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CorrectCare®

The magazine of the National Commission on Correctional Health Care

The background of the cover features a close-up, slightly blurred photograph of a metal scale, likely used for weighing. The scale has a horizontal beam with markings and numbers. The numbers 18, 19, and 20 are visible on the upper part of the beam, and 80, 100, and 120 are visible on the lower part. The scale is made of dark, weathered metal.

HUNGER STRIKES & FOOD REFUSALS

Multidisciplinary Management

The Oral–Systemic Link

Beware the Dangers of
Cognitive Bias

Addressing Racism in
Correctional Health Care

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Position Statements Updated and Endorsed

In an updated position statement, NCCHC reiterates its support for accommodating nursing individuals in custody so they are able to maintain their breast milk supply and, when feasible, directly breastfeed their infants. Wherever possible, correctional facilities that house pregnant and postpartum individuals, including short-stay facilities, should devise systems to enable them to express breast milk or breastfeed.

This statement, originally adopted in 2017, is endorsed by the American College of Obstetricians and Gynecologists.



Photo © Leon Rafael/Shutterstock

Correctional environments are uniquely vulnerable to violence given high rates of victimization among

incarcerated people and the presence of individuals who have engaged in violent behavior. The position statement Public Health Implications of Violence and Correctional Settings, an update to Prevention of Violence in Correctional Settings, calls for addressing violent behavior in the carceral environment using a public health approach.

The 2023 statement Addressing Systemic, Structural, and Institutional Racism in the Juvenile Legal System has been endorsed by the American Society of Addiction Medicine (ASAM).

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

New: Evidence-Based Federal Guidelines for Managing Substance Withdrawal in Jails

The U.S. Department of Justice's Bureau of Justice Assistance and National Institute of Corrections has published a vital new resource, Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals. NCCHC, along with the American Society for Addiction Medicine and Advocates for Human Potential, led early development of the guidelines, which provide essential evidence-based guidance, best clinical practices, and recommendations.

"NCCHC encourages all jail administrators and health services professionals to use this tool when making decisions regarding withdrawal management," says Deborah Ross, CCHP, NCCHC's chief executive officer.

Find the guidelines on the NCCHC website or at cossapresources.org/Tools/JailResources.

NCCHC Foundation Online Auction Opens Sept. 22

The NCCHC Foundation is holding its first-ever online auction! Join us at ncchcfoundation.org/online-auction to bid on great auction items including travel experiences, specialty items, memorabilia, and more. All proceeds benefit the NCCHC Foundation's mission of championing the correctional health care field.



The auction begins on Sept. 22 and closes on Oct. 3 at 3 pm CDT. Sponsored by Physician Correctional USA.

ncchcfoundation.org/online-auction

NCCHC Welcomes Accreditation Advisor

Carrie Reindollar LPN, CCHP, has joined NCCHC as accreditation advisor. She brings to the role nearly 20 years of experience as operations manager, director of training, and regional nurse manager with a correctional health care vendor, where she oversaw medical



program management for facilities throughout the Midwest, as well as being an active NCCHC surveyor. In this new role, Reindollar will work directly with facilities seeking accreditation and continue as a surveyor.

NSA Supports NCCHC Health Services Standards for Juvenile Facilities

In a recent resolution, the board of the National Sheriffs' Association urged juvenile facilities to follow national health care standards, citing NCCHC standards specifically.

"Standards for health services published by the National Commission on Correctional Health Care help juvenile detention and confinement facilities to increase the efficiency of their health services delivery, strengthen organizational effectiveness, reduce the risk of adverse patient outcomes and legal judgments, and improve the health of youths in their care and the communities to which those youths return," the resolution states.

A Brief History of Medical Records

By Pauline Marcussen, DHA, RHIA, CCHP

As summer draws to a close, I am reminded once again of how quickly time flies. It feels like just yesterday that I began my career in the medical records field, as a file clerk in a large city hospital.

At that time, a few decades ago, patient admissions were recorded on 3x5 index cards, and paper records were filed using a unique numbering system rather than an alphabetical system. Lab results were recorded on small pieces of paper that were then taped onto paper forms, and dictated reports were signed in ink by the physicians.

When I was hired at the state prison in the late 1990s, I felt like I had been transported back to the '50s. For the first 10 years, I drafted policies on protecting confidentiality of health information, required patients to sign authorization forms to disclose documents, and streamlined the processes associated with keeping medical records.

I was fortunate to work for a very progressive medical director who had hired me to help move us into the 21st century. For a few years, we had a hybrid medical record – part paper/part electronic – and over time, the staff realized the need to move into a totally electronic environment.

Welcoming the EHR

The most amazing part of working in an electronic environment? Accessibility. We were able to look at trends based on facility and housing units using validated data. With the use of interfaces, lab results were imported into the electronic health record, immunization details were shared with the state health department, and patient information was exported to the state health information exchange to be used by our community partners. There was no longer a need for clerks to move records from one facility to another or to file individual documents in a paper record. Efficiency is the key, and we were well on our way.

NCCHC followed the trend by updating the standards to include Standard A-08 Health Records, outlining the need for a confidential health record using a standardized format. The standard also includes a detailed discussion of the proper use of an electronic health record to protect the security of personal health information and delineates the parameters for access to that information.

For the Benefit of our Incarcerated Patients

Adequate health records exist in a variety of formats, but electronic health records with data stored using centralized, secure, off-site methods (i.e., in “the cloud”) are the preferred format for supporting seamless continuity of care.

The use of electronic health records benefits the incarcerated population in many ways. Paper records are easily lost or unavailable at the time of a patient encounter. With an EHR, data/information cannot be altered once signed and locked by the writer. Records can be shared through regional health information exchanges and/or patient portals, so community providers no longer need to repeat diagnostic testing and exams.

It's refreshing to see how the field of health information has changed over the years. Health care professionals provide better documentation of the care they provide, and team members have access to timely and accurate information by logging into a computer.

