

CorrectCare[®]

The magazine of the National Commission on Correctional Health Care

A Call for NEW MODELS of CARE in CORRECTIONAL HEALTH

*How to Manage COPD
Flare-Ups*

*Pursue These 3 Goals to
Improve Patient Safety*

Root Cause Analysis

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

Beyond a reasonable doubt... Medi-Dose® and TampAlerT®

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They're tamper-evident, ultraviolet inhibitor and minimize errors and pilferage.
Plus Medi-Dose contains no metal or glass!

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitor polyethylene, with either regular or child-resistant screw caps. Each cap contains a tamper-evident seal.
And TampAlerT contains no metal or glass!

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

**There's no doubt about Medi-Dose and TampAlerT,
proven in correctional facilities for over 30 years.**

TampAlerT® System



1
Dispense medication into
TampAlerT bottle.



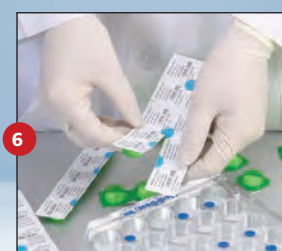
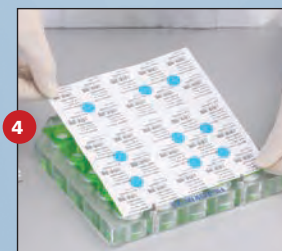
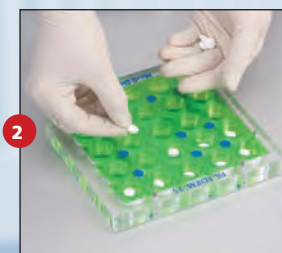
2
Twist TampAlerT cap onto
bottle.



3
A secure, tamper-evident seal
adheres to the bottle when
you twist-off the cap.



Medi-Dose® System



Medi-Dose®, Inc.
EPS®, Inc.

*Responding to pharmacy packaging needs
around the world*

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.medidose.com
E-mail: info@medidose.com

contents

10



Features

- 5** Guest Editorial: Restrictive Housing for Juveniles: Punitive, Not Rehabilitative
- 8** Delay in Treating Fractured Hand: Possibly Deliberate Indifference
- 10** A Call for New Models of Care in Correctional Health
- 14** How to Manage COPD Flare-Ups
- 15** Pursue These Three Goals to Improve Patient Safety in 2016
- 16** Root Cause Analysis: A Patient Safety Powerhouse

Departments

- 2** NCCHC News
- 3** Chair Notes
- 4** Summer Conference Preview
- 7** Spotlight on the Standards: Emergency Response Plan
- 18** Journal Preview: Diagnostic Errors in Mental Health Care
- 19** CCHP Page: Certification as a Talent Management Strategy
- 20** Reader Response: OTPs Matter
- 21** News Watch
- 23** Classified Ads and Ad Index
- 24** Standards Q&A

Cover design by Jill Cooper; cover image © Rob Colvin/Illustration Source

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.

BOARD OF DIRECTORS

- Jayne Russell, MEd, CCHP-A (Chair)**
Academy of Correctional Health Professionals
- Eileen Couture, DO, RN, CCHP-P (Chair-Elect)**
American College of Emergency Physicians
- Patricia N. Reams, MD, MPH, CCHP-P (Immediate Past Chair)**
American Academy of Pediatrics
- Barbara A. Wakeen, MA, RDN, CCHP (Secretary)**
Academy of Nutrition and Dietetics
- Thomas J. Fagan, PhD, CCHP-MH (Treasurer)**
American Psychological Association
- Thomas L. Joseph, MPS, CAE, CCHP (President & CEO)**
National Commission on Correctional Health Care
- Jeffrey J. Alvarez, MD, CCHP**
American College of Emergency Physicians
- Oscar Aviles, CJM, CCE, CCHP**
American Jail Association
- Carl C. Bell, MD, CCHP**
National Medical Association
- Patricia Blair, PhD, JD, CCHP-A**
American Bar Association
- Kevin Fiscella, MD, MPH**
American Society of Addiction Medicine
- Joseph Goldenson, MD**
American Public Health Association
- Robert L. Hilton, RPh, CCHP**
American Pharmacists Association
- Renee Kanan, MD, MPH**
American College of Physicians
- JoRene Kerns, BSN, CCHP**
American Correctional Health Services Association
- Ilse R. Levin, DO, MPH, CCHP-P**
American Medical Association
- Nicholas S. Makrides, DMD, MPH**
American Dental Association
- Pauline Marcussen, MS, RHIA, CCHP**
American Health Information Management Association
- Edwin I. Megargee, PhD, CCHP-MH**
International Association for Correctional and Forensic Psychology
- Robert E. Morris, MD, CCHP-P**
Society for Adolescent Health and Medicine
- Mary Muse, MS, RN, CCHP-RN, CCHP-A**
American Nurses Association
- Peter C. Ober, JD, PA-C, CCHP**
American Academy of PAs
- Joseph V. Penn, MD, CCHP**
American Academy of Psychiatry and the Law
- George J. Pramstaller, DO, CCHP**
American Osteopathic Association
- Judith Robbins, JD, LCSW, CCHP-MH, CCHP-A**
National Association of Social Workers
- Sheriff B. J. Roberts**
National Sheriffs' Association
- Christopher T. Rodgers, MPA, MBA**
National Association of Counties
- David W. Roush, PhD, LPC**
National Partnership for Juvenile Services
- Steven Shelton, MD, CCHP-P, CCHP-A**
American College of Correctional Physicians
- Samuel Soltis, PhD, MHA**
American College of Healthcare Executives
- Sylvie R. Stacy, MD, MPH**
American College of Preventive Medicine
- Carolyn Sufrin, MD, PhD**
American College of Obstetricians and Gynecologists
- Henry C. Weinstein, MD, CCHP**
American Psychiatric Association
- Nancy B. White, MA, LPC**
American Counseling Association
- Liaisons Pending**
American Academy of Child and Adolescent Psychiatry
American Association of Public Health Physicians
Association of State and Territorial Health Officials
National Association of County and City Health Officials

Copyright 2016 National Commission on Correctional Health Care. Statements of fact and opinion are the responsibility of the authors alone and do not necessarily reflect the opinions of this publication, NCCHC or its supporting organizations. NCCHC assumes no responsibility for products or services advertised. We invite letters of support or criticism or correction of facts, which will be printed as space allows. Articles without designated authorship may be reprinted in whole or in part provided attribution is given to NCCHC.

Send correspondence to Jaime Shimkus, Editor
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614
Phone: 773-880-1460; Fax: 773-880-2424
info@ncchc.org; www.ncchc.org
For advertising, contact Carmela Barhany at sales@ncchc.org

Welcome to New Supporting Organization and Board Members



Alvarez



Stacy

The National Commission welcomes the **American Academy of Family Physicians** as its newest supporting organization, and **Jeffrey J. Alvarez, MD, CCHP**, as the AAFP's liaison on the NCCHC board of directors.

Founded in 1947, the AAFP is one of the nation's largest medical organizations, representing 120,900 family physicians, family medicine residents and medical students. In serving its members, key strategic objectives are advocacy, practice enhancement, education and health of the public.

Dr. Alvarez has been the medical director for Maricopa County (AZ) Correctional Health Services since 2010. Dr. Alvarez is a physician surveyor for NCCHC's accreditation program, a physician surveyor trainer and a member of the surveyor advisory committee. He also served on the task forces that prepared the 2014 *Standards for Health Services for jails and prisons* and the 2016 *Standards for Opioid Treatment Services*.

"I am honored to represent the American Academy of Family Physicians on the NCCHC board," said Dr. Alvarez. "I feel the purpose of NCCHC corresponds perfectly with the mission and strategic objectives of the AAFP. Our mission is to improve the health of patients, families and communities by serving the needs of members with professionalism and creativity, while our primary objective is to advance

health care for all. My hope is to successfully represent the many family physicians who work every day to improve the health of our diverse correctional population."

Sylvie R. Stacy, MD, MPH, has also joined the board of directors, serving as the liaison of the **American College of Preventive Medicine**. She replaces Ryung Suh, MD, who served on the board for six years.

ACPM was founded in 1954 and today is a medical society with more than 2,700 members. ACPM aims to improve the health of individuals and populations through evidence-based health promotion, disease prevention and systems-based approaches.

Dr. Stacy is corporate medical director, utilization management, for NaphCare, Inc., Birmingham, AL, where she also provides oversight for clinical aspects of correctional health care operations. She also has experience as a medical researcher and writer.

"I'm a specialist in preventive medicine and public health and I practice in correctional health care, so I am excited to use this combination of experiences and perspectives to assist NCCHC in improving the quality of health care in correctional settings," Dr. Stacy said.

These appointments took effect April 10 during the NCCHC board meeting.

Jail Mental Health Experts Share Advice in NCCHC/AJA Webinar

Three correctional mental health experts shared their knowledge and insights into contemporary issues in jail mental health care in a free webinar cosponsored by NCCHC and the American Jail Association. Held April 1, the one-hour webinar drew some 200 participants.

David Stephens, PsyD, dean of the University of the Rockies School of Professional Psychology in Denver, outlined the continuum and levels of mental health services provided in jails, with considerations for facility size, budget, public health, risk management, recidivism reduction and inmate need.

Steven Helfand, PsyD, CCHP, an expert consultant for the National Commission, spoke about effective management of difficult issues such as self-injurious behavior

and the effects of segregation on mentally ill inmates.

Nneka Jones Tapia, PsyD, executive director of the Cook County (IL) Department of Corrections, discussed how she—a mental health professional in charge of one of the nation's largest jails—is implementing changes to serve a population of whom approximately 25% have mental illness.

