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CorrectCare®

The magazine of the National Commission on Correctional Health Care

IMPLEMENTING A CHRONIC DISEASE SELF- MANAGEMENT PROGRAM



Assessing Risk of Violence

Improve Nurse Retention
With Positive Leadership

To Avoid Lawsuits, Never
Say Never

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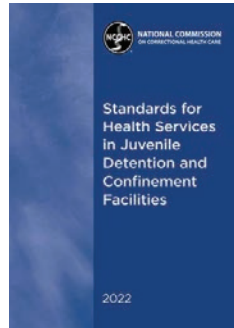
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Now Available: Updated Juvenile Standards

A newly updated edition of the NCCHC *Standards for Health Services in Juvenile Detention and Confinement Facilities* has been published and is now available, after more than 18 months of work by a task force that included physicians, nurse practitioners, nurses, and mental health experts in juvenile health.

The revision brings the juvenile *Standards* up to date with best practices for evidence-based care of youths and reflects new knowledge gained over the past several years, especially in supporting youths with adverse childhood experiences (ACES) such as abuse, neglect, and trauma. Issues of special concern – including self-injury, suicide prevention,



LGBTQI youth, substance use, restrictive housing, and mandated reporting – receive attention in the updated standards.

“Not only does this revision reflect our current understanding of trauma-informed care, critical for supporting youths who are involved in the justice system, but it also acknowledges the disproportionate confinement of minority youth,” says Joseph Penn, MD, CCHP-MH, chairman, Juvenile Standards Task Force.

NCCHC accreditation surveys of juvenile facilities will assess compliance with the new edition starting July 1; the CCHP exam will reference the new standards starting May 1. More information: ncchc.org/juvenile-standards.

New Position Statements Focus on Anti-Racism in the Juvenile System, Nutrition Behind Bars

In a new position statement, NCCHC calls on juvenile detention and confinement facilities to address systemic, structural, and institutional racism by gaining awareness of the problem, promoting policies and practices to eradicate inequities, addressing overt and covert racist attitudes, promoting an inclusive culture, and treating the racial trauma that youth of color have experienced. The statement was drafted by the NCCHC Juvenile Health Committee and approved by the Governance Board in acknowledgement of the fundamental role that systemic, structural, and institutional racism play in every aspect of the juvenile legal system – both internal and external to juvenile facilities.



NCCHC has also released a position statement on Nutritional Wellness in Correctional Settings, asserting that access to a nutritious, palatable diet is essential to personal well-being, a medical necessity, and a fundamental human right.

Learn more about these and all NCCHC position statements at ncchc.org/position-statements.

Upcoming Events

APR 29-MAY 2	SPRING CONFERENCE ON CORRECTIONAL HEALTH CARE, NEW ORLEANS
APRIL 30	CCHP EXAMS, NEW ORLEANS
JULY 14	CCHP EXAMS, WASHINGTON, DC
JULY 15-16	CORRECTIONAL MENTAL HEALTH CARE CONFERENCE, WASHINGTON, DC
AUGUST 2-3	VIRTUAL CORRECTIONAL MENTAL HEALTH CARE CONFERENCE, ONLINE
SEPT 30-OCT 4	NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE, LAS VEGAS
OCT 1	CCHP EXAMS, LAS VEGAS

New Staff Members Contribute to Continued NCCHC Growth

Richard Forbus, CCHP, is NCCHC's new vice president of program development. Forbus has more 25 years of experience in corrections, most recently as corrections captain with one of the largest jail systems in the country. In that role, he was responsible for institutional administration and operations, including medical and mental health care and accreditation compliance.

Susan Schultze is the new executive director of the NCCHC Foundation. She brings to the role more than 20 years of nonprofit experience and expertise in philanthropy and fundraising, including director-level positions with large national organizations Ronald McDonald House Charities and Make-A-Wish Foundation.

Robert Simon, MEd, CCHP, joined the accreditation department as Opioid Treatment Program manager, a new position to oversee the surge in OTP accreditations. He has been in the mental health field for more than 25 years as a clinician and administrator; managed medical operations for four federal correctional facilities and 12 Colorado DOC facilities; and was involved with OTP for the Bureau of Prisons.

Lifelong Learning Is for All of Us

By Pauline Marcussen, DHA, RHIA, CCHP

I am thrilled to take the helms of NCCHC's board now, with our focus on promoting education and introducing students to correctional health care as a career. I am a huge believer in lifelong learning; I strongly believe this is the right direction for our organization and our field.

Education is for everyone and benefits everyone. I've always been that manager who encouraged the staff to take courses at the local community college because people have more opportunities for advancement when they engage in continuing education. That is also the reason I am such a strong advocate of the CCHP program.

About 15 years ago, I started teaching college courses to the incarcerated population. I taught workplace relationship skills, introduction to business, and business management. I found this work to be rewarding because the students were engaged and they wanted to learn. For some, taking a college course was like a dream come true.

I still run into former students who remind me of the impact those courses had on them. The final project for my intro to business class was to write a business plan, from concept to financing to implementation. I always provided feedback on all assignments.

One of my students was so proud of his project that he sent it home to his mother to prove that he had actually taken a college course and that his professor wrote nice things about his work. He was so proud. That story and so many others are a reminder to me that education is for everyone.

The opportunities to learn are everywhere. Sometimes they are forced on us.

Tough Lessons

Over the past three years, we learned more than we ever wanted to about infection control, medical isolation and quarantine, and vaccine efficacy. We learned about working with a diminished staff, about doing less with more, about grief and resilience.

NCCHC, always the leader in correctional health care education, continued in that role throughout the pandemic. When it was hard to know who or what to believe, the field turned to NCCHC for the latest information, reliable guidance, and expertise.

That is still true as we continue to learn more and prepare for what might come next, whether that is another public health crisis, a medical malpractice case, preventing suicides, or working with our juvenile population in a trauma-informed environment.

For me, it all comes back to education. I always tell my students: learn as much as you can, because no one can take that away from you.