Having access to our own personal health records through patient portals is a privilege of living in the free world. That is the ultimate goal for incarcerated individuals as well. ●



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

NCCHC standards specify that health records include:

- Patient identifying information
- A problem list containing medical, dental, and mental health diagnoses and treatments and known allergies
- Receiving screening and health assessments
- Progress notes or flow sheets of all significant findings, diagnoses, treatments, and dispositions
- Prescriber orders for medications, list of current medications, and medication administration records
- Reports of laboratory and other diagnostic studies
- Consent and refusal forms, release of information forms, results of specialty consultations and off-site referrals
- Discharge summaries of hospitalizations and other inpatient stays
- Special needs treatment plan
- Immunization records
- Place, date, and time of each clinical encounter
- Name and title of each documenter

From the NCCHC position statement Sharing of Patient Health Records Upon Release From Incarceration (2021)

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Addressing Racism in Correctional Health Care: Report from the Committee on Systemic Racism

By Mary Muse, MSN, RN, CCHP-RN, CCHP-A, Joel Andrade, PhD, CCHP-MH, and Claire Wolfe, MPH, MA, CCHP

The history of racism and racial inequality in the United States has a direct throughline to our criminal legal system today. That is most obvious in the disproportionate incarceration of people of color, particularly Black men. But it is also reflected in who accesses and receives care (and when); who receives a mental health diagnosis and commensurate treatment; who receives disciplinary sanctions, particularly placement in restrictive housing and other forms of isolation or solitary confinement (and for how long); and many other facets of health care delivery, institutional policies, culture, and overall patient well-being.

To be direct, it does not have to be this way, and change is long overdue.

The importance of this issue needs to be acknowledged and addressed by those who work in corrections. To that end, the NCCHC Committee on Systemic Racism in Correctional Health Care was established with a charter to begin to guide the field toward recognizing and eradicating systemic and other forms of racism in correctional health care through education, research, advocacy, policy recommendations, and clinical practice tools.

The Committee has been working to understand the role correctional health care can play in addressing racism, for both patients and staff. Through open forums at NCCHC conferences, feedback from the NCCHC Board of Representatives, and a webinar focused on the lived experiences of individuals working in corrections, we have received valuable answers to the question: How does racism show up in correctional health care?

A summary of the Committee's key findings:

Reentry challenges: The reality is that Black, Indigenous, and Hispanic individuals are incarcerated at disproportionately higher rates than white individuals. While that reality is beyond the control of correctional health care, time spent in a facility can be one of rehabilitation, where health is prioritized. That can translate into improved health in communities where incarcerated individuals return, if they are able to return healthier and are connected with appropriate health care services upon release.

Following release, continuity of care for physical and mental health and substance use issues is essential and a process in which correctional facilities can have a meaningful impact. Upon returning to the community, many are faced with difficult choices and few options for family or community support, housing, and work. Reentry initiatives using the social determinants of health as a framework – that is, the underlying social, economic, and physical conditions in which people live – can help to ease the transition. Those factors directly impact both the returning individuals and the communities to which they return.



The suggestions we have received on the topic of reentry include the need for increased funding for discharge planning, more community resources, stronger partnerships with community organizations, and data sharing between correctional facilities and community health care and social service organizations.

Staff-experienced racism: Staff of color working in corrections report experiencing both overt racism and microaggressions, defined by the American Psychological Association as brief and commonplace verbal, behavioral, or situational indignities that communicate hostile, derogatory, or negative slights or insults toward members of minority or oppressed groups. Educational credentials and professional experience were not reported to protect against such experiences, with some feeling that higher educational attainment and professional experience increased exposure to racism.

When reported, such experiences of racism need to be acknowledged and an institutional response executed to prevent such occurrences in the future. Feedback that we received includes a need for confidential surveys of staff and qualitative data collection and analyses (without retaliation to respondents) that can provide insights into staff-experienced racism within a specific facility or system.

One idea we have heard repeatedly is that the workforce should reflect the patient population in the facility. This is true for leadership and staff and can help create a culture where all voices and perspectives are respected.

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HUNGER STRIKES & FOOD REFUSALS

Multidisciplinary Management

By Raneer' Wright, MSN, APNP, CCHP-RN, CCHP-MH; Melissa Mitchell, MSN, MHA, CCHP; Jennifer Wollert, BSN, RN, CCHP; and Jackie Havel, RDN

When an incarcerated individual stops eating, refuses food for an extended period of time, or declares a hunger strike, a collaborative approach involving a multidisciplinary team is required to properly navigate the complexities of the situation.

Variations on a Hunger Strike

There are any number of reasons an incarcerated individual might refuse to eat.

A **hunger strike** is a voluntary fast undertaken as a form of protest for longer than 48 to 72 hours, usually to achieve a specific demand, for which the person is willing to risk his or her life. The reasons for hunger strikes can range from political protest to wanting to be released to bringing light to a perceived injustice. The practice dates back hundreds of years, becoming more frequent in correctional settings in the early 1900s when British and American suffragettes fasted to demand the right to vote; some died in prison.

Someone on a true hunger strike is prepared to undergo a long fast, not back down until the goal is attained, and is willing to risk health and life for the cause. Most “hunger strikers” are actually **food refusers**, people who refuse

to eat for a period of time but do not intend to endanger their lives. Rather than a serious protest, food refusals are generally short-lived, more trivial in their demands, and often undertaken in reaction to a specific situation. Individuals who engage in food refusals often do so repetitively or frequently.

With the incarcerated population, it is important to understand that people with **mental illness** are susceptible to refusing food as a result of delusions, paranoia, depression, and/or lack of trust of facility staff. Obvious signs that someone's food refusal has a psychiatric basis include reporting that food is poisoned or contaminated and appearing to respond to internal stimuli. Other clues include food trays that are untouched, food that is scattered around the room, and an apparent attempt to eat with only a minimal amount consumed. Lethargy and decreased urine output may indicate that a patient with mental illness is not eating.

Secondary gain – increased attention, an infirmary stay, or an offer of a sports drink, nutritional supplement, or some other dietary modification – also needs to be taken into consideration when assessing a food refuser. People with personality disorders especially have a tendency

for secondary gain. Recognizing secondary gain can be challenging for the treatment team; it is important to work with mental health professionals to determine if there are behavioral considerations that need to be addressed.

Religious fasting (e.g., for Ramadan) does not need to be monitored like a traditional food refusal unless it goes beyond what the religious fast requires.

When an incarcerated person is informed of the consequences of their actions and continues to not consume calories or liquids, knowing the result may be death, is this considered a **suicide** attempt?

Any kind of hunger strike or refusal to eat – whatever the motivation – needs to be taken seriously, cared for appropriately, and documented carefully.

When a food refusal becomes dangerous or life-threatening, involuntary feeding, usually via nasogastric tube, may be initiated, often against the patient's will. Force-feeding is controversial and can put the patient at risk for refeeding syndrome (RFS), a serious condition that occurs in malnourished people receiving nutritional support.