The speakers addressed numerous questions posed in advance by participants, with special focus on those that have emerged as serious concerns in jails:

- How to serve an increasing population of acutely mentally ill individuals in the face of limited resources
- How to manage administration of involuntary psychotropic drugs on a chronic basis
- Effective practices for rule infractions by the mentally ill
- Combating provider burnout given the challenges inherent in correctional mental health
- Ensuring continuity of care upon discharge
- Availability of court or community programs to assist with reentry of this at-risk population

To access the recording of the webinar and to download the PowerPoint presentation, go to www.ncchc.org/NCCHC-University.

This program will be repeated, with updated topics, this fall. Watch for an email with details and registration information this summer.

Calendar of events

June 17	Accreditation Committee meeting
July 15-16	Correctional Health Care Leadership Institutes, Boston
July 16	CCHP exams, Boston
July 17-18	Correctional Mental Health Care Conference, Boston
August 19	Accreditation Committee meeting
August 20	CCHP exams, regional sites
Oct. 22-26	National Conference on Correctional Health Care, Las Vegas
Oct. 23	Accreditation Committee meeting
Oct. 23-24	CCHP exams, Las Vegas

For the complete list of CCHP exams, including regional exam sites, see www.ncchc.org/cchp.

Celebrating Milestones, Looking Ahead

by Jayne Russell, MEd, CCHP-A

We all know the saying “time flies,” and many of us with appreciable years in correctional health care can reflect on significant and necessary changes, although some at a slow rate. For those of you less seasoned in this field, this may serve to give you perspective and insight on what work remains to be done—and the time is now. Our NCCHC conferences in 2016 will focus on three historic milestones:



- This year is the 40th anniversary of *Estelle v. Gamble*, the Supreme Court landmark case that spurred action in correctional health care.
- The first National Conference on Correctional Health Care was held 40 years ago and we will mark this milestone at this year's meeting, Oct. 22-26 in Las Vegas.
- NCCHC's Certified Correctional Health Professional program celebrates its 25th anniversary.

Crusade for Humane Treatment

Looking back prior to *Estelle*, that was a time when medical care was often performed by inmates in the absence of trained clinical staff. Custody operations were mainly uncensored with little accountability; inmates were truly the property of the state. Movies like “Brubaker” and “The Shawshank Redemption” awakened the general public and remind us that the crusade for justice and humane treatment was not that long ago. We who work in corrections have heard similar shocking stories about the past.

Since 1976, the courts have protected an inmate's constitutional right to health care as established by *Estelle v. Gamble*. This ruling guaranteed three basic rights: the right to access to care, the right to care that is ordered and the right to a professional medical judgment. NCCHC's accreditation standards for jails, prisons and juvenile facilities were developed to support constitutionally mandated care and they promulgate an effective and efficient service delivery system. During the past 40 years, our field has expanded far beyond the basic tenets of guaranteed rights to care. Today we grapple with complex public health issues, widespread substance abuse and treatment, mental health challenges, costly and evolving psychopharmacology, telemedicine, specialty services, HIPAA, LGBT guidelines and cultural competency and sensitivity.

A Respected Profession

The American Medical Association held its first conference on Improved Medical Care and Health Services in Jails in 1977 with about 75 attendees. A decade later, the NCCHC annual conferences were well rooted with a steadily grow-

ing attendance. Today, several thousands of correctional health professionals participate in our educational programs each year. There is no question that correctional health care has earned its status as a qualified, respected profession.

That status is underscored by professional certification. Twenty-five years ago, a small group of NCCHC leaders and supporters initiated the Certified Correctional Health Professional program. This year the program boasts 3,600 participants, including those who have achieved advanced certification or specialty certification for RNs, mental health professionals and physicians. This demonstration of commitment and competency is a strong testament to our colleagues who share our goals and advance our efforts every day.

Challenges and Progress

We have reason to be proud of what we do and the progress we've made; looking back, it gives us cause to celebrate the advancements in our field. Yet we will not lose sight of our current challenges. Opioid use is advancing rapidly into all neighborhoods. The mentally ill have few treatment options in the community. Consequently, correctional systems are strained with mentally ill populations and substance abusers. Jails, in particular, are the first stop for offenders high on unknown substances. Often there is little to no medical history available, and jails bear the burden of keeping these people alive under constant threat of litigation. In addition, correctional agencies continually struggle with fiscal restraint and sometimes minimal staffing.

These community challenges are prevalent in all states and have escalated over decades, while resources remain inadequate. Yet, we are making strides. We now have specialized courts for defendants with substance abuse disorders and mental illness. Multiagency collaborations created these services to facilitate community-based treatment for those who are not a public safety risk. This significant criminal justice component seeks to divert populations from incarceration and offers less costly alternatives. We are experiencing a slow but major shift to reform criminal justice views, and to provide options, treatment and appropriate placement—which need not always be incarceration.

Will there be a landmark case in our future that will allow us to look back 40 years from now and say, “How shocking—we used to lock these folks up and force jails to be their caretakers”? We're not there yet, but looking ahead 40 years, corrections demographics should most certainly shift in accordance with our evolving perspective on criminal justice and social justice.

Jayne Russell, MEd, CCHP-A, is chair of NCCHC's board of directors and serves as the Academy of Correctional Health Professionals' liaison to the board. She works as an independent consultant in correctional health care.



CORRECTIONAL HEALTH CARE LEADERSHIP INSTITUTES

July 15-16, 2016 • Westin Copley Place • Boston, MA

A ONE-OF-A-KIND EDUCATIONAL EVENT

The Correctional Health Care Leadership Institutes is a one-of-a-kind event designed specifically for management team members—clinicians and administrators, seasoned executives as well as emerging leaders on track for the next level. Wherever you are in your career, you will benefit from learning more about critical issues and challenges.

Our esteemed faculty will explore both essential and advanced legal, operational and medical topics, including budgeting, security, safety, quality improvement, productivity, risk management and more.

The Physician/Clinician track is recommended for all staff members trained in direct care who are interested in developing or deepening management responsibilities. The Health Administrator track is designed for professionals charged with achieving executive and operational excellence in their programs.

The tracks are produced in conjunction with the Academy of Correctional Health Professionals and the American College of Correctional Physicians, the largest professional societies for correctional health professionals and physicians in the world. The conference also offers targeted networking opportunities.

Continuing Education: Up to 14 hours of CE credit are offered for physicians, nurses, psychologists and CCHPs.

Enhance Your Knowledge, Advance Your Career

Essential and advanced tracks for physicians and health administrators provide the specialized knowledge and expertise you need. Attend your choice of two dozen sessions, including the following vital topics, presented by some of the most widely respected experts in our field.

- The Benefits of Correctional Health Care Accreditation
- Collaboration With Nursing Colleges
- Help for Your “Help Wanted” Challenges
- How to Develop a Clinically and Fiscally Sound Health Care Program
- Leadership Development: The Transition From Clinician to Physician Leader
- Patient Privacy: An Update on Legal Requirements
- Practical Guide to CQI
- Strategic Operation Management
- Supervisory Liability in Inmate Lawsuits
- Ways to Handle High-Demand Patients

Conference Venue: All events will take place at the Westin Copley Place in the historic Back Bay district of Boston. Reserve your room online or call 800-228-3000.

Registration: Several options are available, including a package that adds the Correctional Mental Health Care Conference and discounts for members of the Academy of Correctional Health Professionals or the American College of Correctional Physicians. Register by June 17 for early-bird savings!

Visit www.ncchc.org for complete details.



CORRECTIONAL MENTAL HEALTH CARE CONFERENCE

PATHWAYS TO SUCCESS

JULY 17-18, 2016
THE WESTIN COPLEY PLACE, BOSTON, MA

UNIQUE OPPORTUNITY TO EXPLORE COMPLEX ISSUES

A 2014 study by the National Sheriffs’ Association and the Treatment Advocacy Center found that there are 10 times as many people with mental illness in the nation’s jails and prisons as in state mental institutions. Caring for mentally ill inmates has become a central challenge for correctional institutions.

The Correctional Mental Health Care Conference is a unique opportunity for mental health professionals and others to gather with colleagues facing similar challenges, exchange ideas and learn about solutions. Nowhere else will you find educational programming designed specifically for you. Taught by top-notch faculty, educational sessions explore everyday challenges, hot topics and thought-provoking issues.

The conference will feature two full days of focused mental health discussions, 30 sessions in three educational tracks and special networking events to help you make lifelong connections. Program faculty have been selected based on their expertise, knowledge and experience in correctional mental health care.

Supported by the Academy of Correctional Health Professionals, the American Psychiatric Association and the American Psychological Association.

Continuing Education: Up to 14 hours of CE credit are offered for psychologists, social workers, physicians, nurses and CCHPs.

Two Days of Focused Education

The conference provides the latest information from correctional mental health experts covering innovations in mental health care research, delivery and treatment. Among the 30 timely sessions are topics like these:

- Across the Great Mind–Body Divide
- Alternatives to Segregation for Seriously Mentally Ill Inmates
- Care of the Transgender Inmate
- Hepatitis C Infection: Antiviral Treatment and Mental Health
- Managing Inmates Who Engage in High-Risk Behaviors
- Medication-Assisted Treatment and Community Linkage
- Perspectives on Opioid and Substance Use Disorders
- Reducing Use-of-Force Incidents With Mental Health Patients
- Serious Mental Illness and Segregation
- Suicide Risk Assessment, Documentation and the Law
- The Many Faces of Trauma: Individualized Treatment for Survivors

Conference Venue: All events will take place at the Westin Copley Place in the historic Back Bay district of Boston. Reserve your room online or call 800-228-3000.

Registration: Several options are available, including a package that adds the Correctional Health Care Leadership Institutes and discounts for members of the Academy of Correctional Health Professionals or the American College of Correctional Physicians. Register by June 17 for early-bird savings!

Visit www.ncchc.org for complete details.