Read a book, attend a lecture, listen to someone who is a subject matter expert. Find a mentor. Ask questions and be informed. It doesn't have to be formal education leading to a degree, just day-to-day learning that builds and grows. Consider being a mentor for people starting out in the field. Be available to answer questions and share your experiences.

Lifelong learning is for all of us – direct caregivers, support staff, and those who are incarcerated. We are all in this together. ●



Pauline Marcussen, DHA, RHIA, CCHP, is the 2023 chair of NCCHC's Governance Board and board liaison of the American Health Information Management Association.

At a Glance: Meet Pauline Marcussen

Career Highlights

- Rhode Island Department of Corrections, health care services administrator, 2018-2022
- Rhode Island Department of Corrections, inter-departmental project manager, 1997-2018
- Southern New Hampshire University, adjunct faculty, 2014-present
- Community College of Rhode Island, adjunct faculty, 2008-present

NCCHC Positions

- NCCHC Board of Representatives, 2010-present
- NCCHC board secretary, 2021
- CCHP Board of Trustees chair, 2020-2022, 2016-2017
- Juvenile health, education, policy and research committee member

Education

- Doctorate in Health Administration (DHA), Medical University of South Carolina
- Master of Science, health services administration, Salve Regina University
- Bachelor of Science, health services administration, Providence College

IMPLEMENTING A CHRONIC DISEASE SELF- MANAGEMENT PROGRAM



By Toya Kelley, MD, and Stephanie Lanham, MPH, RN

While chronic diseases contribute substantially to morbidity and mortality, many – including heart disease, diabetes, chronic pulmonary disease, and arthritis – are manageable through lifestyle changes. Health care costs can be reduced and outcomes improved through chronic disease self-management programs that provide education, coping strategies, problem-solving techniques, and decision-making skills. Regular physical activity contributes greatly to fitness, health, functioning, and quality of life. Social interaction is also an important factor in sustaining a high quality of life.

Considering that approximately 95% of incarcerated individuals will eventually return to their communities, the impact of improved health and positive health behaviors goes far beyond those individuals, reaching into their families and communities as well. The need for incarcerated individuals to understand their health problems and practice self-management of chronic conditions has never been more urgent.

The BOP Southeast Region's Journey Begins

In 2016, health care professionals in the Southeast Region of the Federal Bureau of Prisons began a journey to

address the chronic disease epidemic within our facilities. We took a hard look at the ubiquity of sickness throughout the Southeast Region and found that more than 20% of the population was over age 50 and approximately 60% had at least one chronic illness. The Region was spending a significant amount of money on health care-related overtime, emergency medical trips, and patient hospitalizations.

Through a thorough needs assessment and gap analysis at one pilot facility in South Carolina, it became evident that the root cause of the emergent trips and hospitalizations from that facility was a lack of basic self-management skills on the part of the patients with chronic conditions. We then surveyed other institutions within the Southeast Region to determine if they had similar chronic disease challenges and to identify areas for improvement.

Armed with the information we gathered, we mapped out a course for health care improvement by creating strategies to make positive and sustainable changes within the Southeast Region. Those included simple yet effective changes such as adding healthy commissary options – diet sodas, bran cereal, and low-sodium options – and creating new activities such as classes on managing specific chronic conditions.

We also researched several chronic disease health care programs to identify one that could easily be adapted for use in correctional facilities. We were happy to discover the Chronic Disease Self-Management Program developed by a team of researchers at Stanford University; not only is it an excellent program well-suited to our needs, it was already included in the BOP's list of evidence-based programs.

Introducing the Stanford CDSMP

Stanford University's CDSMP is a well-studied, low-cost, evidence-based program that has been proven to help those with chronic illnesses take control of their own health, improve health behaviors and outcomes, and decrease health care utilization. We were the first to adapt this program for use within a BOP facility.

The program uses a small-group approach over a six-week period, meeting once a week for two and a half hours, to address modifiable risk factors such as diet, exercise, and medication management. The sessions are led by a team of trained lay leaders and are highly interactive, focused on building skills, sharing experiences, and providing support. No health care or teaching experience is required for lay leaders, creating a multidisciplinary approach.

There is growing evidence that the Stanford CDSMP leads to improved health behaviors and outcomes as well as decreased health care utilization. The findings of a Centers for Disease Control and Prevention meta-analysis of 23 CDSMP workshops (not specific to corrections) suggest sustained maintenance over 12 months of improvements in psychological health status, self-efficacy, and select health behaviors. Another national study demonstrated cost-savings – \$364 per participant – secondary to reduced emergency room visits, hospital admissions, and hospital length of stay.

The Next Step: Implementation

Once we chose the Stanford program, we teamed up with the South Carolina Department of Health & Environmental Control, a licensed CDSMP trainer, to obtain lay leader training. We (the authors) were the first two from our pilot institution to go through the training. We then implemented the program locally at our facility and found that it worked.

Based on that success, the program expanded to include four federal prisons, one state prison, and one county jail in South Carolina. We then received approval to open up the program to the entire Southeast Region and provided training to staff from many departments at each facility. Those who were trained included individuals from health services, recreation, education, correctional services, and reentry, creating a robust, interdisciplinary team of leaders.

The Southeast Region's results echo what larger national studies found: facilities that instituted the program noted a decrease in sick call and emergency room visits, along

with improvements in participants' body mass index, hemoglobin A1C, and self-reported quality of life. Those positive health outcomes have been sustained across all participating institutions.



A strong commitment includes committing the time, effort, resources, and personnel necessary to the program's success."

Considering a CDSMP? Some Advice

Implementing a chronic disease self-management program is a process, not an event. The first step in the process is assessing the readiness of your facility to offer a new program to promote wellness.

If the capacity and willingness are there, the next step is to select a program according to your organization's policies that best fits the goals of your facility and the needs of your target population. We suggest starting with resources that are already approved and available.

In our case, for instance, the BOP had already approved the Harvard CDSMP as an evidence-based program. Your system may have an already-approved, evidence-based program available. If not, additional steps may be required to have the program approved for your population. That approval process will be specific to each agency and institution.