Caring for a Food Refuser

A collaborative approach is called for in caring for someone who is not eating. Coordinated care among nursing, medical, and mental health professionals is essential to ensuring a safe progression through the food refusal. Initial medical, nursing, and mental health assessments should occur along with scheduled routine nursing assessments. Plan, transition, and discontinuation should be a collective effort driven by medical and dietary recommendations.

A thorough mental health assessment should be completed to help determine the cause of the food refusal. Although most aspects of the plan of care will be the same regardless of the motivation, sealed meals might be considered for someone experiencing psychosis to prevent any suspicion of food having been tampered with on-site.

Custody staff are also essential to ensuring the individual's safety as well as documenting food and liquid intake. A solid plan of care cannot be developed without accurate documentation by frontline custody staff. They also may be the first to learn or notice that someone is not eating.

As soon as someone states an intention to stop eating or their refusal to eat is noted, begin monitoring and assessments: weight checks, vital signs, labs, full system assessment, and intake monitoring. Be sure the food refuser understands the risks involved with food deprivation.

Ensure that both liquids and food intake (or lack thereof) are documented accurately.

Anyone who completely refuses both food and liquids, called a dry hunger strike, requires immediate medical attention. The body cannot survive more than a few days without fluids.

Discuss the possibility of obtaining a court order forcing treatment should the individual's condition warrant such an extreme measure. Inform the patient that authorization to intervene will be requested when life is in danger.

As you develop the plan of care, make sure to follow policy, procedure, and laws that might limit staff's ability to monitor and treat the patient without a court order.

If the individual has a guardianship/activated power of attorney for health care, ensure frequent communication with the assigned legal representative, who will need to agree with and approve the plan of care.

Check with your facility or system's policies, procedures, and protocols for specific guidance.

Continue ongoing nursing, psychiatric/mental health and medical evaluations to identify increasing risks of complications throughout the food refusal or strike.

Assessment may include:

- Laboratory assessment
- Weight check
- Vital signs
- Dipstick urinalysis
- Blood glucose test
- Oral mucous membrane assessment
- Skin turgor assessment for dehydration

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Rights vs. Responsibilities

Unable to make decisions for themselves, incarcerated individuals can feel like the only control they have is to not eat, the only voice they have is their health and life. A hunger strike is not only a form of protest but also a pressure method, a way to force action. When there is a threat of actual loss of life, decisions need to be made. Doing nothing can be fatal.

On the other hand, doing something – when that “something” is force-feeding – can be dangerous and raises an important ethical dilemma: autonomy vs. preservation of life. Patients – including incarcerated patients – have the right to make decisions for themselves. NCCHC Standard G-05 Informed Consent and Right to Refuse states, “Inmates have the right to make informed decisions regarding health care, including the right to refuse care.” But health care professionals also have an oath to “first, do no harm.” This creates a complex situation.

The rights of an incarcerated individual to declare a hunger strike or refuse to eat must be respected... until it reaches a dangerous level. At that point, saving the person's life takes priority. Laws regarding the consent to treatment and the right to refuse treatment vary from state to state (*see next page*).

What Happens When You Don't Eat? Medical Management of Food Refusers

By Michelle Iglesias, MD, and Sergio Alvarado, MD

The medical complications of not eating are many and varied, ranging from dizziness to death. Complications generally occur according to this timeline:

Week 1: Glucose levels begin to fall, as glycogen stores rarely last more than 72 hours. The body starts losing fat and muscle mass. Resistance to infection decreases. Hunger pangs and stomach cramps disappear after the second or third day and there is often a feeling of well-being and euphoria.

Week 2-3: Neurological problems and lack of motor skills set in due to low levels of vitamin B1: dizziness, feeling faint, difficulty standing, lightheadedness, mental sluggishness, sensation of cold, weakness, loss of thirst. Serum electrolytes are maintained at the expense of intracellular stores. There is a risk of death if the person was already sick or has significant comorbidities.

Week 4: Lethargy and irritability, vertigo, visual disturbances, incoherence; hospitalization may be required.

After 45 days: Risk of severe infection, increasing confusion and incoherence, profound concentration problems, cardiovascular collapse, high risk of death.

We recommend several lab tests for hunger strikers and food refusers: prealbumin (a sensitive marker for increased risk of morbidity; involuntary feeding should generally be initiated before prealbumin levels drop below 11 mg/dL); complete blood count; complete metabolic panel; thiamine, magnesium, phosphorus, vitamin D.

Risk factors for refeeding syndrome – the clinical complications that can occur as a result of fluid and electrolyte shifts during aggressive nutritional rehabilitation of malnourished patients – are directly related to the amount of weight loss and speed of weight gain and include a low baseline of phosphate, potassium, or magnesium prior to refeeding.

Treatment for RFS involves reducing nutritional support and correcting electrolyte imbalances.

Hospitalization should be considered for moderately to severely ill patients with seizures, marked edema, or a serum phosphorous of less than 2 mg/dL.

Michelle Iglesias, MD, is Western regional clinical director, and Sergio Alvarado, MD, is clinical director at the El Paso Service Processing Center, ICE Health Service Corp., U.S. Immigration and Customs Enforcement.

The Legal Implications of Hunger Strikes

By Allison Becker, JD, and Kendra Stark, JD

Refusing to eat is a common form of protest in correctional facilities. Patients may initiate hunger strikes, often called food refusals, for a variety of reasons – to protest conditions in the facility, as an objection to disciplinary or housing decisions, or for personal or religious reasons. A hunger strike raises several legal concerns for the staff, including how to ensure the patient's constitutional rights are being protected and how to best position themselves to defend claims or litigation that may arise from treating the patient. This article provides an overview of how courts look at hunger strike litigation and provides recommendations and best practices for health care professionals who encounter this issue.

Deliberate Indifference Concerns

One of the most common legal claims against health care professionals arising out of a patient's refusal to eat is a

claim for deliberate indifference. In most courts, this claim requires a showing that 1) the patient has a serious medical need that has been diagnosed by a doctor as needing treatment, or one that is so obvious that even someone without medical training would recognize the need for a doctor's attention; and 2) disregard for that medical need was grossly incompetent, inadequate, or excessive (*Farmer v. Brennan*, 1994; *Estelle v. Gamble*, 1976).

While hunger strike claims are common, most courts have held that health care professionals are not required to intervene to stop the fast as long as the patient is being properly monitored and is only experiencing temporary or minor consequences such as discomfort or nonconcerning weight loss (*Owens v. Hinsley*, 7th Cir. 2011). Nevertheless, health care professionals must appropriately monitor the patient's condition to ensure that those consequences do not become more serious and that the refusal to eat is not putting the patient at risk of serious injury or death.

