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CorrectCare®

The magazine of the National Commission on Correctional Health Care

The Evolution of Laws Governing Access to MAT in Corrections

Understanding
Microaggressions

Delusional Infestation

Preventing Type 2
Diabetes: An Evidence-
Based Approach



National Commission on Correctional Health Care
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Careers in Correctional Health Care Videos: View, Share, and Help Us Grow the Field

In its mission to promote careers in correctional health care, NCCHC and the NCCHC Foundation have produced two videos designed to introduce students and young professionals to the field. The videos feature a number of dynamic professionals discussing why they chose this work and why they find it rewarding.

The second, specifically about correctional nursing, was made possible through a generous individual donation from Deborah Shelton, PhD, RN, NE-BC, FAAN, CCHP. It was sent to nearly 1,000 nursing schools and has already received hundreds of views – and rave reviews.



“We hope everyone with a connection to an applicable college, university, or training program will make sure the videos are seen by the next generation of health care professionals,” says Deborah Ross, CCHP, NCCHC’s CEO. “We encourage everyone in the field to share on your individual and corporate social media and forward to your alumni network, universities, and schools.”

These are the first two in a series of four. The next videos will feature correctional physicians and mental

health professionals. Stay tuned!

View the videos on the NCCHC website or YouTube channel: youtube.com/NCCHC.

Position Statement Promotes Anti-Racism

NCCHC’s newest position statement, Anti-Racism in Correctional Health Care, outlines concrete steps correctional health professionals, administrators, and decision-makers can take to mitigate systemic racism and its effects on the incarcerated population – disproportionately people of color – and correctional staff.

The statement calls on facilities to support anti-racism work in correctional health care settings and to recognize and combat the detrimental and traumatizing effects that systemic and other forms of racism have on incarcerated individuals and those working within correctional systems. It follows an earlier statement on Addressing Systemic, Structural, and Institutional Racism in the Juvenile Legal System, adopted in 2023.

Learn more at ncchc.org/position-statements.



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NCCHC Foundation Is Expanding

Julie Haugland has joined the NCCHC Foundation as fundraising manager. She brings to the role more than 25 years of nonprofit expertise and engagement in philanthropy, fundraising, and sales.



Julie Haugland

NCCHC Mourns Correctional Health Legends



Ken Bennett

Ken Bennett, CCHP, longtime lead surveyor and winner of the 2023 Surveyor of the Year Award. Mr. Bennett had a distinguished career with the Idaho Department of Corrections.

Jim Voisard, CCHP-A, NCCHC Resources consultant, lead surveyor, member of the first CCHP “graduating class” in 1991, and the 2020 Bernard P. Harrison Award of Merit recipient.



Jim Voisard

Advocating for Our Patients

By Elizabeth Lowenhaupt, MD, CCHP

The resilience demonstrated by our patients constantly reminds me of why we must work so hard for them. They have experienced trauma, psychosocial adversity, personal and family mental illness, systemic racism, and more. While they are under our care, we are responsible for ensuring they have access to every possible treatment option that will allow them not only to tolerate their period of confinement, but also to grow, thrive, and develop new skills and strategies for taking on the world in healthy and dignified ways when they leave.

But we need to do more. As experts in the field, we possess a unique understanding of patient needs, legal processes, and systems. We understand the ramifications of the legal system, accept our patients' right to treatment without judgment, and set appropriate limits and boundaries when needed. We must use our experience and expertise to advocate for better quality of life for our patients, both inside and outside the walls.

NCCHC recently released a position statement, Anti-Racism in Correctional Health Care, that highlights the impact of racism and recommends steps to mitigate its impact in corrections and on our patients. Access to high quality health care is a basic human right for all people but, too often, that access depends on individual, family, and community factors that are influenced by systemic, structural, and institutional racism. Addressing racism remains an important focus for the organization.

Outside the Walls: Juvenile Reentry

As Board chair, I have chosen juvenile reentry as a related priority area. As we work to ensure our patients receive the best possible services while incarcerated – mental, dental, nursing, legal, educational, vocational, and more – we must also be thinking about how to extend those services before and after the period of confinement.

Over the past few years, I have had the privilege of developing the HOPE for Justice (Hasbro Outpatient Psychiatric Evaluations for Justice-Involved and At-Risk Youth) Clinic to expand psychiatric treatment for youth involved in the juvenile legal and child welfare systems across a continuum of community-based and residential treatment settings. The opportunity to work with patients and their families as they return home to the community following a period of incarceration, and also to offer treatment and services that may allow them to avoid presenting to a carceral setting in the first place, has been incredibly rewarding but also challenging in the face of numerous systemic barriers.

As correctional health professionals, we must support and inform system transformation outside the walls. Ideas we might consider include the development of transition clinics for patients leaving correctional settings, efforts to reduce barriers around health care funding such as the Medicaid Reentry Act, and consultation for our probation and judicial colleagues around health care needs of formerly incarcerated patients in the community.

Thank you for your commitment to our field and to our patients. ●



Elizabeth Lowenhaupt, MD, CCHP, is the 2024 chair of NCCHC's Governance Board and board liaison of the American Academy of Child and Adolescent Psychiatry.

At a Glance: Meet Elizabeth Lowenhaupt

Career Highlights

- Consulting medical and psychiatric director, Rhode Island Training School
- Associate professor, departments of pediatrics and psychiatry and human behavior, Warren Alpert School of Medicine at Brown University
- Founder and director, HOPE for Justice (Hasbro Outpatient Psychiatric Evaluations for Justice-Involved and At-Risk Youth) Clinic

NCCHC Positions

- Board of Representatives, 2016-present
- Chair, Juvenile Health Committee, 2018-2023
- Juvenile standards revision task force, 2020-2022

Education

- Combined residency training in pediatrics, psychiatry, and child and adolescent psychiatry, Warren Alpert School of Medicine at Brown University
- Doctor of Medicine, University of Missouri School of Medicine
- Bachelor of Arts, Harvard University
- Triple board-certified in pediatrics, psychiatry, and child and adolescent psychiatry

Other

- Co-chair, Children and the Law Committee, AACAP

Understanding Microaggressions

By Danotra McBride, CCHP

As a woman of color, I can attest to the negative impact microaggressions cause, both inside and outside the workplace. It has been healing to raise my own awareness of microaggressions and similar situations that rob me of my humanity. Finding ways to identify them, call them out, and educate others helps to not let those negative occurrences overshadow the positive experiences that also occur every day.