Restrictive Housing for Juveniles: Punitive, Not Rehabilitative

by Kevin Fiscella, MD, MPH, and Robert E. Morris, MD, CCHP-P

Recent media reports have highlighted the risks of restrictive housing, i.e., disciplinary or administrative segregation, particularly for juvenile offenders. This practice, referred to in popular parlance as solitary confinement, is distinguished from brief interventions such as “time-out,” a component of some behavioral treatment programs. It is also distinguished from emergency seclusion, which is a short-term emergency medical procedure that is strictly regulated by federal, state and health care regulatory agencies. Notably, health care regulations prohibit the use of emergency seclusion as “a means of coercion, discipline, convenience of staff or retaliation.”

Alexis de Tocqueville commented, “This absolute solitude, if nothing interrupts it, is beyond the strength of man; it destroys the criminal without intermission and without pity; it does not reform, it kills.”

The potential psychological harm and impairment in social functioning that arises from the social isolation of restrictive housing potentially undermines the core rehabilitative component of criminal justice.

Adolescents may be particularly vulnerable to the social isolation of restrictive housing. The adolescent brain, which is still developing and highly sensitive to social and peer effects, is arguably especially sensitive to social isolation. Adolescents learn to self-regulate their emotions by interacting with peers and acquiring their norms. Social isolation undermines the establishment of emotional regulation, potentially increasing the risk for self-harm and hindering the adolescent self-regulatory development needed to adapt to society. In addition, restrictive housing may foster and reinforce an adolescent’s identity as a “bad kid.” Once such an identity takes hold, it can be difficult to change.

A Widespread Practice

Restrictive housing is widely employed in jails and prisons in the United States. A recent U.S. Department of Justice report found that 20% of all prison inmates and 18% of jail inmates had spent time in restrictive confinement. Strikingly, 10% of prison inmates and 5% of jail inmates had spent 30 days or more in restrictive housing. In adult facilities, youth under 20 years of age had the highest rates of time in restrictive housing. Significantly, duration of time in restrictive housing was associated with higher rates of psychological distress and psychiatric disorders.

Restrictive housing is also associated with inmate self-harm. A study conducted at the New York City jail system and published in the *American Journal of Public Health* in 2014 reported that restrictive housing (referred to as

solitary confinement) was associated with self-harm including suicide. Overall, restrictive housing was associated with nearly a sevenfold higher rate of self-harm, even after controlling for a range of inmate characteristics including mental illness. Inmates younger than 19 years old were at highest risk for self-harm.

A Harmful Practice

The absence of high-quality studies, such as randomized trials, makes it difficult to fully tease out the direction of effects—is it simply that inmates who are at higher risk for self-harm are more often placed in restrictive housing, or does restrictive housing result in psychological and self-harm? However, the implication that restrictive housing is harmful is consistent with the science on social isolation and sensory deprivation as well as observational studies.

Evidence is largely lacking that this practice reduces dis-



Fiscella



Morris

continued on page 6

2015 STANDARDS for Health Services in Juvenile Detention and Confinement Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing health services delivery in juvenile detention and confinement facilities.

This edition represents the **culmination of hundreds of hours of careful review** by juvenile health experts, including specialists in medicine, nursing, mental health, substance abuse and gynecology, to ensure that NCCHC standards remain **the most authoritative resource for juvenile health care** in correctional settings.

Notable updated topics include medical autonomy, continuous quality improvement, patient safety, clinical performance enhancement, medication services, health assessment, nonemergency health care requests, contraception and family planning services, emergency psychotropic medication and forensic information. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.



To order or to see a list of all NCCHC publications, visit **www.ncchc.org**.

NCCHC's new position statement on Solitary Confinement is available online at www.ncchc.org/position-statements.

ciplinary problems or improves facility security relative to less potentially harmful alternatives. The U.S. Government Accountability Office, in reviewing the Federal Bureau of Prisons, stated, "Without an assessment of the impact of segregation on institutional safety or study of the long-term impact of segregated housing on inmates, BOP cannot determine the extent to which segregated housing achieves its stated purpose."

The National Research Council, in its report on Reforming Juvenile Justice, concluded, "A harsh system of punishing troubled youth can make things worse, while a scientifically based juvenile justice system can make an enduring positive difference in the lives of many youth who most need the structure and services it can provide."

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty explicitly prohibit restrictive housing for juveniles in correctional facilities. This resolution was supported by the United States and was subsequently endorsed by the American Academy of Child and Adolescent Psychiatry.

Viable Alternatives

There are viable alternatives to restrictive housing that are both more humane and potentially more rehabilitative. Some correctional facilities employ special programming. For example, Washington uses a structured curriculum that teaches progressive development of self-control with gradually improving socialization. Other states have adopted programs based on behavior modification principles. Some facilities have adopted structured sanctions such as mediation, anger management groups, restorative justice approaches coupled with loss of privileges (e.g., access to the commissary, TV viewing, visitation), making amends for damaged property and assignment to less-favored work or shifts. When protective housing is needed, steps can be taken to minimize social isolation and sensory deprivation and to limit the time in such settings, including ongoing engagement with trained staff while the youth is isolated from peers.

Steps We Can Take Today

Prior to deinstitutionalization of patients with mental illness in the late 1960s, psychiatric hospitals became known for abusive conditions that increased rates of violence and harmed mental health. These included overcrowding, use of straitjackets and seclusion. As a result of these abuses, seclusion and restraint became tightly regulated in health care.

Today, jails, prisons and detention facilities house 10 times more mentally ill persons than do psychiatric hospitals. Correctional facilities need to follow the lead of psychiatry and community health care and eliminate restrictive housing, particularly for those most vulnerable to its effects. Health care staff can play an important role in monitoring segregated inmates and advocating for their removal from segregation, especially if the inmate begins to show negative effects of isolation. Also, the health care authority can collaborate with the security administration to adopt policies that reduce or discontinue the use of seclusion. Doing so will better prepare juveniles for reentering society.

Kevin Fiscella, MD, MPH, is dean's professor, Family Medicine and professor, Public Health Sciences and Community Health at the University of Rochester (NY) Medical Center.

Robert E. Morris, MD, CCHP-P, is professor emeritus in the Mattel Department of Pediatrics, University of California at Los Angeles.

Both serve on NCCHC's board of directors: Fiscella as liaison of the American Society of Addiction Medicine and Morris as liaison of the Society for Adolescent Health and Medicine.



Expand your horizons in the GOLDEN STATE
Looking for a meaningful career with great benefits?

We offer outstanding clinical opportunities throughout California - join us!

At California Correctional Health Care Services, our clinicians are part of a collaborative, multidisciplinary team and enjoy a work/life balance with generous paid time off, a 40-hour workweek, paid insurance, license, DEA, and visa sponsorship opportunities. Our competitive compensation package includes excellent salary, fantastic benefits, and retirement that vests in just five years. With 35 locations throughout California, you're sure to find your perfect fit.

Physician & Surgeon (IM/FP)
\$245,268
starting annual (Lifetime Board Certified)
\$258,204
starting annual (Time-Limited Board Certified)

Chief Physician & Surgeon
\$255,108
starting annual (Lifetime Board Certified)
\$268,548
starting annual (Time-Limited Board Certified)

 **CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES**

For more information or to apply online, please visit www.ChangingPrisonHealthCare.org MedCareers@cdcr.ca.gov or (877) 793-4473

EOE

Spotlight on the standards

by Tracey Titus, RN, CCHP-RN

It starts as a typical day in the clinic; medications have been administered and clinics are being conducted. Without warning, inmates in general population begin banging forcefully on a cell door. You know immediately that these are not the usual sounds heard in a jail—this is much more urgent and serious. Smoke begins to fill the corridors and the medical clinic. Custody staff are frantically trying to evacuate inmates to a safe location when more banging begins from other cells. An inmate has set a populated cell on fire, which is quickly spreading to other areas of the facility. Are you ready to respond?

Standard A-07 Emergency Response Plan requires that health staff are prepared to implement the health aspects of the facility's emergency response plan. To comply with this standard, health staff must first have a written plan in place.

Components of an Emergency Response Plan

The standard requires that, at a minimum, the plan include the responsibilities of the health staff, procedures for triage, predetermined sites for care, telephone numbers and procedures for calling health staff and community emergency response systems, procedures for evacuating patients, alternate backups for each of the plan's elements and time frames for response. Each of these components should be addressed in a policy and procedure format or in a separate written plan and must be site specific for each facility. For example, a predetermined site for care at a main facility may be in a court holding area, whereas the predetermined site for care at the satellite facility may be in a large hallway between pods.

Simply having a policy that lists the components of a plan (compliance indicators #1a through #1g) without elaborating on each does not meet the intent of the standard. Health staff should be able to read the plan and understand their responsibilities and where to set up triage if the clinic areas cannot be used. Telephone numbers should be readily available.

Once developed, the plan must be approved by the responsible health authority and facility administrator. Care should be taken to ensure that the emergency response plan for health staff does not conflict with the response plan for custody staff (i.e., predetermined sites for care and evacuation plans should match).

Practicing the Emergency Response Plan

The next step in compliance is to practice the emergency response plan through two types of planned drills: mass disaster and man-down drills.

A mass disaster drill is a simulated emergency potentially involving mass disruption and/or multiple casualties that require triage by health staff. It frequently involves a natural disaster (e.g., tornado, flood, earthquake), an internal

disaster (e.g., riot, arson, kitchen explosion) or an external disaster (e.g., mass arrests, bomb threat, power outage). It is important to note that a mass disaster drill must have multiple casualties in order to meet the intent of the standard. However, an actual event (mass disaster, mass disruption) without multiple casualties may be critiqued and shared with health staff. For jails and prisons, the mass disaster drill must be conducted annually in the facility so that over a three-year period, each shift has participated. For juvenile facilities, at least one mass disaster drill must be conducted annually for each shift that has health care personnel working in the facility.