Courts have held that appropriate monitoring includes continually offering the patient water and three meals per day regardless of refusals, providing daily medical assessments, and monitoring the patient's vitals if the patient consents (*Collier v. Adams*, 3d Cir. 2015). If health care professionals fail to monitor the patient during a known hunger strike and the patient suffers a serious adverse outcome, they may be subject to liability.

Courts do give some leeway in determining how to monitor patients during a hunger strike. For example, some courts have held that one daily assessment constitutes sufficient monitoring. Others have held that placing the patient in isolation in the infirmary for several days to ensure more stringent monitoring was appropriate (*Brown v. Graham*, 2d Cir. 2012). While each facility handles this monitoring differently, it is important to remember to follow any written policies or protocols that exist and to clearly and thoroughly document all monitoring and assessments. If the patient refuses any assessments, meals, or medical treatment, health care professionals should also clearly document those refusals, in the event they may need to defend a claim or lawsuit.

Mental Health and Suicide Concerns

The refusal to eat may also be related to a mental health concern. Courts have recognized that incarceration puts individuals under unique psychological strain, which requires that correctional health care professionals be vigilant about when a hunger strike is a protest, and when it is a symptom of a mental health concern or suicide attempt (*Freeman v. Berge*, 7th Cir. 2006). Hunger strikes may also evolve into attempted suicide over time. Obtaining appropriate mental health evaluations for a patient on a hunger strike, particularly when that patient's fast becomes prolonged, is a key component in defending a claim or lawsuit. It is not uncommon for lawsuits to allege that the patient's refusal to eat was actually a sign of a mental health crisis, and that health care professionals failed to provide any type of mental health evaluation or treatment in response. Referring a patient on a hunger strike for a mental health evaluation, even to rule out any connection to mental health or suicide concerns, can make a significant difference in the defense of a claim.

Forced Intervention

When a food refusal begins to impact the patient's health, staff may question whether they can legally intervene to prevent the patient's further deterioration. Several courts have held that prison administrators have not only a right but a duty to intervene and force a patient to take nourishment if the strike puts them at risk of serious injury or death (*Austin v. Tennis* 3d Cir. 2010; *Owens v. Hinsley*, 7th Cir. 2011). However, it

is always best practice to obtain court approval for this type of intervention before implementation. Remaining in close communication with your facility's administration about the patient's medical condition can help you pursue the necessary legal approvals quickly.

Takeaways

As with so many legal issues, the outcome of treating a patient on a hunger strike may depend on the facts and circumstances of each specific situation. However, implementing these best practices can help provide a stronger defense if a claim does arise:

- Ensure the documentation of all assessments is legible, thorough, and accurate, including specific times for each assessment or attempted assessment.
- Document all refusals in detail, including obtaining patient signatures and explaining any warnings provided to the patient of the potential consequences of their refusal.
- Establish open and reliable communication with custody staff to ensure they are keeping health staff apprised of any change in the patient's condition or behavior.
- Refer food refusers for mental health assessments. ●

Allison Becker, JD, is managing partner of the Raleigh office of Gordon Rees Scully Mansukhani. Kendra Stark, JD, is a senior counsel in Gordon & Rees's Raleigh office.



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The Oral–Systemic Link: The Importance of Dental–Medical Collaboration

By LCDR Erin Heap, PHDHP, BSDH, RDH

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Everyone working in corrections knows that the incarcerated population includes a disproportionate number of individuals with high rates of chronic diseases. Contributing factors include low socioeconomic status, homelessness, lack of routine preventive health care, unhealthy lifestyles, poor nutrition, and tobacco, alcohol, and drug use.

But did you know that many chronic conditions are associated with chronic inflammatory gum disease, known as periodontal disease or PD? In fact, obesity, diabetes, respiratory disease, HIV/AIDS, and coronary artery disease are often associated with PD.

The Gateway to the Body

The American Dental Association reports that periodontal disease affects more than 42% of Americans aged 30 and older. PD is a progressive disease that begins with gingivitis, or inflammation of the gum tissue around the supporting structures of the teeth. With gingivitis, the gums can become swollen and red and often bleed, potentially causing a transient bacteremia (bacteria that are present in the bloodstream for minutes to a few hours before being cleared from the body). Gingivitis is generally painless and reversible with proper brushing and flossing.

Chronic gingivitis can lead to periodontitis, a more serious form of periodontal disease involving destruction of the bony structures supporting the teeth. In later stages, PD can become painful as teeth become loose and the patient develops periodontal infections. The gums recede, and bone can be lost. This loss of attachment can cause the teeth to loosen or fall out. This stage of periodontal disease is irreversible, as bone cannot be regenerated once lost.

Evidence supporting the oral-systemic link is plentiful. Some of the top associations of which the correctional health care team should be aware include:

Atherosclerosis/heart disease: Atherosclerosis, the most common cause of heart attacks and stroke, is the buildup of fats, cholesterol, and other substances in the walls of arteries that causes obstruction of blood flow. A number of studies have indicated that the chronic inflammation of periodontal disease is a risk factor for the progression of atherosclerosis. The presence of periodontal pathogens has been found in human atherosclerotic plaques. According to Harvard-affiliated Forsyth Institute, a nonprofit research organization focused on oral health, adults with gum disease are two to three times more likely to suffer from a stroke, heart attack, or other serious cardiovascular event.

Respiratory issues: The bacteria responsible for periodontal disease is the same bacteria that causes pneumonia and respiratory infections; bacteria in the oral cavity can be inhaled or travel via the bloodstream to the lungs, causing inflammation elsewhere. In a study published in the *Journal of Clinical Periodontology*, COVID-19 patients with periodontitis were found to be three times more likely to suffer severe COVID complications, more than four times more likely to be admitted to the ICU for ventilator assistance, and about nine times more likely to die than those without periodontitis.

Diabetes: PD is a risk factor associated with diabetes. The inflammation associated with PD can contribute to a higher risk of diabetes. The reason for this is not yet clear to researchers, but one theory suggests that systemic inflammation can alter how the body responds to insulin. The reverse is true as well: diabetes is a major risk factor for periodontitis. Susceptibility to periodontitis is increased by threefold in people with diabetes, and ongoing high blood sugar levels contribute to worsening gum disease. When a patient's oral health is well-maintained, it can help keep blood sugar regulated as well, which is why diabetes care and periodontal health go hand in hand.