What Is a Microaggression?

Microaggressions are subtle, harmful words or actions toward a person that discriminate, belittle, and marginalize the person based on personal characteristics such as race, gender, age, stature/size, ability, or sexual orientation. A microaggression can be in the form of a comment, behavior, action, or reaction that is generally rooted in implicit or explicit bias, stereotypes, or prejudicial beliefs. That can be as simple as a comment in passing about someone's weight or diet or an assumption about another person's experience or ability based on how they look. A microaggression can be intentional or accidental.

For some people, being on the receiving end of microaggressions is a daily phenomenon, which can be traumatizing and deeply affect their psyche. I've likened the experience to swallowing a small pebble each time it occurs. That can seem like an easy task initially, but as time goes on, you carry the growing weight as you move through your days, weeks, months, and years. Eventually, those pebbles add up and before you know it, you have a belly full of rocks.

As a recipient of microaggressions, I haven't always realized the impact these situations have on my sense of humanness, since out of survival and protection I would often numb myself to what occurred or how I felt in order to plow forward and continue functioning. I'd often wonder why I minimized my participation in meetings or shrank in the face of opportunity when I knew I had the necessary expertise. I often experience physical reactions when targeted by microaggressions along with feeling distrustful, devalued, and less human.

For context, I am a middle-aged Black woman who has worked in correctional health care for more than 20 years. Although I consider it an honor to serve others, I also often feel conflicted working in a field that systematically locks up people of color like me at disproportionate rates. As I listen to the stories of those who are detained, I often hear similarities between their experiences in the world and my own. For example, when people clutch their purse as

you walk by, or you overhear a racist or sexist joke, or someone comments about your hair, your perception of yourself in the world changes.

In response, I've worked extremely hard to eradicate the negative stereotypes against Black women – by working harder and longer to prove my worth, by being observant to anticipate the needs of others or to be steps ahead, by being overly positive and kind even when I'm upset so as to not fall into the “angry Black woman” category. All of those efforts to change other people's assumptions about an entire race or culture have required an exhausting level of code-switching, that is, adjusting my social behaviors, language, and appearance to fit into the dominant (white) culture and not be perceived as a threat.

I've also regularly faced judgment about my experience and intelligence, even including assumptions about my title and position. People often assume I am the assistant to the director and not the actual director based on how I look and my unique name. In meetings, my ideas and recommendations are ignored when I voice them, only to somehow be heard and accepted when someone who is not a person of color (and often a man) repeats them.

As a Black woman, I have a long history of personal experiences with my hair. Shortly after having my first child, I decided to stop chemically relaxing my hair and to accept and embrace my full self to be a good role model for my daughter. I began to wear my natural kinky, curly, textured hair in twists, puffs, or an afro.

The first time I revealed my natural coif at work I was scared, self-conscious, and unsure of how people would react. I remember worrying the entire weekend before about what reactions and responses I might get knowing I would no longer have my straight, simple, chemically relaxed hair. In the meetings that followed, I was aware of stares and glares, people initially looking at my face but then quickly moving their eyes up toward my hair in wonder and curiosity.

I felt myself shrink. I didn't want attention on my physical appearance, even though it felt so free and wonderful just to wear the hair that naturally grew out of my scalp! Interactions after the meetings included questions like “Did you get a haircut?” from people who had no clue what hair shrinkage was. Other comments like “Can I touch your hair?” were so embarrassing that the next day I braided



it up just to avoid further ridicule and attention. I don't believe that people were intending to target or embarrass me, but the "othering" I felt made it difficult to show up comfortably with my natural hair after that.

More Pebbles

On another occasion, I was working on a team to manage and coordinate complex documentation requests. I am a proud nerd: I pride myself on my ability to take complex information and break it down into simpler, smaller components for processing. The work suited me well and I had a long and trusting relationship with most of the team. At the end of one working session, a new team member, a white man, had a concerned expression on his face. He turned to me, the only person of color in the room, and asked, "Before we leave, did you get all of that, Danotra?" I was angry and mortified. I'm sure he thought he was supporting me, but the only thought I could process was, "Why is he directing his confusion and concern toward me? Why am I being singled out as the one who may not understand this?" As the blood rushed to my face before I could speak, another white male colleague who I've worked with for many years placed his hand on the newcomer's shoulder, softly shook his head, and reassured him, "Believe me, she's got it." It was such a relief to not have to defend myself in that moment! After the meeting, the colleague who defended me apologized for what took place and shared his appreciation for me and the work I do. That was one of my first experiences of white allyship.

Even though this example may seem slight to some and could be interpreted in different ways, I want to highlight that it felt like a slap in the face to me, the only person of color in the room, who had received many accolades for my expertise in this area, to be further singled out from the group and essentially "othered," and for it to be assumed that I needed him to check in about whether I understood what was going on. That experience was infuriating and devastating, but in the moment I felt there was nothing I could do except swallow another pebble, adding to the pile.

Although many people aren't aware of their own biases that play into microaggressions, the impact of those statements and the stains of trauma left behind can ruin relationships and create a workplace environment that is not emotionally or mentally safe or healthy.

As you think about microaggressions in the context of correctional health, it's important to know that people of color are incarcerated at disproportionately high rates; they bring these same traumas and experiences with them into your facilities and expect similar (or worse) experiences while incarcerated. That results in an automatic lack of trust, which can show up in different behaviors, reactions, lack of engagement in care, or acceptance of help. The lack of humanity and humanness that occurs in the criminal-

legal system is already detrimental, and as you layer in the prejudices, judgments, and interactions that occur while incarcerated, humanity is further diminished.

Key question to ask yourself: How are you intentional about not committing microaggressions against your staff and patients? How are you creating and maintaining a professional environment and relationships based in humanness and respect to interrupt the psychological damage that microaggressions create? Being mindful about those opportunities is critical to avoiding further trauma and causing harm to those who bring a history of traumatic experiences with them.

Self Work

Here are some suggestions to intentionally work toward not committing microaggressions.