While it is ideal to coordinate drills with community emergency services such as the fire department or first responders, facilities should not delay drills while waiting for plans to be developed. Delaying drills for this reason may result in compliance concerns for this standard if drills are not conducted annually as required. Fire drills that are conducted by custody staff without the involvement of health staff do not meet the intent of the standard for mass disaster drills, nor do classroom instruction and tabletop exercises where health staff's projected response to emergencies is discussed.

A man-down drill is a simulated emergency affecting one individual who needs immediate medical intervention. It involves life-threatening situations commonly experienced in correctional settings such as suicide attempts, seizures and diabetic emergencies. Actual events are often critiqued to meet the requirement of this standard. Regardless of the type of facility, these drills must be practiced once per year on each shift where health staff are regularly assigned.

If there are no full-time health staff in a jail or prison, then drills are not required.

Documenting Drills

Both mass disaster and man-down drills or actual events must be critiqued and should document activities such as response time, names and titles of health staff, and the roles and responses of all participants. The critiques should contain observations of appropriate and inappropriate staff responses to the drill. The date, time and shift should also be noted on the critique.

For continuous quality improvement purposes, the critiques may be compared to the written emergency response plan to identify any areas of concern. For example, the written plan may specify a time frame for response, but during the drill the response time may have been slower than expected. A process CQI study may be implemented to examine the reasons for longer response time and possible solutions.

It is recognized that not all health staff on a particular shift may be present when a man-down or mass disaster drill takes place. The standard requires that the critique be

A-07 Emergency Response Plan (essential)

Health staff are prepared to implement the health aspects of the facility's emergency response plan.

— 2014 *Standards for Health Services* for jails and prisons

continued on page 21

Delay in Treating Fractured Hand: Possibly Deliberate Indifference

by Fred Cohen, LLM

Illinois inmate Joseph Conley fended off an attack by a fellow inmate by blocking a hit from a combination lock with his right hand. Thus began Conley's rather tortured road to seeking timely health care and, now, financial relief from a federal lawsuit.

Conley successfully appeals a federal district court's grant of summary judgment in favor of defendants: *Conley v. Birch*, 796 F.3d 742 (7th Cir. 2015).

Discussion

This case ultimately is about treatment delayed, not totally denied. In turn, the legal hurdle is whether or not the defendant's delay in diagnosis and treatment constitutes our old friend: deliberate indifference.

The injury occurred Dec. 22, 2009. Conley showed his massively swollen hand to Lt. Felton after being ignored for two days by various prison employees.

Felton had Conley examined by Nurse Potts, who did an exam and noted swelling, discoloration and a possible fracture. Potts then followed procedure and called Dr. Birch at her home. She was the only doctor assigned to this facility.

Presumably due to the holiday season, Dr. Birch did nothing until she returned to work on Dec. 29—some four and a half days after Potts' initial assessment—and she ordered an X-ray.

Not until Jan. 13, 2010, was an X-ray performed and it confirmed a broken hand from which Conley now suffers permanent damage.

Legal Review

The Seventh Circuit panel states that a reasonable jury could find that, based on the information conveyed to her in her Dec. 24 telephone conversation with Nurse Potts, Dr. Birch strongly suspected that Conley's hand was fractured. Because neither Potts nor Dr. Birch has any independent recollection of their Dec. 24 conversation, Potts' treatment notes are viewed as the most probative evidence of the information that Potts transmitted to Dr. Birch regarding Conley's injury. These treatment notes suggest a serious injury: Conley suffered from "severe" swelling despite the fact that his injury occurred two days prior; he experienced loss of function and mobility extending to all four of his fingers and his thumb, even though the blow was to his palm only; his hand was discolored; and, most importantly, Potts described the injury as a "possible/probable fracture." Furthermore, while Dr. Birch insisted in her deposition that Conley's symptoms could have indicated a contusion rather than a fracture, it is highly implausible that Potts would have telephoned Dr. Birch at her home, after working hours, on Christmas Eve, if he suspected that Conley's hand was merely bruised.

Considering this evidence in the light most favorable to Conley—as one must on this review—a jury might reasonably find that Dr. Birch concluded that Conley's hand was probably fractured. Of course, it is not certain that this is a conclusion that Dr. Birch actually drew. State of mind, however, is an inquiry that ordinarily cannot be concluded on summary judgment, and the record suggests that Potts communicated information sufficient to lead Dr. Birch to strongly suspect that Conley had suffered a fracture. Whether she in fact made that inference is a question for trial.

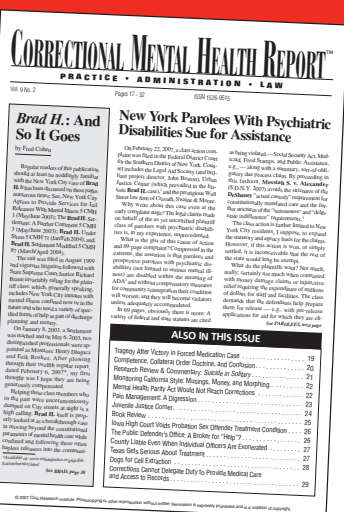
The question now is whether Dr. Birch knowingly disregarded that condition. She did provide for pain killers and ice. Is that enough?

Correctional Mental Health Report

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

- Legal updates and case reviews that analyze important court decisions and their impact on the way you manage, house and treat this difficult population—and help you avoid multimillion-dollar lawsuits;
- Proven treatment programs and operating procedures for assisting and managing mentally disordered offenders—everything from the correct way to prepare treatment plans and progress notes, to the design of residential programs;
- Psycho-pharmaceutical developments;
- Strategies for managing scarce resources—how to get critically needed budget items approved, work with third-party providers, gain the support and cooperation of mental health, medical and other agencies;
- Treatment options for special offender groups—from juvenile to elderly;
- Quality assurance protocols;
- A review of the latest research and writing in the field—new books, journal articles, research reports, monographs—so you can keep up to date on new developments that can help you do your job better.

To order, go to <http://www.civiclesearchinstitute.com/cmhr.html> and click on "Add to Cart". Or call 609-683-4450.



Correctional Mental Health Report
Published in print and online
Frequency: 6x annually
ISSN: 1526-9515
Subscription: \$179.95

CRI Civic Research Institute

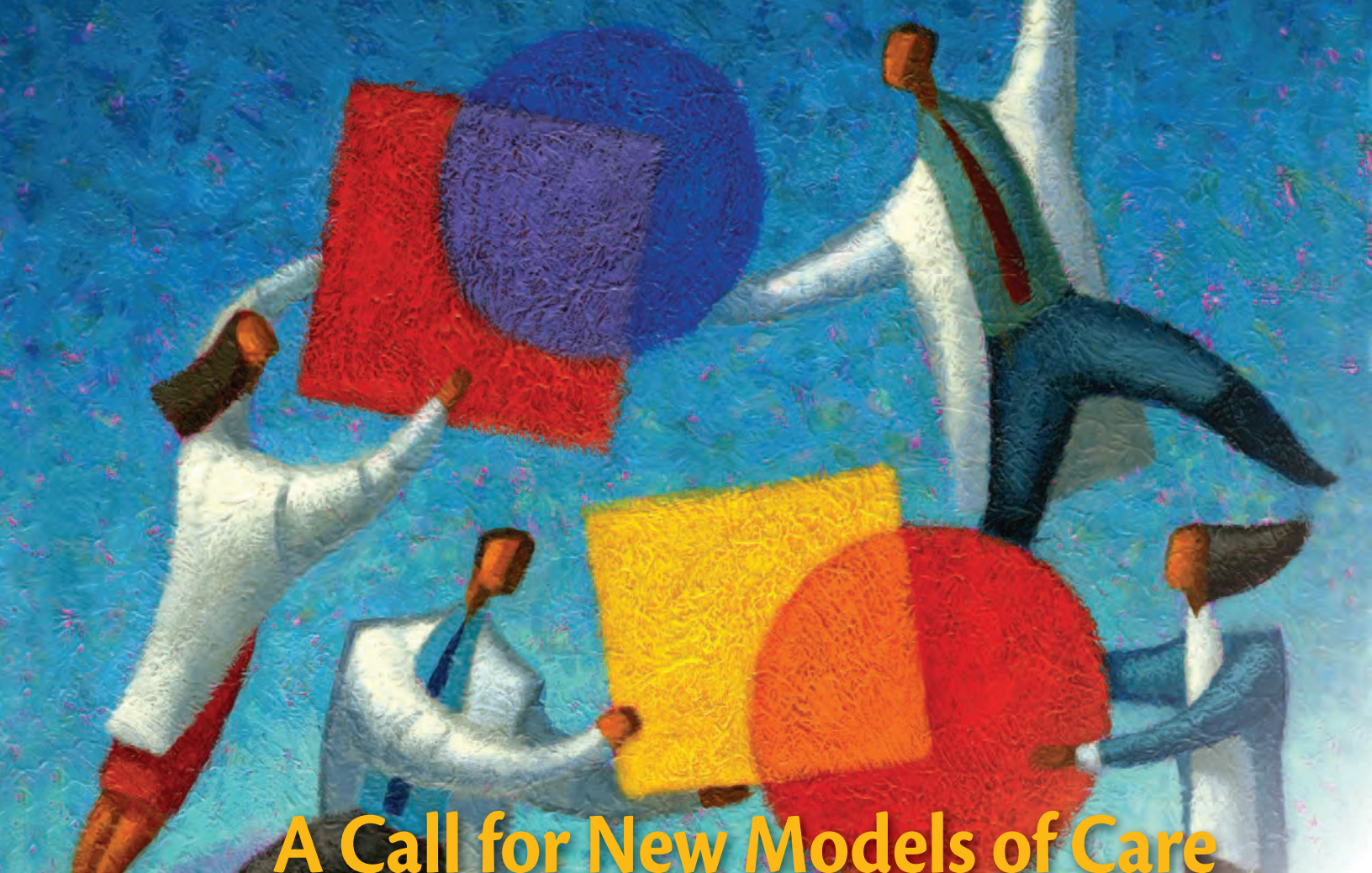
continued on page 20

UNIQUE POPULATIONS HAVE UNIQUE NEEDS.



www.ahatpa.com

Corrections Healthcare Care Coordination Cost Management



A Call for New Models of Care in Correctional Health

This article is based on a presentation at NCCHC's 2015 Leadership Institutes and is the first in a series on innovation in correctional health practice

by Donna Strugar-Fritsch, MPA, BSN, CCHP, and Linda Follenweider, MS, CNP

Across the country, there is growing awareness in prisons and jails that the health care provided in correctional facilities is part of a larger continuum of community health care and public health. Nearly all incarcerated men and women return to the community within two years, and their chronic diseases, infectious conditions, mental illnesses and substance use disorders are with them before, during and after incarceration. The clinical challenges that correctional health providers face in managing their complex patients are no different from those faced by community primary care providers; in fact, their patients are the same people. However, a difference between community primary care and correctional health is evolving: New and effective models of care to improve primary care outcomes and to better manage high-risk patients are not readily moving into correctional health.