Rheumatoid Arthritis (RA): Rheumatoid arthritis is a chronic inflammatory and autoimmune disease. Having learned that periodontal disease is a chronic inflammatory disease it should not surprise us to discover that *Porphyromonas gingivalis*, the main bacteria that causes PD, may be associated with early onset and increased severity of rheumatoid arthritis. The findings of one study indicated that patients with rheumatoid arthritis were nearly eight times more likely to have periodontal disease compared with control subjects.

Inflammatory Bowel Disease (IBD):

A 2020 collaborative study from the University of Michigan Medical and Dental Schools reveals that inflammatory bowel disease (IBD), which includes Crohn's disease and ulcerative colitis, may be another condition made worse by poor oral health via a possible bidirectional "mouth-gut axis," whereby chronic oral or intestinal inflammation can impact the other.

Reproductive health: Some research suggests that periodontal disease also has an effect on fertility. An Australian study published in 2011 found that women with periodontal disease required two more months to conceive compared to women without PD. Hormone changes can also lead to gingivitis, the precursor to PD, during pregnancy. That has caught the attention of many insurance companies, who now cover an additional

dental cleaning for expecting mothers. There is also some evidence that men with PD are more likely to experience low sperm count, poor sperm motility, and erectile dysfunction.

Dementia: A recent analysis led by National Institute on Aging scientists, reported in the *Journal of Alzheimer's Disease*, suggests that bacteria that cause gum disease are also associated with the development of Alzheimer's disease and related dementias, especially vascular dementia.

This information clearly illustrates the importance of two things: the need for regular oral self-care (brushing, flossing, regular cleanings) and the need for collaboration between oral providers and health care providers. Follow these tips:

- When meeting a new patient, review medical and dental histories.
- Refer patients to the dental department for issues such as abscessed and broken teeth or bleeding gums, or when signs of oral disease are found during medical appointments.
- Hold educational courses for individuals with special needs on topics such as blood sugar control, prenatal care, and heart health. With many facilities dealing with low staffing and limited resources, make sure patient education is not pushed aside. The incarcerated population should be made aware of the oral-systemic link in the disease(s) they are battling.
- Encourage proper brushing and flossing.



Oral care is an important component of an individual's overall health care. Poor oral health has been linked to numerous systemic diseases."

NCCHC Standard E-06 Oral Care

In a population of people at risk for a variety of chronic diseases and conditions, medical and dental providers need to work together for their patients' optimal health. Ongoing, collaborative care can minimize the impact of a chronic condition like IBD or RA, help stabilize a patient's blood sugar, prevent a heart attack, and just may save a life. ●

LCDR Erin Heap, PHDHP, BSDH, RDH is a dental hygiene practitioner, registered dental hygienist, and Commissioned Officer in the United States Public Health Service with the Federal Bureau of Prisons.

RELEVANT NCCHC STANDARD

E-06 Oral Care: Inmates' dental needs are addressed.

NCCHC Standards for Health Services 2018

Beware the Dangers of Cognitive Bias

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

Whether we admit it or not, we all have unconscious biases. As human beings, it's impossible not to. In order to make sense of all the information that constantly bombards us and simplify thinking and decision-making, our brains filter information through our personal experiences and preferences.

That is known as cognitive bias, which the Cambridge English Dictionary defines as “the way a particular person understands events, facts, and other people, which is based on their own particular set of beliefs and experiences and may not be reasonable or accurate.”

Cognitive bias allows us to quickly process and prioritize large amounts of data and fill in missing details, but it also distorts our understanding and creates errors in thought that can result in bad decisions and mistakes.

For health care professionals, cognitive bias, left unchecked and unchallenged, can lead to erroneous diagnoses, poor treatment decisions, and bad outcomes.

Types of Cognitive Bias

When working with incarcerated individuals, it is especially important to “leave your biases at the door” and be careful not to fall victim to these common forms of cognitive bias.

Confirmation bias, looking for or overvaluing information that confirms what we already believe or supports our existing ideas. As social psychologist Ziva Kunda, PhD, explained, “We give special weight to information that allows us to come to the conclusion we want to reach.” Confirmation bias impedes our ability to critically examine our own beliefs or seek new solutions to a problem. Our tendency to ignore any new information that is

contradictory to our beliefs leads to poor decision-making. For example, we may disregard or rationalize lab results that do not support a favored diagnosis, thus failing to acknowledge the possibility of other diagnoses.

Representativeness, making decisions based on stereotypes. We believe the likelihood of two things happening together is greater when they resemble or are similar to each other. Biased decisions are made about a current situation or person when compared to past situations and people with perceived similarities. For instance, we might be reluctant to take pain complaints seriously from individuals with substance abuse disorders and instead assume they are drug-seeking.

Availability bias, accepting an idea based on how “available” it is, or how easily it comes to mind. Availability bias is a tendency to think that things that happened recently are more likely to happen again. We overestimate how likely something is to happen based on how easily we remember it happening before. This selective recall of information displaces our ability to accurately interpret probabilities or consider other scenarios. It is a common mistake in health care when clinicians make a diagnosis because it readily comes to mind from similar past events. During the height of the COVID pandemic (and even now) it was easy to assume that every sore throat or fever was COVID without considering other possibilities.

Anchoring bias, a tendency to rely too much on the first information we receive. Regardless of accuracy, that first information is used as a reference point in framing our belief. We may place greater emphasis on initial symptoms and not be able to adjust a diagnosis when additional information becomes available.

Framing effect, arriving at different conclusions from the same information based solely on how the information is presented. An outcome presented as a positive is more favorable to us than an outcome framed as a negative. Consider different framings of two medical procedures being considered for 1,000 people with a terminal heart condition: Procedure A can save 250 people, while Procedure B would result in a 75% loss of life. Even though the results are identical, Procedure A sounds preferable. Too often, we accept problems as they are framed without looking at them deeply, critically, or from other perspectives.

Gender bias, the tendency to assign specific characteristics and behavior to – and provide different treatment based on – a person's gender or perceived gender identity. For instance, studies consistently show that clinicians take complaints of pain from males more seriously than those same complaints when made by females.



Fundamental attribution error, underestimating the influence of a situation on people's behavior. With this type of bias, we believe that people's personality traits have more influence on their actions than other factors over which they don't have control. So when a colleague arrives late to a team meeting, others in attendance may see that person as rude without knowing or considering the possibility that their child is sick at home. The tendency to blame another's actions on their personality as opposed to external factors beyond their control creates conflict and diminishes trust.