- Be intentional; hold the intent of desiring not to harm or offend others.
- Remain self-aware, understand your blind spots and biases, and remain conscious of what you say and do. Think before you speak/act.
- Let go of "Like Me" bias; don't assume everyone else is or should be like you.
- Don't ask anyone to represent an entire community or culture. Don't ask your Black coworker to explain things about "Black culture" or "the Black community" for you.
- Create a sense of belonging: embrace and celebrate differences, center equity and anti-racism, be accommodating to the needs of others.
- Be inclusive: include different people, positions, abilities, etc., whenever possible in an effort to leverage a variety of perspectives; think, plan, and act collectively.
- Confirm the value that others provide. Affirm and give credit for original contributors, not just those who repeat an idea or recommendation; show gratitude for others' contributions.
- If accused of a microaggression, be humble and curious. This is not a time to get defensive, but an opportunity to learn and do better.

Finally, I encourage you to engage in self-work to deepen your understanding and awareness so you can interrupt behaviors that harm others. ●

Danotra McBride, CCHP, is the director for Jail Health Services for Public Health – Seattle & King County and a member of the NCCHC Committee on Systemic Racism.



Illustration © Maria_Petrishina/Shutterstock

The Evolution of Laws Governing Access to MAT in Corrections



By Deana Johnson, JD

As the United States' opioid epidemic has worsened over the past decades, the medical understanding of addiction as a progressive disease has grown, along with scientific evidence that medication-assisted treatment is the most effective route to recovery for individuals with opioid use disorder. Given the preponderance of incarcerated people with opioid use disorders, there is a growing understanding that correctional facilities present a unique opportunity to offer those individuals, literally a "captive audience," this gold-standard treatment.

In legal cases about access to MAT behind bars, however, the courts' decisions continue to be split, which deprives litigants of clear direction as to their rights, despite undisputable evidence that MAT works. It also breeds more litigation, as each case turns on very specific factual scenarios.

Even today, many jails do not provide MAT at all, or only to people who already have a prescription when they enter the system. The long-standing arguments continue to prevail: introducing MAT in correctional settings poses too great a security risk; patients should be able to maintain sobriety with "willpower"; MAT replaces one addictive drug with another; and access to addictive substances, even prescription drugs, increases the risk of relapse and

overdose for those with OUD. Despite evidence that the traditional correctional outlook on MAT creates negative consequences for individuals both during incarceration and postrelease, consistent case law still lags behind.

First Steps

On the federal level, legislative action has driven policy change. In 2018, Congress directed the Federal Bureau of Prisons to review and revise its MAT guidelines as part of the First Step Act. Specifically, the U.S. Attorney General was instructed to review existing recidivism reduction programs, including substance abuse initiatives, in both federal and state prisons. The AG was authorized to direct the FBOP to make policy changes relating to MAT as needed. As a result, the FBOP updated MAT policies to better align with the existing medical standard of care for OUD treatment.

Congress cannot direct similar changes on the state level, however; it is up to each state whether to use legislative authority to mandate access to treatment. A few states, including New York and Colorado, have passed legislation mandating that jails offer MAT to those patients for whom it is medically necessary.

New York's mandate, passed in 2021, requires continuation of treatment plus screening for and initiation of MAT, as deemed medically necessary, for those who had not begun treatment prior to incarceration. This treatment must continue throughout the length of incarceration if medically necessary.

In 2022, soon after the New York law passed, a group of pretrial detainees entering into a New York county jail sued, seeking class certification and immediate injunctive relief requiring continuation of their existing MAT prescriptions. Citing the New York law mandating MAT, the federal district court found the plaintiffs had a likelihood of success on the merits of their claims and granted the requested injunctive relief (*M.C. v. Jefferson County*, 2022). The court concluded that denying their medications would likely be found to violate both the Constitution and the Americans with Disabilities Act (ADA).

That result, however, is an outlier. In similar cases in other states, the vast majority of which do not have statutes requiring MAT in state prisons or local jails, courts have to find other legal bases for analyzing whether the plaintiffs have a right to MAT while incarcerated. The two main legal theories argued to date are those cited in *M.C. v. Jefferson County*, above: the ADA, and the constitutional right to adequate health care based on the Eighth and 14th amendments to the U.S. Constitution (aka the "deliberate indifference" standard).

ADA Claims

To prove an ADA claim, three elements of proof are required:

- A qualified individual with a disability
- A defendant that is subject to the ADA
- A plaintiff who was denied an opportunity to participate in or benefit from services, programs, or activities or otherwise discriminated against because of a disability

The first two elements are met when a person with OUD is incarcerated: OUD is a disability, and jails and prisons are subject to ADA regulations. Thus, most ADA challenges to the availability of MAT in corrections argue that refusal to provide the medications denies meaningful access to health care services or discriminates against those with OUD because of their disease.

ADA claims relating to the availability of MAT have had mixed results. One differentiator is whether the correctional system has a blanket prohibition on MAT or whether the policy allows for a case-by-case determination, even if historically MAT is rarely or never prescribed.

A blanket prohibition can be sufficient evidence of discrimination against those with OUD to make a plausible ADA claim: as concluded in an OUD case from 2018, "Medical decisions that rest on stereotypes about the disabled rather than 'an individualized inquiry into the patient's condition' may be considered discriminatory" (*Pesce v. Essex County*, 2018).

Deliberate Indifference Claims

Deliberate indifference claims relating to unavailability of MAT in corrections require the following elements of proof:

- OUD is a serious medical need.
- The defendant (state or local system) has subjective knowledge of a substantial risk of serious harm if the medical need is not met.
- The defendant acted unreasonably despite knowledge of obvious risks of refusing to make MAT available.

There is little debate in the court decisions as to the first element: OUD is a serious medical need.

As to the second element regarding subjective knowledge of a substantial risk of serious harm to an individual if their OUD medical needs are not met, while earlier cases were split, that is no longer the trend. Recent case rulings have tended to agree that the second element of proof is met.

Still, courts disagree as to the final element: what care decisions are reasonable in light of the current scientific information as to the benefits of MAT?

Ongoing Questions

In *Quintana v. Santa Fe County* (2020), a case examining the actions of security staff in relation to the death of a jail inmate from acute heroin withdrawal after not receiving MAT, both the lower and appellate courts ruled that to a security layperson, frequent vomiting is not an obvious risk of severe withdrawal but bloody vomiting is. Medical staff have been held to a higher standard of knowledge about the risks of withdrawal, with the 7th Circuit Court of Appeals finding back in 2005 that a nurse should have known that severe delirium evidenced potentially deadly withdrawal symptoms and failure to treat the condition, which led to the inmate's death, constituted deliberate indifference (*Foelker v. Outagamie County*, 2005).