In the community, new models of care and tools are addressing health care's goals of improved quality of care, improved health of targeted populations and cost reduction. The patient-centered medical home and integrated physical and mental health care are two models of care

widely recognized to improve care for persons most at risk within the health care system. Both are being widely adopted in community practice.

While not all components of these new models are appropriate in correctional settings, many important features can be used in prisons and jails to bring the same improvements in quality and optimal use of scarce resources that community practices are experiencing. Efficiencies may reduce the overall cost of correctional health care, as well.

This article explores components of new primary care models, how they have advanced community care and the Triple Aim and how they can be used in correctional settings. They offer important advantages to correctional health, including the following:

- Early identification of patients at risk for poor outcomes
- Proactive interventions designed to mitigate risk
- Use of health information technology and population health science to drive and inform care
- Optimized actions of licensed professionals so that each discipline is working at the "top of its license"
- Reduced redundancy
- More timely access and fewer missed opportunities for appropriate care

Robust Team-Based Care

Team-based care may be a component of traditional care delivery or of an alternative model of care. The patient-centered medical home model includes a robust and practical team-based component in which members of a practice restructure their work to function as a team in which all members share responsibility for the entire panel of patients served. The team convenes daily to discuss the day's schedule and to decide on the priorities for the day and for the team's high-risk patients. Team roles are designed to optimize each individual's time with the patient and to maximize efficiency. Tools the team uses include the following:

Daily Huddles: One person organizes the daily huddle in which all team members gather for about 10 minutes—standing, not sitting—to review who is coming in that day, who has been hospitalized, who had an emergency or hospital discharge, what new information has come in from referrals, test results, consults, yesterday's no-show patients, etc. Tasks are assigned to address loose ends, and gaps in team processes become apparent and can be changed. Patient visits and clinic practices become more productive.

Planned Visits: Teams use planned visits based on explicit clinical objectives for each patient related to treatment targets and the patient's plan of care. Planned visits are supported by evidence-based guidelines for chronic conditions that identify screening or testing needed and prompt the team to carry out optimal patient-specific care. Important advance work for visits is identified and the team assures that all information necessary to the planned visit is available when the patient arrives. This creates efficiencies in care and staffing. Health information technology and patient registries are important tools for effective planned visits, as are clinical and administrative prompts in the scheduling or electronic medical record system.

Nontraditional Visits: Traditional visits do not always meet the needs of high-risk, complex patients, so primary care teams use innovative nontraditional visits. These may be patient visits with the nurse/care manager for one-on-one education in self-management, or group visits with patients who share a diagnosis. The visits may center on medications, self-management, diet, clinical progression of the condition, indications for specialty care, etc. They can be led by peers, pharmacists, nurses, providers or a combination. Nontraditional visits may also be phone calls, text messages or video calls between any team member and the patient.

Care Managers: Community primary care practices are increasingly using an assigned care manager for complex/high-risk patients. Different from case managers and care coordinators, the care manager is the primary source of information and contact for the patient and caregivers, the whole team and other providers outside of the practice. These nurses or social workers can intervene quickly where a delay in care could result in a hospitalization or emergency visit, and are especially involved in patient care transitions, where patients transfer from hospital to home, from a psy-

chiatric emergency to home, from a home to nursing home, etc. These transitions pose very high risk of errors, breakdowns or delays in care and hospital readmission.

Changing the Paradigm

Most prison and jail health clinics resemble a community medical practice in that there is a defined population of patients who use the clinic for all of their primary care, a medical record that all of the practitioners can access and a scheduling system. Correctional health services, though, are historically delivered in "silos" that address explicit functions—triaging patient requests, administering medications or "doctor sick call"—that are independent of one another. There may not be a cohesive team that is assigned to the population over time; in fact, in many prisons the clinicians are deliberately rotated.

Services are largely reactive—in response to inmate requests—or prescribed at specified intervals by condition or policy. Providers and nurses are often not aware if other team members are also interacting with that patient or why, and often do not know if the patient has other visits scheduled that day or week. Care is episodic and often fragmented. No-shows may or may not be addressed, and important information about behavior in the housing unit or adherence with medications or other treatments may not be available at the time of the visit. Information about recent urgent or emergent care may also not be readily available. Transitions between correctional facilities or from community hospitals back to a prison or jail create very high risk for breakdowns in care.

Changing the paradigm from line-based care to team-based care requires changing many ingrained processes, habits and attitudes. Shift changes, job descriptions, custody policies and security levels all complicate the evolution to team-based care. Transition may require some training and definitely requires support and assistance from leadership. The benefits, though, can be significant and include increased efficiency, improved clinical outcomes, reduced inmate demand for appointments, improved care transitions and increased job satisfaction for team members.

Applying Population Health Science to Care

An important component of emerging models of primary care is using population health science to assess patient risk and focus care to reduce risk and most effectively use resources. Primary care identifies unique patients (case finding) who merit focused interventions and increased resources. The practice also monitors the status of the population as a whole (surveillance), tracking health main-

Example: Robust Team-Based Care

Core team members—medication nurse, provider, RN, medical assistant, scheduler, corrections officer—huddle in the morning to share key information about the patients coming in that day: medications that are expiring, refused meds or missed appointments, requests for medical care, urgent/emergent care, etc. Three patients are discussed in detail. One, Mr. J., is coming in for his third visit complaining of back pain. He has been refusing his PRN NSAIDs. He requests care frequently and yesterday submitted two requests for athlete's foot and acid reflux that will be triaged today. The team decides that the RN and provider will meet with Mr. J. together and address adherence to back pain treatment, continuing pain and his two open service requests. They decide, with Mr. J., to adjust his NSAIDs to reduce his acid reflux, teach him back-strengthening exercises and treat his athlete's foot. The RN will schedule a nursing visit with him within a week to check on progress of all three conditions. Through a team approach, several nursing and provider visits were avoided.

continued on page 12

Example: Population Health Science

A health clinic of 1,500 inmates has 120 patients with diabetes. Using population management approaches, the clinic monitors the population of 120 patients as a whole, tracking whether it is improving in its HbA1c levels, what percentage received evidence-based diabetes care, hospitalization rates, etc. Using these tools, the clinic also identifies 19 patients with elevated HbA1c, blood pressure and cholesterol. Of them, six had hospital or emergency visits in the last 30 days. A care manager intervenes with the six highest risk patients, and the team develops strategies to see the other high-risk patients at frequent intervals until treatment targets are reached. Worsening of the population metrics over time is referred to the QI program for analysis.

tenance and screening services using rules set by the system to notify when patients are due for service based on their need and status. Using surveillance and case finding to drive care focuses resources in the most effective way. Care is concentrated on individuals at the point in time and with the intensity that is needed to move them toward wellness. The approach allows patients in excellent control to be managed with very few provider resources. Those in poor control receive different and more frequent interventions tailored to their needs until they reach treatment targets. The overall focus is on clinical outcomes.

The historical approach in correctional health is very different. The approach is generally based on repli-

cable and measurable intervals of care, especially for chronic diseases. Quality assessment of chronic care typically measures whether patients are seen according to required schedules based on broad levels of control, and do not consider appropriateness of care for specific patients. There is limited measurement of or attention to clinical outcomes.

Integrated Primary Care and Behavioral Health

Historically, community health care has addressed physical and mental health needs in separate systems of care, in different locations and with minimal sharing of plans of care or medical records. In the new model of integrated care, a patient's medical, mental health and substance use disorders are addressed in a whole-person approach by an integrated team of medical and behavioral health practitioners.

Example: Integrated Care

Inmate Jones has bipolar disorder, anxiety, hypertension and asthma. Control of all of his conditions varies over time. His behavior in the housing unit results in frequent "tickets" and periodic placement in observation status. He is currently expressing anger at his primary care provider for not prescribing the hypertension medication he wants and he refuses his medication several times a week.

Based on his level of medical, behavioral and mental health risk, he is assigned to the integrated care team. After reviewing his status and recent history, the team brings him in for a group visit with the PCP, nurse and mental health clinician. Mr. Jones expresses his frustrations and the team works with him to identify medical and behavioral goals for the next 30 days. The plan includes an appointment with the PCP to address antihypertensive options and his treatment plan. At the end of the visit, the patient expresses reduced but continued frustration with the PCP, relief that his team is working together and with him rather than him "trying to figure it all out myself" and commitment to treatment adherence for the next two weeks.