Continued on page 19

Introducing a Self-Management Program: Key Points to Consider

- Choose a program that aligns with your organization's policies and priorities.
- Seek out an established evidence-based program that is already approved within your organization, if possible.
- Bring the stakeholders into the process early. That will be instrumental to allocating resources, removing roadblocks, and gathering support.
- Ensure reasonable privacy and confidentiality for participants. A safe environment sets the tone for genuine and productive sharing.
- Maximize rapport and self-disclosure among everyone involved to aid relationships with participants, fellow program team members, and leadership.
- Conduct comprehensive training for health and custody staff. If possible, include a multidisciplinary team for diversity of opinion and expertise.
- Collect and share data: lessons learned, strategies used, and tools developed provide the foundation for the next wave of improvement in chronic illness management.

To Avoid the Risk of Lawsuits...



**NEVER SAY
NEVER**

By Taylor Denslow Brewer, JD

Nearly every deliberate indifference and medical negligence lawsuit involves an allegation that the facility denied care because of a rule cited by medical or security staff. Incarcerated patients file lawsuits over these seemingly rigid rules, arguing that the rules violate their constitutionally protected right to health care. Their allegations gain traction in court because, of course, health care professionals should tailor clinical care to the patient and not according to blanket rules. Judges and juries tend to assume a breach of the standard of care occurred when it appears that the health care provider applied a black-and-white rule with no exceptions instead of clinical discretion.

To prevent such lawsuits, facility staff need to avoid referring to rules, mandated guidelines, and inflexible protocols when communicating with incarcerated individuals about their health care. Even if written or unspoken policies exist to support those rules, be careful to avoid citing those policies in conversation or responses to requests and grievances. After all, anything you say can and will be used against you in a court of law.

Below are a few of the statements that most frequently lead to liability against correctional health care professionals.

“We never prescribe narcotics.”

Some iteration of “We never prescribe narcotics” appears in almost every case involving allegedly untreated pain. To add to the already complex relationship to controlled substances in health care, attitudes toward it are shifting as federal and state legislators implement new laws to confront the opioid epidemic. For instance, in April 2022, the Department of Justice announced the inclusion of opioid use disorder as a chronic disease in an amended

section of the Americans with Disabilities Act. This change protects incarcerated patients with OUD against discrimination and increases access to appropriate medical treatment through medication assisted treatment programs. As the law changes to acknowledge and accommodate patients with substance use disorders, correctional facilities are incorporating MAT programs involving buprenorphine, methadone, and naltrexone.

As national recognition increases regarding the opioid epidemic and the addictive properties of controlled substances, protocols for treating pain are changing in all settings from acute to palliative care. Today, physicians are far more reluctant to prescribe these medications than they were 20 years ago.

While most correctional providers may rarely, if ever, prescribe narcotic medications, avoid telling patients that it *never* happens. Instead, explain that narcotics carry high risks for abuse and addiction, and for those reasons, providers often prescribe alternatives after weighing the risks and benefits. You can also explain that clinical discretion leaves room for exceptions.

In other words, assure the patient that the provider will exercise his or her judgment – based on education, training, and experience – to identify the circumstances that call for narcotics. Just because an outside specialist prescribed a narcotic does not mean the correctional provider will continue it. But do assure the patient that the provider will review the records, assess the patient, and speak with the specialist if necessary to determine the best therapeutic regimen.

Those conversations need to be documented in detail with attention to nuance. Instead of statements like, “Told patient this facility does not give narcotics,” for example,

write, “Explained to patient risks and benefits of oxycodone and provider’s determination that an NSAID best fits the current presentation; will prescribe naproxen for a limited time and reexamine in four weeks.”

Do not tell patients that the formulary does not contain narcotics; that the provider must input a utilization management request for narcotics; or that the only exceptional circumstances that merit narcotics are, for example, postsurgical and end-stage cancer patients. Those statements are too black and white.

“We never treat preexisting conditions.”

Although routinely repeated by staff within the walls of jails and prisons to lower the expectations of incoming patients with preexisting conditions, the statement “We never treat preexisting conditions” is rarely true.

Hypertension, for instance, is one of the most treated conditions in corrections, and it is almost always pre-existing. It is misleading, then, to say that correctional health care does not provide for preexisting conditions. For litigious patients, distinctions among the terms “elective,” “emergency,” and “preexisting” can be blurry. When a patient presents with a concern he or she believes needs treatment, staff must examine and assess the patient as any health care professional in the “free world” would do. That the patient did not seek treatment for years prior to incarceration is irrelevant to the course of treatment.

In contrast to hypertension, a stable hernia is a classic example of a preexisting condition that typically remains untreated in the correctional setting. The best approach is to explain to the patient that the hernia does not require surgery if it is reducible and unless it becomes incarcerated; order chronic care follow-up appointments to monitor the status and prescribe analgesic medications for discomfort.

That mirrors what would occur in the office of a general surgeon in the free world. The difference occurs if the incarcerated patient expresses desire for – or insistence upon – immediate surgery. In the free world, undoubtedly the patient could find a surgeon who would operate on a nonemergent hernia, but in corrections, patients cannot demand elective surgery.

Still, avoid making comments like, “We don’t offer elective surgery” or “We don’t treat standard hernias.” Instead, document the reasons surgery is not medically necessary, citing specific findings from the patient’s objective examination, and describe follow-up efforts to ensure the hernia remains stable and the discomfort is controlled.

Hepatitis C is another typically preexisting condition that receives significant attention from courts, and approaches to its management and treatment differ widely by state. Many patients with hepatitis C request antiviral medications immediately upon booking, despite having lived untreated for years. Be sure to approach communications regarding hepatitis C very carefully to ensure your explanation to patients conforms with state-specific requirements

and Department of Corrections guidelines. Site medical directors need to remain knowledgeable on these guidelines and counsel staff on updated protocols within the facility.