One of the older arguments, that prescribing medication to treat the side effects from withdrawal rather than MAT is reasonable and therefore meets the constitutional standard, was soundly rejected by a district court in a recent deliberate indifference case in New Mexico (*DeVargas v. Santa Fe County*, 2021). The case involved a pretrial detainee who, in the midst of withdrawal, obtained nonprescribed Suboxone®, injected it with a dirty needle, and developed a deadly infection as a result. The Court's ruling for the plaintiff was based on the important distinction that treating the symptoms of withdrawal is not the same as treating OUD with the use of opioid-based medications.

Another compelling component of the DeVargas case is that the county planning commission recognized the need for use of both Suboxone and methadone to treat pretrial detainees at the Santa Fe jail and informed the county sheriff that offering nonopioid-based medications was insufficient. Despite the recommendations, the

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The Many Benefits of Accreditation

Photo © Nach_Noth/Shutterstock

By Thomas J. Weber, JD, and Tommy Williams, BSN, RN, CCHP

For almost 50 years, the National Commission on Correctional Health Care has been dedicated to improving the quality of correctional health care services through the implementation of their health care standards in correctional facilities across the United States. NCCHC's standards are widely regarded as the most thorough and stringent correctional health care standards available and have been upheld as such by the courts in legal cases. NCCHC accreditation, based on those standards, helps correctional facilities improve their health care systems and is recognized as an important endorsement of a facility's health services.

While accreditation is voluntary, we feel it is essential. We strongly encourage facilities that use our health care services to become accredited, because evidence indicates it improves the quality of care provided, as well as the quality of health care programs, services, and operations. Even in facilities that are not accredited, we operate consistent with the current NCCHC standards to maintain consistency of training and service delivery.

Adherence to Health Care Standards

The most obvious advantage of accreditation is that it verifies compliance with NCCHC's nationally recognized standards. Developed by a multidisciplinary group of correctional health care experts, these standards outline recommendations for managing medical and mental health care delivery in jails, prisons, and juvenile facilities. Specially selected task forces regularly review and revise the standards to reflect changes in the field and the latest understanding of best practices.

The standards establish a structured operational framework for the proper management of our correctional health

services delivery system. Often based on the latest research and evidence-based practices, they help ensure that the most current and effective treatments and interventions are utilized, and they allow our health care professionals to measure their performance and make improvements to the care they provide. We have found clear guidelines and protocols facilitate better communication and collaboration between health care professionals. Disparities in health care are also addressed by promoting equitable access and cultural competence.

Covering a wide range of both clinical and operational aspects of health care delivery, each standard is categorized as either essential or important. To earn accreditation, a facility must demonstrate compliance with 100% of applicable essential standards and at least 85% of applicable important standards.

Compliance plays a crucial role in improving the quality of care and can lead to better patient outcomes. We have found consistent application reduces variability, thus minimizing errors, while efficient processes lead to quicker diagnoses. Patient safety also is promoted by establishing policies and procedures for infection control, medication administration, suicide prevention, emergency preparedness, and more, reducing the risk of medical errors and adverse events. The standards facilitate interoperability in health information technology, streamline administrative processes, and foster accountability.

For each individual standard (more than 50 in all), compliance indicators spell out how to meet the standard, allowing for flexibility that can be adapted to each correctional facility. (See the sidebar on the next page for more information on the various types of standards and accreditation.)

Liability and Litigation Protection

We find that accreditation helps our facilities follow legal and regulatory requirements related to health care, and adherence to the NCCHC standards reduces the risk of health care-related lawsuits and legal challenges.

In the event of a legal challenge, being accredited by NCCHC is a valuable asset as it demonstrates a proactive commitment to an objective standard of care, which can be used to defend against claims of inadequate or negligent care. Voluntary compliance with NCCHC's standards indicates to government officials and the courts a facility's understanding of the legal requirements of correctional health care. The courts know that an accredited facility has undergone a rigorous evaluation by an independent, third-party organization and view that as evidence of a commitment to providing quality health care services in compliance with legal requirements and federal, state, and local laws and regulations.

Enhanced Safety

In our experience, we have found that accreditation contributes to a safer environment within correctional facilities by creating an overall culture of safety and in several concrete ways (Standard B-08 Patient Safety).

Access to care is emphasized, helping to ensure the prompt receipt of medical attention that can prevent minor health issues from becoming more serious and reduce the risk of complications and emergencies. Access to care is, in fact, the basic principle established by the U.S. Supreme Court in the 1976 landmark case *Estelle v. Gamble* and the fundamental principle on which all NCCHC standards are based (Standard A-01 Access to Care).

The standards require the provision of mental health services and care, which can identify and address issues that may lead to disruptive or violent behavior. Incarcerated individuals who receive proper care are less likely to engage in violent behavior due to untreated mental health issues (Standards E-05 Mental Health Screening and Evaluation, F-03 Mental Health Services).

Accredited facilities are expected to have a comprehensive institutional program in place that addresses surveillance, prevention, and control of communicable disease to prevent the spread of illness among the incarcerated population and staff (B-02 Infectious Disease Prevention and Control). Medication management, including medication administration, storage, and record keeping, promotes the correct and safe use of medications, preventing adverse reactions, complications, and misuse (Standards C-05 Medication Administration Training, D-02 Medication Services). All of this leads to a safer, more well-managed facility.

Quality Assurance

Continuous quality improvement is a systematic process designed to ensure health care services consistently meet established quality standards, requirements, and

expectations. CQI focuses on preventing errors and deficiencies rather than detecting and correcting them after they occur.

For example, CQI has minimized medication errors in our facilities. Regular audits and reviews allow us to identify errors and trends. When an error occurs, a root cause analysis is conducted to understand why the error happened. Based on those findings, we can then implement effective corrective measures.

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Three Types of Accreditation

NCCHC offers three types of accreditation:

Health services accreditation for jails, prisons, or juvenile facilities is based on the NCCHC *Standards for Health Services*, which come in separate manuals for jails, prisons, and juvenile detention and confinement facilities. Accreditation requires compliance with standards in several areas:

- Governance and Administration
- Health Promotion, Safety, and Disease Prevention
- Personnel and Training
- Ancillary Health Care Services
- Patient Care and Treatment
- Special Needs and Services
- Medical-Legal Issues

Mental health services accreditation is based on NCCHC's *Standards for Mental Health Services in Correctional Facilities*. These standards parallel those of health services but make more explicit what the standards require for delivery of mental health services.