Affinity bias, favoring people with similar characteristics, backgrounds, and experiences as our own. That can include not only those who share our ethnicity, religion, or political views, but also our personal interests, favorite sports teams, or musical tastes. We tend to be most comfortable around those who are like us. But when affinity bias is strong, we reject others who act or look differently, creating unwarranted preferential treatment and depriving us of valuable insight from others to whom we do not gravitate.

Survivorship bias, assuming all necessary information is contained in a success while ignoring past failures. For every favorable outcome, there are a multitude of unfavorable ones. We succumb to survivorship bias when we pay attention only to groups or sets that have passed a selection process while ignoring those that have not. Focusing solely on material or conditions that led to success leads to incorrect conclusions because of incomplete data. Similarly, the positive-results bias is where we are more likely to accept positive results over negative results.

Bandwagon effect or herd mentality, going along with the crowd. This is our habit of adopting certain behaviors or beliefs because "everybody's doing it." We take a particular view, follow an idea, or find something desirable because everyone else does too. Our decisions in these instances are based on emotion and not logic.

Dunning-Kruger effect, those with limited understanding or skill in a field overestimate their own knowledge and abilities. This bias arises because those who are incompetent in an area lack the understanding necessary to be aware of their incompetence. The converse is also true: those with significant knowledge or skill in a particular area tend to underestimate their competence. Not surprisingly, overestimation of knowledge, skill, or capability often leads to mistakes.

Combating Cognitive Bias

Cognitive bias in all its forms prevents the exchange of accurate information, as we tend to avoid information we do not like or agree with. While we believe that we receive information objectively, our brains unconsciously filter data, distorting our perception of reality. Because bias can distort our critical thinking, we become prone to making irrational decisions and inaccurate judgments about others.

To overcome our cognitive biases, it is first necessary to acknowledge that they exist and that we are susceptible to them. Understanding common biases allows us to more easily recognize them when they occur.

Remember these tips to keep yourself from acting out of bias:

- Be aware that biases are more likely to distort decision-making when you are rushed, multitasking, or tired.
- Be cautious of data that immediately supports your views; reevaluate every time new evidence is presented.
- Thoroughly research questions and problems.
- Solicit feedback before presenting your own thoughts or opinions.
- Consider data from all positions, weighing them equally.
- Play "devil's advocate" with your own beliefs or suppositions; question yourself.
- Consider different perspectives and surround yourself with multiple viewpoints. Diverse views from others with dissimilar lived experiences will expose you to other facets and alternative solutions to a problem.
- Acknowledge the possibility that you might not be right; be aware of your own limitations.
- Do not succumb to peer pressure and, if needed, take additional time before making a decision.
- Foster a positive culture that emphasizes strong relationships, empathy, and patience.

With understanding and practice, awareness of cognitive bias can lead to positive patient outcomes, healthy collaboration, and better decisions. ●

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



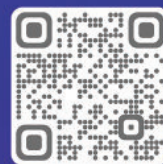
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Digital Badges: A New Way to Share CCHP Pride

The CCHP program has launched a new digital “badge” option for all Certified Correctional Health Professionals, including those with advanced and specialty certifications.

A digital badge is sometimes called an icon or micro-credentials, but that makes it sound small, and it’s actually a big deal! Much like the paper certificate CCHPs receive when they initially pass the exam – and each subsequent year when they recertify – a digital badge is documentation of the accomplishment. But instead of being displayed on your office wall where only you can see it, this badge goes everywhere. Your badge can be shared electronically with others via email or social media networks, and can be displayed on resumes, personal websites, email signatures, job boards, or anywhere across the web.

Visually, the digital badge is simply the CCHP logo. But click on it, and it connects to metadata – detailed information about your specific certification, including your name, title, employer, the date of your most recent certification and its expiration date, the name of the issuing organization (in this case NCCHC), a description of the criteria for earning certification, and the skills and knowledge associated with it. In that way your badge is authenticated and verifiable, unlike a printed certificate. It also links to the NCCHC website and the CCHP page for further information about the organization and the program.

“Badges provide employers primary source verification of what you earned, how you earned it, and the value you now bring as a result of the achievement,” explains Matissa Sammons, CCHP, MA, vice president of certification. “And you can celebrate your achievement by sharing on social media.” Suggested uses include:

- Add the badge to your LinkedIn profile so anyone looking at your page can learn what the CCHP credential

means. It will even generate a LinkedIn post for you announcing your recertification.

- Put it on your Facebook page and let it generate a Facebook post for you.
- Share on Twitter and Instagram.
- Use the email sharing option to send it to an email address – a potential employer, colleagues, or your licensing board.
- Send it to prospective employers to confirm that your certification is up to date.

Digital badges are becoming more popular among training programs and organizations such as NCCHC, who are able to specify expiration dates to prevent sharing of expired badges. Recipients of shared badges can rest assured that credentials are current and verified.

“Many CCHPs don’t have a need for – or a place to put – a printed certificate, so this is an alternative,” says Sammons. “Printed certificates are attractive, but sometimes get lost or damaged in mailing and take about 10

days to receive. With a digital badge, it takes just a few minutes for information to populate the digital record.”

Everyone will still get a printed certificate when they first earn certification as a CCHP, but during the annual recertification process, you will now be able to select whether you want a printed certificate or a digital badge.



CCHP - CERTIFIED BADGE	
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Company	Your company here
Certification Enrollment Number	Your certification number here
Issued By	National Commission on Correctional Health Care
Location	Chicago, IL
Issue Date	04/01/2023
Expiration Date	03/31/2024
Description	Becoming a Certified Correctional Health Professional is the next step in your professional advancement. The CCHP credential shows your mastery of NCCHC standards and your ability to apply them to support the quality of patient care. It's a signal to the field that you are committed to correctional health care as a career. You'll gain credibility with colleagues with this tangible evidence of your expertise.

Whichever option you select, you can still print a paper certificate through your myNCCHC account. Instructions are available on the website under Certification FAQs.

If you choose the digital option, you will receive an email from cchpbadges@ncchc.org with instructions for claiming your badge. It might land in your junk mail folder, so be sure to check. Once claimed, the badge is yours to use. Share it widely and spread the word about your accomplishment. ●



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Correctional Health Care Litigation: A Snapshot

Five years, 359 lawsuits, and at least \$292 million in plaintiffs' awards paid by jails for deaths in custody. That's the financial bottom line of an examination of litigation conducted by a team of researchers at Georgetown Law Center's O'Neill Institute for National and Global Health Law. Funded by the U.S. Department of Justice, the study sought to update and expand on prior research concerning litigation against jails by identifying the types of deaths giving rise to lawsuits, as well as the patterns and characteristics of such litigation.