Hepatitis C patients should receive consistent and routine blood work, and the results need to be discussed with the patients every time. At each visit, document the discussion and the plan moving forward and, as always, refrain from making overarching comments about whether and when the facility will offer treatment.

“We never send patients out for physical therapy.”

This statement appears in more allegations since the transition of many health care services from in-person to remote/telehealth during the COVID-19 pandemic. Those who work in corrections understand that facilities try to minimize off-site transportation for any reason, medical or otherwise. Fortunately, most judges observe firsthand the resources required to safely transport incarcerated individuals to court appearances and therefore understand the need to limit transport.

Nevertheless, telling a patient, “We don’t allow physical therapy” is much more likely to lead to a lawsuit than saying, “If the physical therapist deems it appropriate, we encourage a home exercise program.” Like stable hernias, ailments that benefit from PT rarely constitute medical emergencies. Still, those conditions can produce pain that PT will eliminate or significantly reduce, and occasionally the therapy is necessary. Therefore, do not tell patients that no formal PT program exists at the facility or that no PT patient gets transported to the therapist.

Instead, explain that while many PT patients can undertake exercises independently and with the help of on-site staff, some may require off-site visits. Assure the patient that the health staff will review the records, assess the patient, and speak with the physical therapist to determine the type and duration of PT – and of course, document all conversations with the physical therapist and the patient.

Health care is not one-size-fits-all, as any practitioner knows, and every incarcerated patient deserves the standard of care. Courts will look skeptically on any health care professional who explains a treatment tactic through wholesale, absolute terms that may not fit the patient’s situation.

Correctional health care professionals must remain conscientious of the language used in correspondence and communication with patients and must document the clinical decision-making behind all treatment choices. Avoid describing a typical treatment method as the only method and do not commit the health care team to any single approach. And remember: when in doubt, never say never. ●

Taylor D. Brewer, JD, is a partner with Moran Reeves & Conn in Richmond, Virginia.

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Assessing Risk of Violence and Level of Immediate Dangerousness Toward Others

By Pamela Rollings-Mazza, MD, BSN, CCHP, and Tommy Williams, BSN, RN, CCHP

Prisons and jails can be dangerous places, housing large populations of individuals with a history of violence, personality disorders, and serious mental illnesses. People who work in correctional facilities are at a much higher risk of being physically assaulted than those in other professions; incarcerated individuals are at an elevated risk as well.

An accurate assessment of an individual's risk of violence toward others and level of immediate dangerousness can help keep health staff, custody staff, and other incarcerated individuals safe, as it helps determine necessary interventions to mitigate the risk.

In considering risk of violence, it is important to understand that violence or assaultive behavior is almost always related to an underlying condition (the etiology, or cause) and supported by evidence (signs and symptoms).



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Substance abuse withdrawal, which is frequently accompanied by irritability and hostility, both of which can manifest as violence

A history of aggression or violence toward others, as past behavior is considered a useful predictor of future results

Supporting signs and symptoms of violence – the evidence of risk – are generally obvious. Patients may engage in loud, profane speech, sometimes with verbal threats

toward others. They may display provocative or agitated behavior, becoming argumentative, confrontational, overactive, irritable, or demanding, or they might slam, bang on, or throw objects, pace, or purposefully destroy property.

Physiologic cues such as muscle tension, clenched fists, or rigid or threatening posture may also be noticeable.

Etiology and Evidence of Violence Risk

Several underlying conditions can contribute to assaultive behavior. Those include:

Cognitive impairment, including intellectual disabilities, dementia, or other disorders that limit mental functioning, communication, self-help, or social skills and can lead to frustration that escalates into physical aggression

Impulsivity or impulsive aggression, an automatic emotional response of violence to a stimulus without considering the consequences of such an action

Rage reactions, explosive outbursts out of proportion to what triggered the episode

Psychosis, characterized by some loss of contact with reality and typically accompanied by hallucinatory activity (disturbed visual or auditory perception such as hearing voices) or delusions (false beliefs including paranoia, in which the patient feels threatened by others)

Biochemical/neurologic imbalances, such as a high level of testosterone, increased levels of dopamine and norepinephrine, or a low level of serotonin

Introducing the PCM-IDAT

Establishing a person's risk for violence allows for the determination of immediate dangerousness. Assessment tools for risk of violence and dangerousness have been used in the legal and correctional systems for some time, but most are designed solely for use by mental health professionals, rather than by custody staff and in decisions about housing recommendations and restrictions.

Furthermore, none of the existing tools recognize the connection between underlying conditions and supporting evidence of signs and symptoms and their relationship to violence. Missing was an intuitive tool that could be used by anyone – something that not only accurately assesses risk of violence and immediate level of dangerousness, but also communicates how each level was determined and what needs to change for the risk to lessen.

In order to aid health care teams and provide custody staff with a tool to facilitate their own appraisals, we developed the PCM Immediate Dangerousness Assessment Tool for use within our own organization (see box at right).

Patients with an absence of any related conditions who display nonviolent behavior, can verbalize control of their

feelings, and interact with others appropriately have no predictable risk of violence toward others and are not immediately dangerous. Those with no related conditions other than a history of violent behavior who lack any supporting signs or symptoms indicating an elevated risk of assault are considered a low risk of violence toward others.

The likelihood of assaultive behavior significantly increases when a related condition is present and evidenced by supporting signs and symptoms. Those patients pose a moderate risk of violence toward others. Patients who possess multiple related conditions and exhibit numerous supporting signs and symptoms of assaultive behavior are a high risk of violence toward others and should be considered dangerous.

Because the PCM-IDAT tool utilizes both reasons for and evidence of violence, we can then implement interventions to address those reasons, as the etiology (“related to”) identifies what needs to be targeted and supporting data (“evidenced by”) validates the assessment. Risk level is easily communicated to other professionals along with any related condition(s) and supporting evidence.

Treatments can then be designed to affect the patient’s underlying disorders, symptoms, thinking patterns, or behaviors that increase violence risk. These may include psychotropic medications, counseling, drug and alcohol treatment programs, and anger/stress management programs.