Opioid Treatment Program accreditation uses as its foundation the NCCHC *Standards for Opioid Treatment Programs in Correctional Facilities*, which are based on the latest federal regulations. By federal law, a corrections-based OTP must obtain certification from SAMHSA, an agency of the U.S. Department of Health and Human Services; to become certified, the OTP first must be accredited by a federally approved body. NCCHC is the only approved body specializing in corrections.

Accreditation may be pursued individually or in any combination. Facilities that attain all three types of accreditation earn NCCHC's Pinnacle Recognition, the highest honor in correctional health care.



Preventing Type 2 Diabetes in the Correctional Setting: An Evidence-Based Approach

By Angela Bowen, JD, MPA, Chrisanne Wilks, PhD, MPA, Pamela Geis, Linda Follenweider, MS, APRN, and Julie White, MSW, CCHP

As correctional health care professionals, an important part of your job is caring for patients' chronic diseases and educating them on how to manage those conditions. Another critical step in improving health outcomes is providing services that help incarcerated individuals prevent the onset of common chronic diseases such as type 2 diabetes.

Diabetes prevention training gives patients the opportunity to focus on skills that will support long-term health while also preventing associated health complications and expenses. One strategy that has been shown to be effective in correctional settings is the Centers for Disease Control and Prevention's National Diabetes Prevention Program (National DPP) lifestyle change program.

About the Program

The National DPP lifestyle change program is a yearlong evidence-based program developed by the CDC, in which participants meet for 22 sessions in a group setting with a trained lifestyle coach to learn how they can reduce their risk of developing type 2 diabetes. Participants are taught practical steps to increase physical activity, make healthier food choices, and reduce stress. The curriculum is designed to promote weight loss, lower A1C levels, and improve other cardiometabolic outcomes. During the program, participants are expected to lose 5–7% of their weight and engage in physical activity for 150 minutes per week.

The program began as a 27-center randomized clinical trial across the U.S. between 1996 and 2001 and now has

a 21-year follow-up study supporting its effectiveness. Implemented in many different settings and among diverse populations, it has been proven to reduce the risk of developing type 2 diabetes by 58% in people with prediabetes, a serious health condition in which blood sugar levels are higher than normal, but not yet high enough to be diagnosed as diabetes. (The risk reduction goes up to 71% in people over the age of 61.)

It is estimated that more than one in every three individuals in the United States has prediabetes, and individuals who are at higher risk of developing type 2 diabetes are overrepresented in correctional settings. According to the CDC, without making lifestyle changes many people with prediabetes will develop diabetes within five years.

To date there have been two successful implementations of the National DPP lifestyle change program in correctional settings. The first was a study published in 2019 in which 47 people from a federal correctional facility participated in a modified version of the program. Participants who completed the program demonstrated significant reductions in their body mass index and A1C levels. Weight loss in the study was similar to that typically achieved by National DPP lifestyle change program participants in the community. The second successful implementation is ongoing within the Wisconsin Department of Corrections.

Spotlight: Wisconsin Department of Corrections

The Wisconsin DOC has offered the National DPP lifestyle change program in three facilities – the Oshkosh,



Photo © Satyrenko/Shutterstock

Redgranite, and Fox Lake correctional institutions – confirming that the program can work in a real-life setting.

The curriculum is designed to be taught by anyone interested in becoming certified as a lifestyle coach; clinician status is not required. In the Wisconsin facilities, 19 custody sergeants and recreational therapists who were enthusiastic about wellness volunteered to be trained and certified. The program is overseen by the National Diabetes Prevention Program state quality specialist in the State of Wisconsin's Division of Public Health.

To date, 131 individuals across the three Wisconsin facilities have participated in the program. Of those, 84% were Black and 16% were white; 100% were male; average age was 45.6 years; and 58% were eligible for the program based on blood test results.

The results were overwhelmingly positive: participants lost an average of 8.3% of their body weight, well above the program goal of 5–7% weight loss. Some reported that they shared what they learned in the program with their families. And the sergeants who became lifestyle coaches reported increased job satisfaction because of their new role.

The Wisconsin DOC plans to scale the National DPP lifestyle change program to all appropriate facilities in the future.

Lessons Learned and Application to Other States

Other states could likely replicate or modify Wisconsin's approach to fit their unique needs. For others considering going that route, Wisconsin's experience offers these lessons learned.

Educate leadership and obtain buy-in. Support from the medical director of the Wisconsin DOC Bureau of Health Services was critical to implementing the program, as was assistance of the director of nursing and the warden at each facility. Without their support, the program could not have been successfully implemented.

Identify at least one high-level person to champion the program. The ideal person for this role recognizes the programs' value, can articulate the case for implementation to leadership, and is willing to shepherd the process from conceptualization to implementation and through evaluation of the first cohort. In Wisconsin, that person was the National DPP state quality specialist at the Division of Public Health, who championed the program and has served as the coordinator since the program's inception.

Be aware of the time commitment. The Wisconsin DOC has estimates that it takes approximately 65–70 hours per lifestyle coach to prepare and deliver the program and conduct data entry for a one-year cohort.

Obtain necessary CDC approval. To provide the program, the Wisconsin DOC needed to meet CDC requirements to become a CDC-recognized organization.

Adapt the program to meet individual situations. States vary in how they fund and deliver health care in correctional settings. For some, Wisconsin's model may not be feasible or politically viable. For a discussion of alternative ways the program could be applied, see the white paper "Implementing the National Diabetes Prevention Program Lifestyle Change Program in Correctional Settings." ●

FOR MORE INFORMATION

National Diabetes Prevention Program Coverage Toolkit:
coveragetoolkit.org

Implementing the National Diabetes Prevention Program Lifestyle Change Program in Correctional Settings, HMA white paper:
healthmanagement.com/insights

Angela Bowen, JD, MPA, Chrisanne Wilks, PhD, MPA, Linda Follenweider, MS, APRN, and Julie White, MSW, CCHP, are with HMA, a health care consulting firm that supports payer coverage of the National DPP lifestyle change program. Pamela Geis is the diabetes program coordinator and National Diabetes Prevention Program state quality specialist in the State of Wisconsin's Division of Public Health. The authors and contributors perform funded work to expand the National Diabetes Prevention Program nationally.