At subsequent visits, the mental health clinician reviews adherence with the medical plan of care and explores readiness for changes in treatment goals. Changes are communicated to the whole team. The nurse reinforces education about his antihypertensive regimen, brings him in for frequent BP and asthma checks until his conditions stabilize and reinforces his plan for anxiety management. The nurse, mental health clinician and custody officer advise the whole team about indicators of a change in medical or mental health, or behavioral/safety risk, and resources are deployed accordingly.

The team uses a single integrated problem list and integrated plan of care. Mental health clinics may include a primary care provider and address all of their patients' needs in that clinic. Primary care practices may include mental health practitioners, and many are moving to "consulting psychiatry" in which patients on psychotropic medications who are stable are managed by primary care with support and consultation as needed from a psychiatrist. This approach is gaining traction across the country as the demand for psychiatry continues to surpass supply.

In integrated care, the whole team can apply evidence-based behavioral health interventions, such as motivational interviewing, to chronic medical conditions. The team can also help patients better manage depression and anxiety that often accompany chronic medical conditions. The team can work with the patient on the complex interplay of medical and psychiatric symptoms and treatment options. This is especially important for those with serious mental illness, who have an extraordinarily high burden of metabolic syndrome, smoking and shortened life expectancy.

Integrated care brings all of the benefits of team-based care plus the benefits of a whole-person approach to care. In communities across the country, integrated care is demonstrating significant improvements in patient adherence to treatment plans, clinical outcomes of medical and behavioral conditions, the use of emergency services and hospital inpatient care, and patient satisfaction. Models of integrated care are also demonstrating enhanced provider satisfaction, which supports recruitment and retention of a high-quality health care workforce.

In prisons and jails, mental health and medical care are nearly always separated and the separation is often exaggerated by physical plant, separate provider contracts and even separate medical records. Integrated care can bring all of the benefits noted in community settings. It also offers a means to address inmate behavior in housing units and can potentially improve safety for inmates and staff. The integrated care model is especially relevant to correctional health because of the high volume of serious mental illness and chronic medical conditions in correctional populations.

Share Your Experience

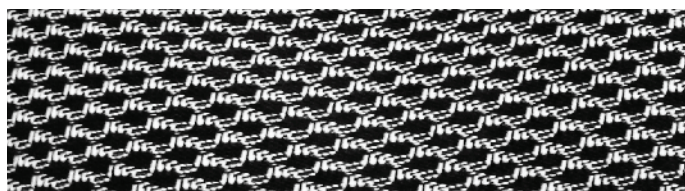
A few correctional settings have implemented the components of primary care presented in this article, in whole or in part, in spite of the absence of funding or research to support implementation of these models of care in corrections or development of corrections-specific applications. Future issues of *CorrectCare* will highlight case studies that illustrate the challenges and rewards that arise when prisons and jails implement these emerging components of care. If your setting has experience to share, please contact us.

Donna Strugar-Fritsch, MPA, BSN, CCHP, is a managing principal of Health Management Associates and is based in San Francisco. Linda Follenweider, MS, CNP, is a principal of HMA and is based in Chicago. Reach the authors at dstrugarfritsch@healthmanagement.com or lfollenweider@healthmanagement.com.



We have taken systems proven effective in large state Medicaid programs and introduced them to corrections with strong positive results.

BECKY LUETHY, RN, MSN, LNC, CCHP
DIRECTOR OF OPERATIONS DEVELOPMENT
28 YEARS OF EXPERIENCE



CORRECTIONAL HEALTHCARE



THE CENTURION DIFFERENCE

Centurion is committed to improving the health of the community one person at a time through healthcare programs for incarcerated patients. Our commitment includes specialty services that support our focus on whole health. To help us achieve this, Centurion has access to all Centene specialty service offerings, collectively referred to as **Envolve™**.

These specialty service offerings include:

Nurse Advice Lines

Women's Wellness Services

Lifestyle and Disease Management Services

Patient-centric Intergrated Utilization Management Services

Predictive Modeling and Care Management Analytics Solutions

Envolve is a service offering unique to Centurion, encourages inmates to take a more active role in their overall health, and better prepares them for managing their health in the community after release from prison.



800.416.3649

Visit www.centurionmanagedcare.com for more info.



How to Manage COPD Flare-Ups

by Aleksander Shalshin, MD, CCHP

Chronic obstructive pulmonary disease is a cause of major morbidity and mortality throughout the world and here in the United States. Care for COPD patients remains a challenge in both the community and inpatient settings, as exacerbation of this disease contributes to economic and social burden. The natural history of disease is intermixed by flare-ups that have short- and long-term implications.

Given the rapid growth of the population of aging inmates, health profiles of correctional patient population carry far-reaching public health implications. Research shows that among inmates older than 55 years of age, COPD prevalence estimates were more than five times higher than among inmates who were 45 to 54 years old.

Symptoms and Assessment

COPD is a preventable and treatable condition that is mostly a result of tobacco smoke and pollution. It is most commonly characterized as irreversible obstruction of airflow, especially on exhalation, that results in symptoms of shortness of breath at rest and on exertion, thereby limiting activities of daily living and productive existence. Patients with advanced COPD suffer from persistent dyspnea, which leads to decreased mobility, deconditioning and social isolation.

Most COPD exacerbations are triggered by a combination of viruses and bacteria; a small percentage are due to environmental pollution. On occasion, patients with heart disease and/or pneumonia may present with symptoms that mimic COPD exacerbation. A good number of patients with COPD suffer from cardiac decompensation, cirrhosis and renal insufficiency. In patients who present with multiple medical problems, careful analysis of the etiology of dyspnea may point to an accurate diagnosis of COPD vs. other conditions.

Generally, COPD exacerbation presents with symptoms of increased dyspnea, increased cough and increased production of sputum often accompanied by a change in sputum color and consistency. Patients with long-standing disease will report that they are more short of breath than usual and more limited in their daily physical performance. Many COPD exacerbation triggers are due to lower respiratory infections; however, decompensated heart disease, pulmonary embolism, pulmonary hypertension, gastroesophageal reflux and environmental pollution may play a role.

To assess the severity of COPD exacerbation, clinicians should look for the degree of dyspnea, noting the difference between the patient's baseline symptoms and current presentation. The ability to perform typical daily tasks also may be a good clue to degree of exacerbation. Physical examination must include vital signs, respiratory rate and pulse oximetry both at rest and on exertion if tolerated by the patient. Signs and symptoms of tachypnea, accessory muscle use, wheezing and cyanosis may necessitate transfer to the hospital. In the clinic, after a short walk in the corridor, exertional pulse oximetry may indicate significant hypoxemia and the need for referral to an inpatient location.

Treatment and Prevention

Treatment of COPD exacerbation starts with use of albuterol, a short-acting bronchodilator (SABA). Properly administered inhaled bronchodilators are as efficacious as nebulized therapy; however, patients in distress may find it easier to comply with nebulized solution of SABA. An additive effect in some patients with severe exacerbation may be attained from ipratropium bromide, a short-acting anticholinergic agent (short-acting antimuscarinic agent). For patients with a history of prostatic hypertrophy and/or urinary retention, anticholinergics may aggravate the problem.

The addition of systemic glucocorticoid therapy may provide a modest benefit in the management of outpatient COPD exacerbation. Dose and duration of therapy is not firmly established, but most patients benefit from 40 mg per day for five days. Higher doses and longer duration of therapy must be carefully weighed against potential complications and side effects of systemic steroid therapy, hyperglycemia, weight gain, gastrointestinal bleeding and fluid retention. This medicine has an excellent bioavailability profile, and either oral or intravenous administration may be used. The use of antibiotics is suitable for patients with moderate to severe flare-ups and those with reports of abnormal ancillary tests, e.g., chest radiograph, complete blood count and hypoxemia on pulse oximetry. Inhaled corticosteroids have a modest benefit in the care for COPD exacerbation, and the cost-effectiveness of these drugs in the acute phase is not legitimized. Inhaled corticosteroids are best when used with long-acting bronchodilators for maintenance of disease.

Additional steps to prevent and treat COPD exacerbation are supplemental oxygen for patients who have 88% and below saturation on room air, and continuous assessment for chronic oxygen supplementation need. An immunization profile for all patients who qualify for pneumococcal and influenza vaccination is extremely important. An effective smoking cessation program reduces exacerbations in those who continue to smoke and decreases the number of hospitalizations required for severe COPD. Educating patients on the proper use of inhaler devices and explaining the indication for each drug seems to improve treatment success. Support groups, involvement of diet and nutritional services, physical therapy and pulmonary rehabilitation all contribute to patient well-being and reduced exacerbations.

COPD remains one of the leading chronic care diagnoses. As the correctional population ages, the number of patients with COPD behind bars increases. Correctional health professionals must be competent and confident in the management of COPD and its exacerbation. Using good public health principles to prevent COPD exacerbations and tested therapy axioms for treatment of acute disease, clinicians in correctional settings can provide quality care with excellent outcomes.

Aleksander Shalshin, MD, CCHP, is a pulmonary specialist in private practice. He is the former medical director for Correctional Health Services, New York City Department of Health and Mental Hygiene.

As the correctional population ages, the number of patients with COPD behind bars increases

Pursue These Three Goals to Improve Patient Safety in 2016

by Susan Laffan, RN, CCHP-RN, CCHP-A

As correctional health care providers, we understand that the care given within correctional facilities must meet the community standards of care. Each year, The Joint Commission develops National Patient Safety Goals based on its determination of the highest priority patient safety issues and how best to address them. For laboratory services, the three patient safety goals for 2016 are as follows:

- Identify patient correctly
- Improve staff communication
- Prevent infection

Although these goals were identified for laboratories, they can be applied to every patient-provider encounter, whether in the community or in correctional settings. Most correctional facilities already have systems and policies in place to address these goals, yet it is always worthwhile to review your facility's compliance for these systems and policies. Each goal will be addressed individually, with suggestions for realistic ways to achieve the goal.