To obtain a broad snapshot of recent (2015-2020) litigation, Taleed El-Sabawi and colleagues analyzed a dataset created by text mining jury verdicts, settlements, and civil lawsuit dockets for monetary damages in cases filed by the estates of people who died in jail custody. The sample was extracted from three databases: LexisNexis's Jury Verdict and Settlement, Westlaw's Jury Verdicts and Settlements, and Westlaw's Dockets. Rather than examine all injuries that led to lawsuits, the study focused on deaths because they "represented some of the most egregious injuries and were more likely to result in greater exposure to liability."

JCHC Vol. 29, No. 4: August 2023

- COVID-19 Burden in Adult Correctional or Detention Facilities and the Surrounding Communities
- Compulsory Psychotropic Medication in the California State Prison System
- Targeted Approaches, Universalism, and Targeted Universalism: Opportunities for Correctional Health Care
- Assaults by Scalding in British Prisons
- Criminal Sexual Behavior of Individuals With Autism Spectrum Disorder and Recommendations for Correctional Professionals
- The Effect of a Group Physical Activity Program on Behavior of Incarcerated Youth
- Dying Inside: Litigation Patterns for Deaths in Jail Custody
- Reliance on Community Emergency Departments by People Ever Detained in Jail: Cross-Sectional Study
- Rethinking Jail Rehabilitation: Evaluating an Intensive Outpatient Program
- Access to Services for Pregnant People With Opioid Use Disorder in Jails in the United States

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.

Case Characteristics

The final sample contained 477 cases. Overall, 87% were filed in federal courts. Health care providers were named defendants in 58% of cases; this includes individual medical staff as well as health services entities and third-party providers. Correctional officers were named personally in at least 51% of cases.

Publicly available information concerning the outcomes was lacking in 24% of the cases, which means the sum cited at the start of this article underrepresents the actual amount paid to plaintiffs.

Of the remaining 359 cases, 72% ended in a settlement, 6% were jury verdicts for the plaintiff, and 22% were judgments or verdicts for the defense. Settlements ranged from \$4,000 to \$12,850,000, with a mean of \$1,376,816 and a median of \$575,000. Awards from jury verdicts ranged from \$119,000 to \$11,857,344, with a mean of \$3,397,908 and a median of \$1,600,000.

The median number of days between the date of arrest and death for all causes of death was five, ranging from one to 1,569 (the median varied depending on the underlying cause of death). Deaths occurred within the first 24 hours of custody in 23% of cases. The most common causes during the first 24 hours were suicide- or substance-related, including withdrawal and overdose, and suicides while undergoing withdrawal.

Cases that attributed the cause of death to an officer's use of force had the highest average plaintiff award, \$2,243,079. Yet the categories of cases involving withdrawal, physical illness, suicide, and officer use of force all included at least one case with an award greater than \$11.5 million.

Conclusions

The authors conclude that findings underscore the importance of reform efforts targeting the first 24 hours of custody; this includes proper screening of people at risk for suicide, overdose, withdrawal, or other medical issues; provision of medications for substance use disorder and mental health conditions; and evidence-based withdrawal management protocols.

They also propose the following measures to save public funds and improve health outcomes for people involved in the criminal justice system: diversion or deflection of people with mental health conditions and substance use disorders into appropriate treatment; clear protocols and training for staff and officers to better screen and address such conditions; and greater access to quality treatment for both behavioral and physical health needs. ●

Unconscious bias: Everyone has biases. However, when they are acted upon, either consciously or unconsciously, harm occurs, both on an individual and systems level. Unconscious bias training is often conducted to draw attention to biases and counteract their harmful effects.

Feedback received by the Committee overwhelmingly suggests that, in addition to or instead of such training, what is needed is an approach that aims to change the overall culture within the facility and throughout the correctional department. To aid in this culture change, it can be made clear, both during the hiring process and within the facility, that disrespectful, prejudiced, and racist behaviors, whether directed at staff or incarcerated individuals, will not be tolerated. Leadership buy-in and top-down modeling is essential for this to be effective.

Lack of data collection: The Committee has received overwhelming feedback on the need for data to be collected and analyzed in a way that will capture racial inequities in correctional health care. For example, research in the community suggests that racial disparities are common in the treatment of pain, with Black patients left undertreated relative to white patients; research also suggests that Black patients are disproportionately diagnosed with schizophrenia relative to white patients.

Disparities like those have very real consequences for patients and their well-being. Without facility- or system-specific data collection, however, we are left in the dark about racial and gender disparities in individual facilities and systems.

The Committee solicited recommendations on areas where such data collection would be valuable. Responses varied widely but included collecting data on mental health, health education, culturally competent communication, diagnoses, grievances, measures related to the workforce and leadership (including hiring and promotion decisions), and outcomes (including recidivism and disease course).

When asked how NCCHC can provide guidance on data collection, suggestions included providing education on valid, reliable data collection strategies and providing examples of best practices. It is important to note that both quantitative and qualitative data collection is valuable. After data is collected, education on what to do with the findings is needed.

What's Next?

To begin to tackle the complexities of systemic racism in correctional settings, listening and awareness are needed, as well as education on how racism impacts incarcerated individuals and facility staff. Above all, the feedback the Committee received reflects a clear need for culture change.

If you find yourself feeling uncomfortable or opposed to discussing this topic, it may be a sign that this work could be beneficial to you and those you work with. Having champions in leadership positions who are willing and able to speak out and lead the way can make all the difference. Listening is the first step toward acknowledgement, informed action, and change.

If you have suggestions on how the Committee can best support this work in the field, please join us at the NCCHC fall conference, where we will continue this essential dialogue. Letters to the editor are welcome at editor@ncchc.org. ●

Mary Muse, MSN, RN, CCHP-RN, CCHP-A, and Joel Andrade, PhD, CCHP-MH, are cochairs of the NCCHC Committee on Systemic Racism; Claire Wolfe, MPH, MA, CCHP, program manager, NCCHC Resources, is the committee staff liaison.

FOR MORE INFORMATION

NCCHC position statement on Addressing Systemic, Structural, and Institutional Racism in the Juvenile Legal System, 2023. [ncchc.org/position-statements](https://www.ncchc.org/position-statements)

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The treatment team should also include a registered dietitian, who can help investigate the reason for the food refusal, complete a thorough nutrition assessment, provide nutrition recommendations to the team, and identify the individual's risk for refeeding syndrome.