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Is Your Patient Infested With “Invisible Bugs”?

by Alexandra Mendelson, Taisuke Sato, and Alysse Wurcel, MD, MS

Delusional infestation is a disorder in which individuals have a fixed, false belief that they are infested with bugs, parasites, bacteria, worms, fungi, mites, or other living things against all medical evidence. The condition, sometimes called “delusional parasitosis,” Ekbom syndrome, or parasitophobia, is classified by both the DSM-5 and ICD-10 as a delusional disorder.

Patients with delusional infestation usually present with itching and scratches on the skin, insisting they are infected with bugs. The condition can occur as a primary disorder or as secondary to another psychiatric or medical condition. While the disorder is considered to be rare, delusional infestation disproportionately affects individuals who are socially isolated, those who have psychiatric illness, and those with substance use disorder — all populations widely represented within corrections.

It is crucial to address delusional infestation because the disorder can result not only in intense distress and discomfort but, left untreated, often leads to self-inflicted skin lesions, infections, and complications from repeated attempts to remove imagined infestations.

Distressing in any setting, delusional infestation is especially challenging in corrections, where the symptoms can intensify agitation and heighten the risk of violence or altercations. Claims of infestations can also incite panic or create false health crises in densely populated facilities.

Stigmatization can exacerbate the symptoms and delay proper care. When symptoms are dismissed as attention-seeking behavior, the patient might be isolated from the general population, further jeopardizing health and well-being. Early recognition and treatment of delusional infestation by correctional health care professionals can prevent distress and promote the well-being of the individual patient, other incarcerated people, and staff.

Diagnosing a Patient With Infestation Symptoms

Keep in mind that a patient’s sensation of “bugs” is not necessarily a delusion. It’s essential that health care professionals are not neglectful or dismissive toward delusional infestation patients. A full medical and infectious diseases workup should be completed to rule out an underlying medical condition or an actual infestation.

- Ask the patient about recent travel and any exposure to an infected individual or infested environment.
- Perform a dermatological exam to assess for characteristic lesions of scabies, bedbugs, or other insects. A delusional infestation can occur after a true infection has cleared; the absence of a current infestation does not mean that the person was never infested.

- Complete blood work including a CBC with differential (looking for eosinophils, a parasitic infection) and liver tests (looking for liver-related causes of itchiness). Screen for thyroid disease, diabetes mellitus, syphilis, and HIV, as well as common nutritional deficiencies: vitamin B12, niacin, and folate deficiency.
- Ask whether the patient has started any new medications coinciding with the onset of symptoms, which may be a medication side effect.
- Screen for recent substance use or withdrawal.
- Approach the patient with cultural sensitivity. In certain parts of the world, parasitosis can be a genuine concern; that fear can manifest as delusional infestation, especially under the stress of incarceration.
- Evaluate any possible underlying psychiatric disorders such as schizophrenia, mood disorders, or dementia. Treatment for those conditions may be different than for primary delusional infestation, requiring mood stabilizers or a neurologic evaluation, for example.
- Be aware of other indicators of delusional infestation. In addition to scratching and itching, those include frequently requesting medical attention, obsessively cleaning or disinfecting personal areas, and avoiding communal facilities due to fear of spreading or contracting an infestation.

Treating Delusional Infestation

Once diagnosed, treatment requires consultations across multiple specialty services, including infectious disease, dermatology, and psychiatry.

For infectious disease specialists, the focus is on ruling out actual infectious causes, such as scabies and avian mite-induced dermatitis, and managing related symptoms.

Dermatologists are pivotal in addressing the cutaneous manifestations, differentiating delusional infestation from conditions like intense excoriation found in other skin disorders, and evaluating potential environmental exposures to chemical irritants and fiberglass.

If the patient is willing, antipsychotics are often the first-line treatment. Second-generation antipsychotics are generally preferred over first-generation for their side effect profile. Risperidone is the best-studied medication for delusional infestation, but aripiprazole, quetiapine, and olanzapine have also been successfully used in published case reports.

Empathetic care is the most effective way to ensure a strong therapeutic relationship and to encourage patient engagement in pharmacological treatment and follow-up

continued on page 21



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Standards Training/CCHP Testing Hits the Road

Did you know that NCCHC offers a review session on the NCCHC standards and administers the CCHP exam on-site for interested organizations? Here, two clients share their recent experiences and discuss how this convenient, personalized approach to training and testing is helping them reach their goals.

Rhode Island Department of Corrections

Who 68 RIDOC health care professionals

What On-site NCCHC standards review/training by an NCCHC educator, followed by on-site CCHP exams

Where RIDOC training and conference center

When Two review days (one during day shift, one during 3-11 pm shift); two testing dates (one during day shift, one during evening shift)

How The idea came to Assistant Medical Director Kimberly Kane, APRN-BC, CCHP-CP, CCHP-RN, and HSA Leslie Bridgman JD, MA, CCHP, when they attended a preconference seminar on the standards at an NCCHC conference, just as they were in the beginning phases of thinking about seeking accreditation for health services. "It was evident that it would be valuable for all staff to learn the standards directly from NCCHC, and the best way to do that, from a logistics, cost, and buy-in perspective, was to host it on-site," says Kane. "We had begun paying for staff to take the CCHP exam the year before and had 26 people certified, so it was clear that interest was high."

Why "To bring excitement, awareness, and momentum to our accreditation vision," Kane says. "NCCHC standards are written into every policy and guide our overall delivery of care. Our goal is to become accredited for health services, and the best way to get there is to have everyone on board. This event was a huge step in the right direction for us."

Help and advice Kane suggests:

- Schedule more than one day to allow more staff to attend.
- Incentivize staff participation through stipends and paid time off to attend the review session and test.
- Provide a standards book for each participant, with plenty of time for review/study.
- Consider offering specialty exams as well as the basic exam; NCCHC can provide prerecorded specialty-specific review sessions for those exams.

What next? RIDOC now asks new employees to take the CCHP exam within six months of being hired – and foots the bill. Leadership is also looking forward to innovative ways to continue integrating standards into practice and supporting staff with on-site continuing education.

NaphCare Corporate Headquarters, Birmingham, AL

Who 26 NaphCare employees from the TechCare technology team and the STATCare team, which includes nurse practitioners who provide 24/7 telehealth services

What On-site NCCHC standards review/training by an NCCHC educator, followed by on-site CCHP exams

Where NaphCare's corporate training hub

When Training and testing were split up over two days, one team per day

How "NaphCare supports and encourages clinical staff to participate in NCCHC training, but this was the first time our technology team took part," says Patrick Lozito, MBA, CCHP, senior national account manager, who organized the event. "I knew it would be beneficial for them to better understand the NCCHC standards that we use as a baseline in our corrections-specific EHR. I contacted Matissa Sammons (vice president of the certification department), learned about the convenient on-site option, and she provided everything I needed to get started."