For instance, an individual with no predictable risk of violence based on an absence of related conditions evidenced by display of nonviolence toward others, verbal control of feelings, and appropriate interaction with others, would require no interventions.

For someone with a moderate risk of violence related to cognitive impairment as evidenced by argumentative and demanding conduct, interventions to reduce the negative

behaviors include clear communication, sensory exposure, and distractions.

For an individual with a high risk of violence related to psychotic symptomology, impulsivity, and a history of violence toward others as evidenced by reports of command voices instructing patient to harm others, non-reality-based thought with themes of paranoia, verbal threats toward others, poor impulse control, and destroying the bedding and mattress, medication would be expected to lessen the psychotic symptoms.

For another person at high risk of violence – this time related to rage reaction and a history of violence toward others as evidenced by loud and profane speech with verbal threats against others, confrontational behavior, and severe agitation including banging on cell door and throwing dinner tray – decreasing stimuli and providing physical activities as an outlet for anger is likely to diminish the provocative and agitated behaviors.

Regardless of a patient’s risk of violence and level of immediate dangerousness, it is imperative that facility staff always practice situational awareness and understand how to avoid potentially dangerous situations.

As jails and prisons increasingly house more individuals with personality disorders, serious mental illness, and withdrawing from illicit drugs, it is important to understand the risk of violence toward others and provide interventions to reduce level of immediate dangerousness. While it is not possible to predict the risk of violence with 100% accuracy, a comprehensive risk assessment tool can help identify management techniques that mitigate the risk. ●

The authors are with PvrimeCare Medical, Inc. Pamela Rollings-Mazza, MD, BSN, CCHP, is chief medical officer; Tommy Williams, BSN, RN, CCHP, is the clinical research and informatics analyst.

PCM IMMEDIATE DANGEROUSNESS ASSESSMENT TOOL

Immediate Dangerousness to Others	Related to Conditions	Evidenced by
No predictable risk of assault or other-directed violence	Absence of any related condition such as cognitive impairment or intellectual disability, impulsivity, rage reaction, psychosis, biochemical imbalance, drug withdrawal, or hx of violence.	Displays nonviolent behavior towards others, verbalizes control of feelings, and interacts with others appropriately.
Low risk of assault or other-directed violence	Absence of any related condition such as cognitive impairment or intellectual disability, impulsivity, rage reaction, psychosis, biochemical imbalance, or drug withdrawal. May have a hx of violence.	Absence of any signs or symptoms of assaultive behavior.
Moderate risk of assault or other-directed violence	Presence of a related condition including cognitive impairment or intellectual disability, impulsivity, rage reaction, psychosis, biochemical imbalance, drug withdrawal, or hx of violence.	Engages in loud or profane speech. May exhibit mild provocative behaviors (e.g. argumentative, confrontational, demanding) or agitated behaviors (e.g., banging, slamming, destruction of property). Occasionally displays poor impulse control.
High risk of assault or other-directed violence	Presence of two or more related conditions including cognitive impairment or intellectual disability, impulsivity, rage reaction, psychosis, biochemical imbalance, drug withdrawal, or hx of violence.	Engages in loud or profane speech with verbal threats of detailed harm towards others. Exhibits significant provocative behaviors and/or agitated behaviors. Regularly displays poor impulse control. Physiologic cues evident (e.g., muscle tension, clenched fists).

Improve Nurse Retention Through Positive Leadership



By Sheila Burns, MS, BSN, RN

Photo © Monkey Business Images/Shutterstock

The nursing shortage has been a simmering issue for decades, relieved only slightly in the U.S. by the economic downturn of 2008 and 2009, when many nurses returned to the workforce. Any gains that were made then have since been lost, however, and the extreme challenges of COVID-19 did not help the situation. It looks like the nursing shortage is here to stay, as more nurses continue to retire than enter the profession.

Add to that the fact that correctional nursing is not an obvious choice for most new nurses. Either they have never considered the possibility, or they might harbor some preconception about nursing behind bars that turns them off. It is true that correctional health care is not everyone's cup of tea; it takes a special kind of person. Staff shortages are a serious problem.

It's hard to stay positive in light of these challenges, but positivity is exactly what nurse leaders need to practice to attract and, more importantly, retain their employees.

Good First Impressions

In correctional health care they say that discharge planning should start at booking. Similarly, recruiters and nurse leaders need to address the retention issue from the first contact with an applicant. First impressions do count! An organized recruiting process, with a dedicated contact person and regular communication, can really encourage

the applicant and create a positive impression of your organization and the field as a whole.

For starters, ensure that lobby security staff are aware an applicant will be arriving and have a staff member ready to meet the applicant and escort him or her to the interview room. A welcoming, well-coordinated interview process will help the potential new staff member feel more secure and positive about the position, the workplace, and the field.

Support and training are key elements to staff success, regardless of how long a nurse has worked with you. Orientation time needs to reflect a new employee's requirements, not the workplace's requirements. I know you want them up and running the cart next week, but some people just need a little bit longer to gain confidence and competency; it is well worth making that investment if it means hanging on to a good nurse.

Mentorship or preceptorship for new recruits is a very useful retention tool. Having a peer or supervisor assigned to support and work with the new staff, show them the ropes, be available to answer questions, and guide them on their journey is invaluable. Not only does it help the new staff member, but it is also a highly effective way to recognize the mentors' skills and show them they are valued. Feeling valued and included in the workplace improves staff morale and promotes retention.

Creating a Positive Workplace

As leaders, it is vital that we work toward creating a positive workplace. Studies show that the way in which a workforce is led is by far the biggest factor affecting morale and retention.

Think about this question: What makes you qualified to lead? Did you go to leadership school? Probably not. But leadership takes skills and knowledge, just like any job. Think back to when you were a brand-new nurse in your first role. You rode a huge learning curve to master time management, medication management, medical devices, patient assessments, medical records, and much more. Yet most of us do not get formal training in how to manage, lead, or be effective in a leadership role. Most of us have to learn those skills on the job. How?

