC standards to deepen her knowledge and understanding of the issues and challenges.

A Deep Dive

"Really diving into the standards in preparation for the CCHP exam gave me a greater appreciation for the intricacies of the field, especially as they relate to incarcerated patients' rights and legal considerations," she says. "Understanding both the big picture and the details gives me a very solid grounding from which to work with our consultants (who are themselves CCHP-certified) and clients."

She now also has direct, firsthand understanding of the importance of certification for clients who are struggling with complex health-care problems or aiming to become NCCHC-accredited.

In preparing for the exam, she found that attending the all-day preconference review session to be especially helpful. "Sitting down with the standards books was important," she says, "but it was the review session that really brought it all alive for me." She strongly recommends attending one of the review sessions, which are offered in conjunction with each NCCHC spring and fall conference as well as available online.

Like many who stumble into correctional health care, Reed quickly came to appreciate the importance of the work. About NCCHC and NCCHC Resources she says simply, "We help save lives." ●



Loretta Reed, left, with NCCHC Resources consultants Barbara Mariano, RN, CCHP; Charles Lee, MD, JD, MBA, CCHP-P; Marci Mackenzie, PhD, LCSW, CCHP; and project manager Claire Wolfe.

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A Roundup of Correctional Health Care News

"Managing Substance Withdrawal in Jails: A Legal Brief" Published by BJA

In anticipation of soon-to-be-released clinical withdrawal guidelines being developed by NCCHC in partnership with the Bureau of Justice Assistance and a prestigious group of national organizations, the BJA website recently published a legal brief that addresses substance withdrawal in jails, describes the scope of the challenge, provides an overview of key legislation and significant court cases, and outlines steps for creating a comprehensive response.

"Managing Substance Withdrawal in Jails: A Legal Brief" was developed by Advocates for Human Potential, Inc., in partnership with BJA and the National Institute of Corrections, along with the support of Georgetown University Law Center.

BJA, NIC, NCCHC, the American Society of Addiction Medicine, and AHP collectively are working with an advisory committee of clinical and nonclinical experts in addiction medicine, correctional health care, and jail administration to develop the guidelines, designed to help jail administrators detect and manage withdrawal from alcohol, sedative-hypnotic drugs, opioids, and stimulants among individuals in custody.

The guidelines, due out later this year, will be informed by best and evidence-based medical practice, while accounting for the practical realities of medically managed withdrawal in jails.

ncchc.org/managing-substance-withdrawal-in-jails-a-legal-brief

Naloxone Use Position Statement Updated

The NCCHC Position Statement on Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths has been updated to reflect the newest understanding of this lifesaving drug's important role during incarceration and after release. Given the widespread need for and acceptance of easy access to naloxone, the revised position statement calls for making naloxone kits and training available to all people in the facility, including those who are incarcerated, staff, and visitors, and advises that naloxone kits be provided upon release to people with opioid use disorder and at elevated risk for overdose.

ncchc.org/position-statements

Treatment for OUD in Jail Reduces Risk of Return, Study Suggests

Men in a rural jail who received medication to treat opioid use disorder had a reduced likelihood of being arrested or returning to jail or prison after release, according to a recent study by researchers at Baystate Health Medical Center and the University of Massachusetts. Overall, after adjusting for factors that increase the likelihood of recidivism, men who received MOUD while incarcerated had an estimated 32% lower risk of recidivism. While these results need to be replicated in larger, more diverse populations, they suggest the promise of drug treatment in helping to reduce reincarceration.

ABOUT CORRECTCARE®

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Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP

Is a Grievance Log Required?

Q Is a log necessary for tracking grievances? It is not in the compliance indicators for the grievance process standard, but it is something we were asked to show to the surveyors during our survey.

A You are correct, Standard A-10 Grievance Process for Health Care Complaints does not specifically require a grievance log. However, a detailed record of grievances can provide valuable feedback regarding opportunities for improving health services and can be an important source of information for your continuous quality improvement program. Having all grievances (regardless of founded or unfounded results) tracked on a log makes it easy to review topics for a CQI study at your facility. The log can be designed in whatever format is most functional for your CQI program; however, many find it valuable to track the nature of the grievances by topic, monthly totals for each topic, duration (in days) of response time, and whether the grievance was founded or unfounded after investigation.

The Importance of Refusal Forms

Q If we document a patient's refusal to a treatment or medication offered in the patient's health record, why do we also need to include a refusal form in the health record?

A The main reason for having the patient sign a refusal form is to document that the patient was made aware of the service being offered. A chart entry by a staff member that "the patient refused" is not sufficient to meet the requirements of NCCHC standards A-08 Health Records and G-05 Informed Consent and Right to Refuse. NCCHC's standard on Informed Consent and Right to Refuse includes a requirement that any health evaluation or treatment that is refused is documented, and the documentation must include a description of the service being refused, evidence that the patient has been informed of any adverse health consequences that may occur because of the refusal, the signature of the patient (or a second witness if the patient does not sign the refusal form), and the signature of the health staff member who speaks to the patient. The completed refusal form document is direct evidence that the involved patient was given the opportunity for the service being offered and was made aware of the health consequences that can occur if they do not receive the service or treatment.

Scope of Practice with Patient Care Needs

Q I work in a jail and am trying to find guidance on what credential a jail nurse needs to have. Does the nurse have to be an RN or LPN, or would a medical assistant suffice?

A This is a common question as facilities struggle to find nursing staff and consider using various levels of licensure or certification to fill direct patient care positions. The simple answer is that it depends on the state. Each state has specific scope of practice guidelines for nurses and other medical professionals. NCCHC encourages every facility to research its state's applicable nurse practice act or nursing scope of practice regulations if there is no state NPA. The scope of practice information in those regulations will tell you the minimum level licensure or certification necessary for medical professionals in relation to various nursing-related tasks. ●

Wendy Habert, MBA, CCHP, is NCCHC's new director of accreditation. Send your standards-related questions to accreditation@ncchc.org.

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