Why "NaphCare's leadership understands the value of having more of our teams, beyond clinical, trained on correctional health standards," says Lozito. "Participants saw this as an opportunity not only to better themselves, but also to help them provide the best services possible to our patients and partners. Each TechCare team member works closely with health care partners on a daily basis. Understanding the NCCHC standards allows them to assure customizations are there to help provide better patient care."

Help and advice More suggestions from NaphCare:

- To encourage participation and show your support, cover the cost of the standards books, training, and test.
- Provide breakfast and lunch during training/testing days.
- Look beyond health care teams and include other departments who will also benefit.
- Contact NCCHC, who will work with you every step of the way.

What next? "Other groups at NaphCare have asked about hosting more standards training/testing opportunities," says Lozito. "We hope to continue offering this on-site program as part of our learning and development." ●

For more information or help scheduling a training/testing event, contact Matissa Sammons at CCHP@ncchc.org.



Patients are our passion.

Together, we can tackle the opioid addiction crisis.

The opioid crisis is a national public health emergency, and the criminal justice system is also feeling the impact of the epidemic. People using opioids have a 52–77% chance of becoming involved in the criminal justice system. Opioid use disorder can be treated effectively with medication, and such medication is not only effective, but can save lives.¹



Reference:

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. U.S. Department of Health and Human Services. 2019. PEP19-MATUSECJS. Accessed February 2023.

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How to Write a Jail Health Services Contract That Ensures MOUD Care

If your jail wants to provide medications for opioid use disorder to treat patients who need it and also contracts with a third-party health care provider, get it in writing! That's the advice shared in a Viewpoint article in the February issue of the *Journal of Correctional Health Care*.

Written by a multidisciplinary team from the University of Kentucky, Lexington, the article describes a well-resourced effort to provide MOUD in an urban county jail, the reasons it failed, and a practical solution to ensure evidence-based care for OUD in jails.

Significant Barriers

The authors state that current OUD treatment practices in many jails violate the Eighth and 14th Amendments to the U.S. Constitution and the Americans with Disabilities Act, not to mention medical ethics, and therefore the criminal legal system needs widespread policy change concerning provision of MOUD. But even with policy change, such as in Massachusetts, significant barriers exist.

A recent study of factors influencing the availability of MOUD in 185 county jails found that the greatest barriers were lack of funding to purchase and administer MOUD-related services, hire and train clinical staff, and prevent diversion; and the need for education, training, and technical assistance for staff, medical providers, and other stakeholders.

The case study in Kentucky involves a jail that already provided injectable naltrexone and extended-release buprenorphine when people with OUD were released to the community, but wanted to also offer buprenorphine treatment for those who screen positive for OUD immediately after intake/booking. Partnering with the HEALING Communities Study (funded by the National Institute on Drug Abuse), they "seemingly surmounted all the obstacles" in terms of financial, equipment, and staff resources; technical assistance and training; community partners; and support from leadership.

Nevertheless, the authors explain, the "medical provider and jail struggled with this new treatment paradigm whereby MOUD would start at jail entry and continue throughout incarceration. There was a lack of bandwidth and knowledge among existing jail and medical staff along with challenges hiring additional medical staff to conduct intake screening and treatment processes, for which there were limited examples in other jails around the county."

Leverage the Contracting Process

Given the urgent need to combat the opioid epidemic, the authors argue that pursuing policy and legal interventions, such as federal legislation or changes to Medicaid payment exclusions, is too time intensive. Instead, they recommend that requests for proposals require health services contractors to include MOUD initiation and maintenance at intake in their bids.

"These bids may be more costly than historical contract amounts," the authors write, "but opioid abatement funds from pharmaceutical company settlements are affording unprecedented resources to municipal and state governments to fund overdose reduction programs."

The article lists the minimum criteria to specify in RFPs; jails can adapt this language for their own RFPs and use it to guide their evaluation of proposals. It also mentions a new, customizable budgeting tool to estimate the costs of various MOUD delivery models. Find it at [jsatjournal.com/article/S2949-8759\(22\)00014-5/fulltext](https://jsatjournal.com/article/S2949-8759(22)00014-5/fulltext). ●

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Accreditation provides a structured framework for CQI. Through the process of becoming accredited, health staff regularly review and evaluate their services, identify areas for improvement, and implement changes. In fact, there is a CQI-specific standard that requires the facility to have a quality improvement committee, spells out that committee's role and duties, and calls for at least one process and/or outcome quality improvement study each year (Standard A-06 Continuous Quality Improvement Program).

Professional Development

NCCHC accreditation encourages workforce training and development, leading to a more skilled and competent staff. That encouragement is both explicit – health and custody staff must meet specific educational and training requirements, ensuring they are knowledgeable in several aspects of care – and implicit in the culture of a facility focused on quality (Standards C-03 Professional Development, C-04 Health Training for Correctional Officers, C-05 Medication Administration Training).

We also encourage staff to achieve and maintain certification as a CCHP (Certified Correctional Health Professional). Certification recognizes our employees' mastery of the NCCHC standards while demonstrating their expertise and

commitment to professional development. CCHPs also may opt to pursue Advanced certification (CCHP-A) as well as specialty certification for mental health professionals (CCHP-MH), clinical providers including physicians, NPs, and PAs (CCHP-CP), and registered nurses (CCHP-RN).

Other Benefits

Public accountability. Accreditation signals a facility's commitment to transparency and accountability. The accreditation process is voluntary, independent, and impartial, ensuring that the facility's health care services are held to an objective standard and reducing the potential for bias or conflicts of interest. By complying with NCCHC standards, our facilities demonstrate their commitment to providing quality care, and because accredited facilities are resurveyed every three years, they can be held accountable if they fail to continue to do so.

Reduction in health care expenditure. By implementing best practices and focusing on robust screening and preventive care, our accredited facilities have reduced expenditure of health care delivery, benefitting both the facility and incarcerated individuals through additional programs that would not otherwise be possible. It also benefits society as our patients are returned to their communities as healthier citizens.