As a leader, it is important that you self-reflect on questions such as these: How do you talk to your staff? How do you manage conflict? What tools do you use to develop staff morale? Where do your weaknesses lie? Take some time to think of the answers to those questions and then ponder the effect your style may have on your team.

Leadership styles vary, but some have been proven to be more successful than others. The only way to have a successful team is for you, the leader, to show by actions and words that you care about your employees and about the standard of care being delivered. If you don't set that tone, then you can't expect good performance from your staff.

Red/Green Tool

Using a tool to assess how your team is functioning can be a great starting point. A quick and easy one is the Red/Green tool. If you have a leadership team, get together and do this exercise – or just do it on your own.

Get two pieces of paper and write “Red” at the top on one and “Green” on the other. First, think about a negative, miserable workplace. What does it look, feel, and sound like? Brainstorm if you are working with others. Record what you come up with on the “Red” piece of paper. Examples could include silence, staff in silos, conflict, and high sick rate.

Then think about how a happy, productive workplace looks, feels, and sounds. Examples might be laughter, helping each other, and covering for each other. List those on the “Green” sheet.

Sit back and assess where your team is in relation to what you've written. Circle the words on the sheets that are seen in your department. Be honest. You can bet that there will be a mixture of both.

With that information, create a plan for managing any “Red” aspects – there are bound

to be some – so that you are moving toward the “Green.” The key to success is for the leaders to behave in a “Green” way every day; people who are positive will start to follow.

In my experience using this tool, I found it took a lot of patience, time, and energy to turn a toxic environment into a positive one – several months, in fact. But what you will find is that people who want that “Green” environment will follow you very quickly. Those are the staff members you want to start recognizing and placing as mentors.

This caring-based model can help generate a team atmosphere in which positivity is the expected norm. If new recruits feel cared for, there is a higher chance that they will go on to care for their teammates and, in turn, become caring mentors. With this cycle, a positive team dynamic is developed and a healthier work environment is created. And who wants to risk leaving a great workplace to go somewhere else that may be toxic? Research shows that if employees are happy, they are reluctant to leave, even when there are other opportunities available to them.

Being a positive leader, actively listening to your employees, supporting their needs, incorporating their ideas, and encouraging their growth will go a long way to reducing staff turnover. ●

Sheila Burns, MS, BSN, RN, is an accreditation facilitator with NaphCare, Inc.



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Introducing a New CCHP Specialty Exam!

CCHP-CP Includes Physicians, NPs, and PAs

After many months of careful consideration and hard work, the CCHP program has launched the Certified Correctional Health Professional - Clinical Provider (CCHP-CP) exam, a new program that includes physicians, nurse practitioners, and physician assistants/associates.

The new exam is being welcomed by clinical providers and advanced care practitioners, who have long sought recognition through a specialty CCHP program.

"The work of the multidisciplinary committee of physicians, NPs, and PAs has come to a triumphant conclusion as NCCHC staff prepares to launch the new CCHP-CP exam at the Spring Conference in April," says Matissa Sammons, MA, CCHP, NCCHC vice president of certification. "People have been asking for this since CCHP-Physician first launched."

NPs and PAs: Playing a Critical Role

Over that time, the number of CCHP-certified NPs and PAs, while high, had not reached a tipping point to qualify for the necessary investment in a brand-new exam, per certification criteria set by the CCHP Board of Trustees. In 2022, the CCHP-P subcommittee and CCHP Board of Trustees saw a path forward.

Like it did for so many issues in health care, COVID helped focus attention on the critical role NPs and PAs play in correctional health care. A multidisciplinary committee began to meet to assess whether it might be possible to

update and expand the elements of the CCHP-P program to recognize the commonalities required for success in all those roles.

"I was in favor of this new program from the beginning," says committee vice chair Jeffrey Alvarez, MD, CCHP-P, CCHP-A, chief medical officer for NaphCare. "In the community, and especially in corrections, NPs and PAs provide a huge amount of primary and emergency care. A specialty certification that defines what clinical providers need to know to be effective in corrections raises the level of quality in the field and promotes the idea of correctional health as a clinical specialty."

Committee chair Peter Ober, JD, PA-C, CCHP, who has been the NCCHC Board liaison from the (recently renamed) American Academy of Physician Associates for 23 years, says the special knowledge

needed to diagnose, treat, and prescribe in correctional institutions should be recognized. At his firm, Rappahannock Creative Health, he recruits and supervises correctional physicians, PAs, and NPs.

"You can be the best provider in the community, but it can take a year to figure out how to be effective in a correctional environment," he says. "Defining the necessary knowledge, such as how to effectively advocate for your patients with correctional staff and leaders, can literally save lives. Administrators may focus on short-term expense, where



Continued on page 15


Who Is Eligible for the New CCHP-CP Program?

All qualified physicians, nurse practitioners, and physician associates are eligible. Prior to submitting an application, applicants must have:

- Current CCHP certification (no minimum amount of time as a CCHP required)
- Unrestricted license (MD, DO, PA, NP) in good standing to practice in at least one U.S. state
- Practice in a provider role in the correctional environment over the course of at least three years (no minimum requirement of hours)
- 18 hours of correctional health-specific continuing education within the past three years

For more information, visit ncchc.org/professional-certification/clinical-provider-certification.

Next Steps for CCHP-P Physicians: Physicians with a CCHP-P can start using the new CCHP-CP credential right away. Alternatively, at recertification, the CCHP-P credential will change to CCHP-CP. Physicians will remain on their existing recertification schedule.



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we as clinicians must use appropriate language, tools, and expertise to get patients the care they need.”

Updated Content

Committee members reviewed CCHP-P content areas and came to consensus on an updated list of questions that are relevant and appropriate for all clinical providers. They added a new focus on substance use and also added questions specific to transgender care. Content areas in the new exam are weighted differently.