Refeeding Syndrome

The American Society for Parenteral and Enteral Nutrition defines refeeding syndrome as “a measurable reduction in levels of one or any combination of phosphorus, potassium, and/or magnesium, or the manifestation of thiamin deficiency, developing shortly (hours to days) after initiation of calorie provision to an individual who has been exposed to a substantial period of undernourishment.”

Individuals identified as being at risk for RFS should be regularly monitored per recommendations from the registered dietitian. Though recommendations will be tailored to the individual situation, they may include monitoring vital signs, labs, intake, weight trend, peripheral edema, and signs of thiamine deficiency and electrolyte imbalances (hypophosphatemia, hypokalemia, and hypomagnesemia). The patient should be started on dietary supplements and assessed for further dietary modifications.

RFS does not only happens when someone is receiving enteral or parenteral nutrition support. RFS can occur no matter the route of nourishment, including orally. Another common myth is that someone with a larger body mass index is not susceptible to RFS; that is not true.



Early warning signs of RFS include:

- Loss of appetite, GI discomfort
- Nausea, constipation, bloating
- Apathy, irritability, anxiety, depressed mood
- Headache, dizziness
- Drowsiness, impaired concentration
- Slow movements or weakness
- Decreased blood pressure and respiratory rates
- Muscle aches and pains
- Electrolyte effects

If the patient meets the diagnostic criteria for being in active RFS, he or she needs to be evaluated for further medical complications. Risks include congestive heart failure, seizures, coma, and death. The patient may require hospitalization.

Collaboration among health, mental health, and custody staff is always a best practice. With an issue as complex and high-stakes as hunger strikes and food refusals, it is imperative. ●

Ranee' Wright, MSN, APNP, CCHP-RN, CCHP-MH, advanced practice nurse; Melissa Mitchell, MSN, MHA, CCHP, director of nursing; Jennifer Wollert, BSN, RN, CCHP, nursing supervisor; and Jackie Havel, RDN, clinical dietitian, are with the Wisconsin Resource Center.

RELEVANT NCCHC STANDARD

Standard G-05 Informed Consent and Right to Refuse: Inmates have the right to make informed decisions regarding health care, including the right to refuse care.

NCCHC Standards for Health Services 2018

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Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP, and Robert Simon, MEd, CCHP

Who Participates in an OTP Survey?

Q A community vendor is providing opioid treatment services in our facility. Are health staff and custody staff required to participate or share responsibility for any part of the Opioid Treatment Program (OTP) accreditation process?

A Yes! While OTP accreditation focuses on opioid treatment services, the intent is the proper management of the entire correctional health care delivery system, including health services, custody, and the opioid treatment provider. Each plays a role in ensuring quality health care and working toward accreditation.

Health staff, including medical, dental, and mental health, will address the day-to-day and chronic health care needs as well as any medical emergencies that involve an OTP patient. Additionally, as health staff treat and care for OTP patients, they fall under the requirements included in Section C – Personnel and Training – of the *Standards for Opioid Treatment Programs in Correctional Facilities*.

Custody staff plays an integral role in ensuring the safety of all staff and patients. They facilitate movement, assist with diversion prevention, and monitor during suicide watches.

Telehealth for Mental Health Care Services

Q Our local mental health resources are limited. Is it possible to use telehealth services to meet accreditation standards regarding mental health?

A If done correctly, telehealth services, including mental health care, can help facilities meet their patients' health care needs, provide cost-effective care, and comply with various NCCHC standards, including but not limited to:

- Written, site-specific policies and procedures addressing telehealth services provided at the facility must be in place (Standard A-05 Policies and Procedures).
- All credentialing requirements must be in place as if the qualified mental health professional were on-site, including licensure verification and an inquiry of the National Practitioner Data Bank (Standard C-01 Credentials).
- Clinical performance enhancement reviews must be conducted annually (Standard C-02 Clinical Performance Enhancement).
- Licensure, certification, and registration requirements must be met for the state in which the mental health professionals practice (Standard C-01 Credentials).
- Consent for treatment – specifically treatment via telehealth services – must be obtained from the patient (Standard G-05 Informed Consent and Right to Refuse).

Details re: New Juvenile Standards

Q Where can I find details about what has changed in the 2022 *Standards for Health Services in Juvenile Detention and Confinement Facilities*?

A Go to the NCCHC website (ncchc.org) and find the Standards tab. At the bottom of the Juvenile Standards page, you will find a link to a detailed explanation of each change and new concept. Note: All surveys of juvenile facilities are now being conducted using the 2022 standards. ●

Wendy Habert, MBA, CCHP, is NCCHC's accreditation director for health services; Robert Simon, MEd, CCHP, is accreditation manager for Opioid Treatment Programs and mental health services. Send your standards-related questions to accreditation@ncchc.org.

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– CMO Pamela Rollings-Mazza, MD, BMedSci, BSN, RN, CCHP.

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BECOME AN NCCHC SURVEYOR

ACCREDITATION IS GROWING AND WE NEED TO GROW OUR TEAM. **JOIN AN ELITE TEAM:** NCCHC IS SEEKING GENERAL AND PHYSICIAN SURVEYORS (OTP AND HEALTH SERVICES).

- ✓ Learn from visiting a variety of correctional facilities around the country
- ✓ Mentor health care professionals on NCCHC standards
- ✓ Help raise the level of correctional health care quality nationally
- ✓ Contribute to the professionalism of the field
- ✓ Enjoy discounts on conference registration and *Standards* manuals
- ✓ Receive daily honoraria and travel per diems
- ✓ Be part of an extraordinary team

WHAT DO SURVEYORS DO?

NCCHC-trained surveyors conduct thorough evaluations of correctional health services. They measure a facility's compliance with NCCHC standards through assessment of patient health records, documentation, staff and patient interviews, and observation of processes. They are critical to assuring the credibility of NCCHC's accreditation program.

REQUIREMENTS

- ✓ Travel and attendance at one NCCHC conference per year (Spring or National)
- ✓ Participation in at least one survey per year
- ✓ At least five recent years of experience in correctional health care
- ✓ Current, unrestricted credentials for clinical roles
- ✓ Not affiliated with a health services vendor (due to conflicts of interest)
- ✓ CCHP certification or willing to obtain within one year



READY TO LEARN MORE?

Email us at accreditation@ncchc.org.



NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE

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