Among those facilities that contract with us for health care services, the benefits of accreditation are clearly evident. As Warden Mac McDuffie from the Mercer County (PA) Jail says, "Accreditation ensures we comply with and maintain the highest standards of care, leading to a safer and more rehabilitative environment for both staff and our incarcerated population, ultimately reducing recidivism rates, and making our community a better place."

Major James McGowan of the Monroe County (NY) Jail states, "NCCHC standards allow us to establish baselines for care that we would otherwise have a difficult time achieving. They have been extremely helpful when conducting monthly audits with our medical vendor. We use these standards to review everything from intake assessments to sick calls."

Overall, accreditation helps correctional facilities fulfill their duty to provide health care to incarcerated individuals, protects against legal challenges, and contributes to a safer and more accountable correctional environment. Achieving NCCHC accreditation demonstrates a commitment to high-quality correctional health care and overall well-being of incarcerated individuals and staff alike. ●

Thomas J. Weber, JD, is CEO of PrimeCare Medical, Inc. Tommy Williams, BSN, RN, CCHP, is the company's clinical research and informatics analyst.

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sheriff refused to implement an MAT program. The district court concluded that the sheriff's office's refusal to offer opioid-based treatment was unreasonable and, therefore, constituted deliberate indifference to the needs of the plaintiff.

As the stigma of drug addiction continues to erode, so too does one of the most widely used exceptions to eligibility for MAT in corrections: a positive drug screen. In fact, the New York state law specifically dictates that testing positive for banned substances cannot be used as a disqualifier to participation in an MAT program.

The issue was at the heart of a recent decision (*Ferguson v. Palm Beach County*, 2023) in which a jail inmate who was initially not prescribed MAT self-medicated with Suboxone®, had a positive drug screen, and was placed on buprenorphine by the jail physician. When custody learned of the prior positive drug screen, he was taken off MAT. The court ruled there was sufficient evidence to make a claim of deliberate indifference; the Judge wrote, "A jail

official's decision not to treat a 'serious medical need' for nonmedical reasons is textbook 'deliberate indifference.'"

Almost all MAT cases decided to date involve jails; however, it is only a matter of time before legal challenges to prison policies progress. For instance, one challenge to the MAT policies of the Florida Department of Corrections (*Johnson v. Secretary Dixon*, 2023) made it through an initial frivolity review, only to then be dismissed because the two named plaintiffs had not yet been transferred from jail to the FDOC system. These plaintiffs could refile the case when and if they do end up in state prison.

As the science and related community standard of care relating to the management of OUD continues to evolve, I predict it is only a matter of time before the judicial rulings become more uniform in their analysis of the right to treatment during incarceration. ●

Deana Johnson, JD, is executive vice president and chief legal officer with MHM Services/Centurion.

Delusional Infestation *continued from page 15*

care. Clinicians must be careful not to dismiss patients' complaints while also not validating the delusions, which can worsen the condition.

Explain that their symptoms can be caused by a number of conditions or by an old infection. Acknowledging their discomfort and how their symptoms have impacted their life can be a meaningful way to build rapport.

Addressing delusional infestation is not only about health; it's also about rehabilitation. Continuity of care must be considered in discharge planning, as proper care can be instrumental in an incarcerated individual's successful

reintegration into society. Linking people to support and medical care in the community is essential.

Equipping yourself with a foundational understanding of this unusual condition and ensuring access to care can be transformative for the patient. ●

Alexandra Mendelson is a medical student at Tufts University School of Medicine; Taisuke Sato is a research assistant at Tufts Medical Center; Alysse Wurcel, MD, MS, is associate professor at Tufts University School of Medicine and an infectious disease physician at Tufts Medical Center.



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Expert Advice on the NCCHC Standards

by Wendy Habert, MBA, CCHP

Documenting Nonemergent Health Care Requests

Q What specific touchpoints should we document for clinical nonemergent medical, dental, and mental health care requests?

A Per Standard E-07 Nonemergency Health Care Requests and Services, all aspects of the health care request process, from review and prioritization to subsequent encounter, must be documented, dated, and timed. Specific documentation of the following date and time stamps are required:

- Date and time the nonemergent health care request is received by health staff
- Date and time the nonemergent health care request is reviewed and prioritized by qualified health care professional
- Date and time the face-to-face encounter by a qualified health care professional is completed for all clinically based requests

Depending on the facility's procedures, these three things may occur simultaneously or within minutes, but each component of the process should be documented. For example, in some facilities nurses collect and read paper health care requests right after med pass and then meet with the patient at that time. In others, night shift nurses collect requests, and the face-to-face encounters occur the next day with day shift nursing staff. Regardless of the process, the dates and times of these three aspects should be documented in the health record.

75% Requirement for Custody Health Training

Q Standard C-04 Health Training for Correctional Officers indicates that to comply with the standard, at least 75% of the custody staff must be current in their health-related training. Does that 75% requirement refer to the entire first, second, and third shifts or only those working during the time of the survey?

A Standard C-04 applies to all custody staff on all shifts. When evaluating the 75% threshold requirement for each of the required topics in the standard, a facility should have documentation of completed health training for all applicable custody staff employed at the time of the survey who have direct contact with inmates in custody, including any satellites, not just those who are on duty on the date(s) of the survey.

Applicability of Female Standards

Q Our facility only holds incarcerated females on-site for up to 72 hours but not longer. Do Standards B-06 Contraception and F-05 Counseling and Care of the Pregnant Inmate apply to us since the women are not here for more than three days?

A If your facility houses females in custody for any length of time, whether on a temporary hold basis for two to three days or for extended periods of time, Standards B-06 and F-05 do apply. It should be noted that compliance indicators 9 and 10 in Standard E-02 Receiving Screening would also apply in your situation: if a woman is pregnant, an opiate history must be obtained, and any woman who reports current opiate use must immediately be offered a pregnancy test to avoid opiate withdrawal risks to the fetus. ●

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

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- ✓ 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



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Meet your everyday hero in aisle seven.

She is a dedicated Correctional Healthcare Nurse, who provides health and rehabilitative services to incarcerated persons in a nearby correctional facility. Her healthcare services *go beyond patient care*, helping to restore the lives of her patients as they prepare to return to the community. More than a nurse - she ensures a safer, healthier society for us all.

**Thank you for your
public service and
commitment to your
community.**

Beyond **PATIENT CARE**



To learn more about the meaningfulness of correctional healthcare, scan the QR code or visit TeamCenturion.com.