“There is appropriately less emphasis on clinical knowledge, such as what to prescribe for a particular condition, and more emphasis on the skills you need to be excellent as a clinical provider in a correctional environment,” says Jennifer Clifton, DNP, FNP-BC, CCHP-A, a committee member and the American Association of Nurse Practitioners liaison to the NCCHC board. “Clinical knowledge is covered by our State boards. Furthermore, this new specialty certification will help other clinicians understand how effective NPs can be when we are permitted to show all the expertise we have and that our licenses permit.”

She notes that many states allow NPs to be a facility’s chief

The CCHP-CP program will debut with a test at the Spring Conference on Correctional Health Care on April 30 in New Orleans and will be available at future conferences, at Prometric Test Centers, and online. Find more information at ncchc.org/professional-certification/clinical-provider-certification.

medical officer and hopes that the new CCHP-CP program is the first step in complete recognition of NPs as licensed independent providers within correctional health care where state law allows.

NCCHC Board Chair Pauline Marcussen, RHIA, DHA, CCHP, chaired the CCHP Board of Trustees from 2018 to 2022 and is a strong CCHP advocate. “We are very grateful to the members of the committee who worked so hard to make CCHP-CP a reality and clarified what it means to be a clinical provider in corrections,” she says.

“The program will bring more recognition to the field as a specialty and will help shine a light on the many educated, qualified, and dedicated people who do the day-to-day work of providing correctional health care.” ●

CCHP-CP Committee Members

- Peter Ober, JD, PA-C, CCHP (chair)
- Jeff Alvarez, MD, CCHP-P, CCHP-A, (vice-chair)
- Jennifer Clifton, DNP, FNP-BC, CCHP-A
- Brent Gibson, MD, CCHP-P
- Kimberly Kane, APRN, CCHP-RN
- Rebecca Lubelczyk, MD, CCHP-P
- Leonora Muhammad, DNP, CCHP
- Juan (Rudy) Nunez, MD, CCHP-P
- Patrick Ober, PA-C, CCHP
- Esmail Porsa, MD, MPH, CCHP-P, CCHP-A
- Johnny Wu, MD, CCHP-P, CCHP-A



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Does Your Formulary Have Clozapine? It Should

Given the high prevalence of serious mental illness among people in prisons, one might expect high usage of clozapine, an antipsychotic medication that is very effective in managing treatment-resistant psychosis. But clozapine presents logistical challenges that result in its underutilization, not only in prisons but also in the community.

In the April issue of the *Journal of Correctional Health Care*, a team of physicians describe those challenges and how a novel partnership in North Carolina devised ways to overcome them and provide better care, leading to reductions in self-injurious behavior, disciplinary infractions, assaults on custody staff, and time in restrictive housing.

Clozapine Pros and Cons

The benefits of clozapine, available for more than 30 years in the United States, are outlined by authors Megan Pruette, MD, Theodore Zarzar, MD, and Brian Sheitman, MD. The only FDA-approved medication for treatment-refractory schizophrenia and reduction in suicidal behavior in schizophrenia or schizoaffective disorder, clozapine has been shown to be superior to other antipsychotics in treatment-refractory psychotic patients. Studies find

that about 40% of patients with treatment-refractory schizophrenia benefit from clozapine, which is available as a low-cost generic drug.

Nevertheless, in the community, less than 10% of eligible patients receive clozapine. A major barrier is the need for weekly blood monitoring upon initiation because of risk of white blood cell count reduction. Prescribers, pharmacies, and patients must be registered in the Clozapine Risk Evaluation and Mitigation Strategy system, and lab values must be communicated between the lab, prescriber, and pharmacist. The initiation process is complex and time consuming. Among the rare but significant side effects that may arise are myocarditis and colitis.

Prisons, of course, present their own difficulties, such as inadequate mental health staffing and frequent patient transfers between or within prisons. But, as the authors note, "State prisons are closed systems that can ... bring together various departments including pharmacy, nursing, medicine, laboratory, and mental health to provide a clear protocol for prescribing and monitoring clozapine."

The North Carolina Model

Since 2014, the University of North Carolina School of Medicine's Department of Psychiatry has provided in-person and telehealth services for patients throughout the state prison system. Some of the UNC psychiatric providers had seen dramatic improvements in psychosis and self-injurious behavior in state hospital patients on clozapine.

In 2016, the prison system revised its policy on clozapine use based on the community standard in use at UNC. The policy covers criteria for consideration for treatment, prescriber registration, informed consent, routine lab monitoring, dispensing, discontinuation, and provision of prescriptions at release from prison. All patients or their legal guardians were required to sign a standard informed consent form. Program setup required considerable coordination among disciplines and professions.

Initially, prescribers could start clozapine at any prison with 24-hour nursing coverage, but some prisons had difficulty with timely blood draws and monitoring vital signs. So instead, all initiations take place at two prison-operated inpatient mental health units (one male, one female).

Clozapine initiations under the program began in mid-2016. Between July 2014 and June 2020, the number of patients on clozapine increased 390%, from 21 to 82. In addition to the benefits cited above, treatment costs were greatly reduced. The authors conclude that the benefits of increasing clozapine prescribing far outweigh the increased time and effort needed to safely use the medication. ●

JCHC Vol. 29, No. 2: April 2023

- Prescribing Psychotropic Medications for Justice-Involved Youth
- Expanding Clozapine Use in State Prisons: A Review of the North Carolina Experience
- Juvenile Detention and Primary Care Utilization: Are They Related?
- Obesity Epidemic in U.S. Prison Populations: A Meta-Analysis and Review of the Literature
- These Issues Aren't Separate: The Relationship Among Being Indigenous, Motherhood, and the Criminal Justice System
- Pulse Oximetry Improves COVID-19 Screening Sensitivity by Detecting Asymptomatic Infections in a Case Control Study
- Corrections Officers' and Sheriffs' Perceptions of COVID-19 Vaccine Operationalization
- Implementing Opt-Out HIV Testing in the Alameda County Jails

Note: The *Journal of Correctional Health Care* is published six times a year by Mary Ann Liebert, Inc. Certified Correctional Health Professionals receive a 30% subscription discount.