Identify Patient Correctly

Providers must use at least two ways to identify patients during each encounter. Examples of patient identifiers include a patient name (first and last), date of birth and facility identification number (on an identification bracelet/badge). If the patient is awake, alert and oriented, then the provider should always ask the patient to verify the patient identifiers.

Identifying the patient correctly means fewer mistakes in documentation (such as documenting information on the wrong patient chart); ensures that the correct patient receives the proper provider orders, medications and treatments; and demonstrates a patient-provider relationship.

Tips to ensure that the patient receives the care intended for that individual are to keep work areas organized and neat, and to complete tasks and documentation as soon as possible.

Improve Staff Communication

This goal focuses on getting important and/or critical results, assessments and findings to the appropriate staff person in an appropriate time frame.

With regard to laboratory testing and results, most facilities use an outside company to process the tests and report the results. Policy and procedures should be in place to address the reporting of important and/or critical results. Most laboratories have a policy that in the case of a critical result, not only is the printed information sent to the facility but, more importantly, the laboratory will call the facility with the critical result. For accountability purposes, the laboratory representative reporting the critical result will

obtain the name of the person in the facility to whom that critical result was reported. (See the Summer 2014 issue for more on lab test reporting.)

Whenever there is a critical result, critical finding or critical event, the appropriate provider must be notified in a timely manner. When dealing with any critical issue, the report to the provider must include the following: the provider name and title, the date and time, and any further orders/treatment/care to be completed. In addition, any reevaluation or confirmation that the patient received the treatment/care must be documented.

Prevent Infection

The best way to prevent the spread of infection is to use proper handwashing techniques—optimally, the hand hygiene guidelines from the Centers for Disease Control and Prevention. Proper handwashing does not pertain only to health care providers. Rather, these techniques should be taught to and used by all people within the facility, including correctional staff and inmates.

It is the responsibility of health care staff to educate correctional staff and the inmate population on basic infection control principles and practices to reduce the spread of infection. This can be accomplished by educational classes, in-service training sessions and signs or posters.

When there is an outbreak of skin conditions such as rashes or boils (which inmates often describe as “spider bites”) or complaints of itching, the medical providers must become detectives. If an infectious disease is identified, there needs to be a policy and procedures in place to address cleaning and housing issues in addition to the treatment of the infectious disease. Policy and procedures should also include a facilitywide cleaning schedule.

Evaluate Compliance

After you have reviewed your policies and procedures to address these 2016 goals, it is important to evaluate compliance. For each goal, a corresponding compliance indicator tool should be developed, and review should be ongoing. A compliance indicator tool can be developed in a few simple steps:

- Identify the goal
- Monitor compliance by observation or record review
- Report findings (negative and positive) to all involved
- Reevaluate the procedure if there are negative findings

Susan Laffan, RN, CCHP-RN, CCHP-A, is a consultant in correctional health care and is based in Toms River, NJ. She may be reached at njailnurse@aol.com.

image © LovArt Shutterstock.com

Root Cause Analysis: A Patient Safety Powerhouse

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the sixth in a series on patient safety.

Analysis of adverse events, whether near misses or actual clinical errors that cause patient harm, is an important part of a patient safety system. A primary mode of adverse event evaluation is root cause analysis, which reconstructs the events and trajectory of an incident to determine causative factors and safety failure modes. The strength of root cause analysis is the ability to thoroughly evaluate all possible contributing causes for the event, rather than simply relying on the first or most obvious cause discovered on investigation.

By fully evaluating an adverse event, both active and latent causes of clinical error can be identified. Active causes are readily apparent at the point of care and often include actions of staff members. Latent causes are more

insidious and involve less obvious system design issues or process failures.

The root cause analysis process involves asking three primary questions about the event:

1. What happened?
2. Why did it happen?
3. What can be done to prevent it from happening again?

Systematically answering these questions can reveal latent and active components of an incident so that evaluators are able to develop a more accurate picture of the context of a clinical error.

What Happened

The starting point of any good investigation is an understanding of what happened. Often a written incident report or error report is submitted. This can form the basis of an inquiry but is only a starting point. A full understanding of an adverse event requires interviews with involved parties and review of medical documentation and pertinent policies and procedures. It is important to keep an unbiased mental framework during this phase. Get all the facts out in the open before beginning to determine causality.

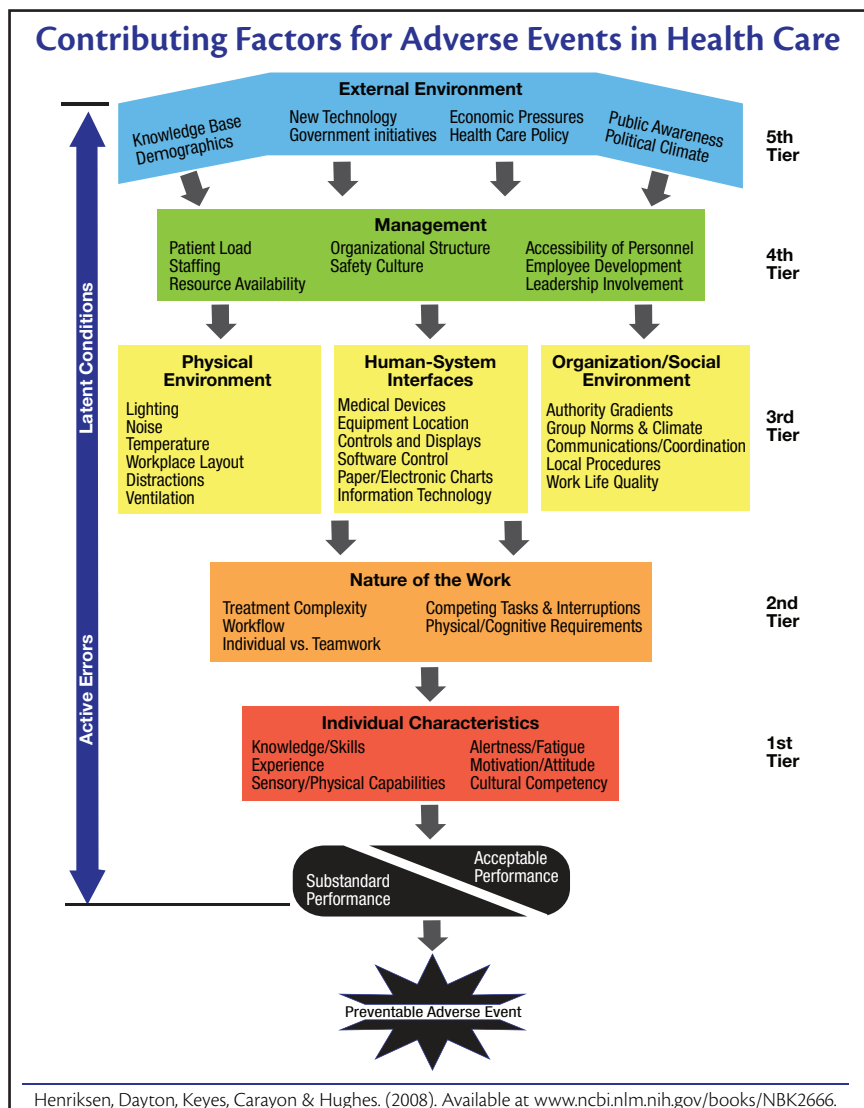
Why Did It Happen

The “why” question should be asked multiple times to dig deeper into causality. For example, failure to notify the provider about a critical lab value that resulted in a patient injury may, at first, seem to be a communication error on the part of the laboratory service. Asking the “why” question successively, it is found that the laboratory automatically faxes critical values to the site. The fax machine is located in the health service administrator’s office, which is locked and unattended on Saturdays, the day of the event. Per protocol, the laboratory service also calls the phone of the ordering physician. The physician in this example does not carry his work cell phone when not on-call, and the on-call physician for that weekend uses a different cell phone number posted for weekend staff but not available to the laboratory service.

Developing an effective root cause analysis requires a determination of all possible factors contributing to adverse events in the clinical setting. Henriksen and colleagues provide a thorough framework for determining contributing factors, from latent conditions to active errors (see figure). This five-tier framework is appropriate for correctional health care programs to use in evaluating adverse events.

When using the framework to evaluate causation, begin with the first tier (closest to the patient) and move outward, considering the contribution of each tier to the resulting event. Latent conditions that may be hidden from view in the initial evaluation become visible.

System change is necessary when a latent issue emerges regularly in the root cause analysis of individual adverse events. For example, if staff fatigue is implicated in a first-tier evaluation of several events, additional consideration



can be given to patient load and staffing conditions in the fourth-tier evaluation.

“How” and “why” questions guide a root cause analysis through the various tiers of contributing factors. In the initial round of evaluation, this is an educated guess on the part of the investigation team. Validation of the resulting hypotheses then determines the next course of action. The team may find that they must search further back in the sequence of events for latent causes not apparent in the initial resulting error evaluation. A rich field of inquiry is produced from a thorough root cause analysis of a single significant adverse event or multiple similar events that might suggest a system failure.

Mental tendencies and personal preferences can invade the adverse event analysis and require vigilance to prevent or eliminate. Three common evaluation biases are of particular concern:

- **Hindsight bias** results when investigators look back on a situation with the knowledge of the outcome. From this vantage point, the error trajectory is clearly visible and assumed to be clearly visible to the individuals at the point of care. However, at the time of the actual event, multiple variables were vying for the individual's attention and judgment, making the future outcome less apparent.

- **Attribution error bias** pins a clinical error on a character flaw or defect in the individual at the sharp end of care delivery. An attribution error bias would likely settle primary blame for a clinical error on the negligence or incompetence of the staff involved rather than seek full understanding of the system issues contributing to the event.

- **Confirmation bias** is a tendency to accept evidence that supports a favored working hypothesis. Hindsight bias and attribution error bias can contribute to confirmation bias. In an environment that seeks out individuals to blame, confirmation bias would encourage investigators to stop seeking causation once individual error is identified.