A Roundup of Correctional Health Care News

ACP Calls for Improved Correctional Health Care Access and Quality

In a new position paper, NCCHC supporting organization the American College of Physicians spells out its commitment to supporting the health needs of incarcerated individuals and eliminating health disparities for that uniquely vulnerable population.

Recently published in the *Annals of Internal Medicine*, Health Care During Incarceration: A Policy Position Paper offers recommendations to policymakers and administrators to improve the health and well-being of incarcerated adults.

"Health equity has become a high priority for ACP, but until now those efforts have been centered on health in the community setting," says Newton Kendig, MD, ACP's liaison to the NCCHC Board of Representatives and the position paper's main author. "The COVID pandemic really shined a light on needs within correctional facilities and focused attention on health equity for the incarcerated."

President Biden Signs MAT Act

In a major victory that will save lives, reduce stigma, and open the doors to recovery from opioid use disorder, President Biden signed the bipartisan Mainstreaming Addiction Treatment Act as part of the Consolidated Appropriations Act for 2023. NCCHC worked with a coalition of hundreds of national organizations to call on Congress and the White House to pass the MAT Act, which eliminates burdensome federal rules around prescribing buprenorphine, a gold-standard FDA-approved medication for opioid use disorder. Correctional facilities will now find it easier to treat OUD and provide an appropriate handoff to the community following release, an important step in preventing overdose, relapse, and recidivism.

Physician Assistants Are Now Associates

NCCHC supporting organization the American Academy of Physician Assistants has changed its name to the American Academy of Physician Associates.



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Once the program has been identified and approved, the next step is to secure buy-in. Early in the process, building relationships and credibility may be the most important thing you can do, as a successful program requires a strong commitment by the entire facility. Involving key stakeholders early on will lead to stronger organizational support, increased credibility, and, ultimately, a more effective effort.

For us, those key stakeholders included regional and institutional executive administration, reentry affairs, health services administration, and the education and recreation departments.

A strong commitment includes committing the time, effort, resources, and personnel necessary to the program's success. The step-by-step process for implementation needs to be identified and addressed: planning for the program's structure and time frame, determining staffing needs, training personnel, deciding on space and equipment needs, and determining what will be measured and/or monitored.

In terms of staffing, we found that opening the training to staff outside the health services department reduced the burden on health services to manage the program alone and created more support from other departments.

Every journey begins with the first step. Correctional health care professionals are challenged with combating the chronic disease epidemic in our facilities and, ultimately, in our communities. Launching a well-studied, evidence-

based chronic disease self-management program to improve the health of our incarcerated population is an important first step. ●

Toya Kelley, MD, is a Lieutenant Commander in the United States Public Health Service Commissioned Corps and senior clinical education consultant with ICE Health Service Corps in Honolulu, Hawaii. Stephanie Lanham, MPH, RN, is a Lieutenant Commander in the United States Public Health Service Commissioned Corps and regional quality improvement/infection prevention & control consultant with BOP South Central Region in Edgefield, South Carolina.

RELEVANT NCCHC STANDARDS

NCCHC Standard B-01 Healthy Lifestyle Promotion: Health care policies, procedures, and practices emphasize health promotion, wellness, and recovery.

NCCHC Standard F-01 Patients with Chronic Disease and Other Special Needs: Patients with chronic disease, other significant health conditions, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards.

NCCHC Standards for Health Services in Prisons 2018

FOR MORE INFORMATION

The Stanford Chronic Disease Self-Management Program (sometimes known as Better Choices, Better Health or BCBH) now belongs to the Self-Management Resource Center: selfmanagementresource.com

The opinions expressed in this article are those of the authors and do not necessarily represent the opinions of the Federal Bureau of Prisons, the U.S. Department of Justice, or the U.S. Public Health Service.

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Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP

Mass Disaster and Man-Down Events in Facilities with Multiple Buildings

Q Our facility has one medical unit that serves multiple buildings on the same campus. Health services staff work out of the medical unit and respond to various buildings for med pass and emergency calls. Do we need to do a mass disaster and man-down drill in each individual building to be in compliance with Standard D-07 Emergency Services and Response Plan?

A Re: mass disasters, based on your clinic and campus structure, an annual mass disaster drill or event encompassing multiple buildings would sufficiently meet this standard, as long as all buildings participate in the drill. When mass disruption occurs on a campus as you describe yours, it will typically affect multiple, if not all, buildings on the campus that house incarcerated individuals. Emergency preparedness for mass disasters is usually seen as a campuswide event, with campuswide training protocols. Each building may have its own specific measures to follow; however, when one building is affected with a mass disaster situation, it is common that all buildings on the campus are operationally affected in some capacity,

even if that means an unintended emergency lockdown and formal count of the incarcerated population and staff.

Re: man-down events, based on your clinic and campus structure, unlike with mass disaster drills, annual man-down drills are required within each individual building to ensure staff in each building know how to respond. The rationale for this has to do with man-down events affecting one individual who needs immediate medical intervention. These instances are isolated to the location in which the medical emergency occurs and any subsequent movement of that patient. When a facility has multiple separate housing units on the same campus, man-down responses are unique to the specific building and usually do not involve operational or staffing needs (other than health care staff) from other buildings. Staff within each facility have protocols for responding to these emergencies and are required to practice their response annually.

Control and Accountability of Non-OTC Meds

Q Does NCCHC require facilities to follow a specific way to account for/record their control and accountability for non-over-the-counter medications?

A NCCHC does not require facilities to follow a specific medication accountability system for their medications. NCCHC does, however, require facilities to show evidence of how they account for adequate control and accountability of applicable medications within their facility. Whether it is logging each individual pill on the back of a blister card or log sheet, using a pharmacy-provided gun to scan each medication barcode every time the medication is dispensed, using a medication-dispensing machine that requires a patient's name/identifier in order for the machine to dispense the medication, or utilizing another written form of documentation, there are many options a facility can implement. Inventory control and accountability measures should be in place to account for all non-OTC medications within the facility, including in medication rooms, medication carts, clinic areas, and dental suites, where applicable. ●

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



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