How to Prevent It From Happening Again

The investigators must determine all possible causes of a clinical error in order to create a plan of action. Active causes are easier to correct than latent causes and, therefore, it can be tempting to primarily focus on correction of active causes. Correction of latent causes, however, will result in more significant harm reduction organizationwide because these causes, at the blunt end of care delivery, affect multiple aspects of care.


Adverse event analysis by determining root causes is a primary function of an effective patient safety program. A structure that supports patient safety principles in reporting and analyzing adverse events will also support the reduction of patient harm and liability in the correctional setting.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation on projects to improve professional practice and patient safety. Her latest book, the Correctional Health Care Patient Safety Handbook, is available from amazon.com. Contact her at lorry@correctionalnurse.net.

NCCHC RESOURCES, INC.

Leveraging NCCHC's expertise in correctional health care, NCCHC Resources, Inc., provides customized education and training, preparation for accreditation and professional certification, performance improvement initiatives and technical assistance to correctional facilities interested in health care quality improvement. NRI will put together a team of experts – clinicians, educators, administrators or other thought leaders – to address any sized project or challenge. A nonprofit organization, NRI works to strengthen NCCHC's mission: to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities.

NRI provides:

- Education and Training
- Performance Improvement Initiatives 
- Preparation for Accreditation
- Preparation for Professional Certification
- Technical Assistance

“I am convinced that the decision to ... reach out to you for technical assistance is undoubtedly one of the best that I have made since my arrival.”

—Medical Director, Department of Youth Rehabilitation Services, Washington, DC

For more information on how NRI can help your facility improve the quality of health care delivery, contact info@ncchcresources.org or **773-880-1460**.



NCCHC Resources, Inc.

www.ncchc.org/NCCHC-Resources

Diagnostic Errors in Mental Health Care: An Unstudied Problem

How common are errors in diagnosis of inmates' mental health? What factors contribute to the risk of such errors? And how can they be prevented, or their consequences reduced? Given the potential harm that may arise from diagnostic error—whether underdiagnosis or overdiagnosis—a team of researchers from the University of Ottawa, Ontario, sought to examine these questions.

Writing in the April issue of the *Journal of Correctional Health Care*, Michael Martin and colleagues found that, despite the high prevalence of mental illness in correctional settings, there is a lack of studies that examine the prevalence of diagnostic error in these settings or their causes.

However, previous findings have determined that brief screening tools produce false negatives in at least 25% of inmates who have a mental illness and false positives in approximately 25% of inmates without an illness. After

Diagnostic errors are defined as discrepancies in an inmate's diagnostic status depending on who is responsible for conducting the assessment and/or the methods used.

adjusting for staff correction of these errors, the authors estimate that 10% to 15% of all inmates retain an incorrect diagnosis. They also note that agreement in two assessments does not guarantee a correct diagnosis, and thus their estimate of diagnostic error is likely too low.

Potential Causes

Using a 2006 conceptual model that groups causes of errors into patient, clinician and system factors—and interactions among the three—Martin and colleagues identify possible sources of errors in mental illness diagnoses.

Inmate-related factors include malingering of psychiatric symptoms and nondisclosure of symptoms, whether because of inability or unwillingness to do so. A history of trauma is another factor, since patients may present physical health complaints with ill-defined pathology, which may reflect psychological distress or unrecognized mental illness.

Factors related to clinicians include the use of heuristics in situations where time or information is limited (e.g., confirmation bias), screening and assessment processes, interview style and training, and the availability of information from previous providers or others close to the patient.

At the system level, factors include policies that fail to account for situational stressors (e.g., admission to jail) or the relationship between the assessor and the inmate (e.g., lack of rapport). The latter is especially important with regard to corrections officers, who play an important role in identifying inmates with mental illness.

Potential consequences of these types of errors are outlined in the article. However, it is unknown how often diagnostic errors translate into worse outcomes for inmates or when they may lead to inefficient use of resources.

A Need for Better-Informed Policies

With virtually no existing research into this subject, the authors do not make recommendations for mitigating the problem. However, they note that identifying characteristics of inmates, situations or environments that give rise to disagreements in diagnosis would be a worthwhile effort. It would inform policies and practice that minimize the risk of diagnostic error and mitigate the consequences for those who are misdiagnosed. This would lead to cost-effective mental health services that support optimal outcomes.

JCHC Volume 22, Issue 2

Screaming Behind a Door: The Experiences of Individuals Incarcerated Without Medication-Assisted Treatment — Shoshana V. Aronowitz, MS, FNP-BC, Jennifer Laurent, PhD, FNP

Diagnostic Error in Correctional Mental Health: Prevalence, Causes, and Consequences — Michael S. Martin, MA, Katie Hynes, BSc, Simon Hatcher, MD, MBBS, Ian Colman, PhD

Preparing Corrections Staff for the Future: Results of a Two-Day Training About Aging Inmates — Julie L. Masters, PhD, Thomas M. Magnuson, MD, Barbara L. Bayer, APRN, Jane F. Potter, MD, Paul F. Falkowski, PhD

Social Factors Related to the Utilization of Health Care Among Prison Inmates — Kathryn M. Nowotny, MA

Substance Use, Disordered Eating, and Weight Gain: Describing the Prevention and Treatment Needs of Incarcerated Women — Linda L. Drach, MPH, Julie E. Maher, PhD, Margaret J. F. Braun, PhD, Stefanie L. Murray, MPH, Elizabeth Sazie, MD, MPH, CCHP

Goals and Plans of Incarcerated Men Postrelease — Jacob J. van den Berg, PhD, Beth C. Bock, PhD, Mary B. Roberts, MS, Donna R. Parker, ScD, Rosemarie A. Martin, PhD, L.A.R. Stein, PhD, Jennifer G. Clarke, MD, MPH

Awareness and Environmental Exposures Related to Coccidioidomycosis Among Inmates at Two California Prisons, 2013 — Kaitlin Benedict, MPH, Anne E. Purfield, PhD, Janet Mohle-Boetani, MD, MPH, Charlotte Wheeler, MD, MPH, Benjamin J. Park, MD

Each issue offers continuing education credit through an online self-study exam. Members of the Academy of Correctional Health Professionals receive *JCHC* (print and online) as a member benefit. To obtain *JCHC*, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; <http://jchc.sagepub.com>.

Certification as a Talent Management Strategy

by Matisa N. Sammons, MA, CCHP

Corrections is a unique environment from a staffing perspective because it's not a place that can easily absorb staffing shortages, nor is that a safe idea. You might need to sometimes fill a position with a warm body, but what price are you willing to pay for someone ill-equipped for the job? The cost to replace employees can cripple a tight budget. The answer is talent management.

Talent management increases workplace productivity by improving processes for attracting, developing, retaining and utilizing people with the required skills and aptitude. More simply, it is how you select, manage and reward people. CCHP certification should be a part of that strategy.

Certification is a process by which one takes an exam to demonstrate mastery of NCCHC's *Standards*. This knowledge is important because the *Standards* guides health professionals in delivering quality care in a correctional environment. At its core, the *Standards* promotes quality of care equivalent to that in the community, which is also (generally) the legally accepted minimum level of care.

Candidate Selection

What knowledge, skills and abilities are most important when attracting top talent? Generally, for a health care position, it is important that a candidate possesses knowledge and techniques needed to treat injuries and diseases, active learning and critical thinking skills, oral comprehension and deductive and inductive reasoning.

What about the corrections-related aspect that is an important part of health care delivery? One option is to make correctional health experience a requirement, but that does not guarantee the knowledge base you are looking for, and it might exclude otherwise well-qualified candidates. Training on the job is an option, but you must expect and accept that mistakes will be made.

A better way to prescreen potential candidates is by indicating that "CCHP is preferred." It's an effective way to weed out the applicant pool, and to save training dollars and time later. Most importantly, you'll be hiring someone who has already demonstrated professional commitment to the field in making the investment to become certified.

Professional Development

Continuing education is necessary for professional development and a requirement for professional licensure as well as continuing CCHP certification. This education can take many forms: academic courses, CCHP certification, attending educational conferences, facility in-services and more. Development needs should be discussed and agreed upon by the employee and the immediate supervisor and relevant to the scope of work performed, but also to the employee's personal and professional goals.

Employers are improving when it comes to including CCHP certification as part of continuing development, according to a recent survey. Of 565 CCHPs who responded, 34% reported receiving paid time off to take the CCHP exam and 40% received reimbursement for exam fees. For continuing education such as an NCCHC conference, 38% received paid time off to attend and 36% received reimbursement. This is a step in the right direction, but what about the remaining 60% to 66% of certified staff?

Employee Appraisal

Performance appraisals are usually conducted once per year, but serve two different purposes: administrative and development (pay and promotions). Employee development should be an ongoing process where the employee and supervisor meet quarterly to review and evaluate performance objectives. The administrative process should align performance objectives with commensurate pay.

What performance indicators are being set for your staff? If they include important objectives like learning the standards, writing policies and procedures or learning relevant legal principles, then one performance indicator that suggests these goals have been met is whether the employee has achieved CCHP certification. When an employee is able to perceive a relationship between performance objectives and rewards, desired behaviors become reinforced.

Unfortunately, few CCHPs reported alignment between achieving certification and pay. Only 7.9% reported advancement or promotion, 7.4% reported a salary increase and 1.3% a one-time bonus. Compared to the personal rewards and accomplishment felt by CCHPs, employers have a long way to go with rewarding CCHPs for their efforts and the value they add to operations, which benefit everyone, including the employer.

Matisa N. Sammons, MA, CCHP, is vice president of certification for NCCHC.

Why Is Certification so Important?

More than 90% of respondents to the CCHP survey said they pursued certification because it:

- Provides personal satisfaction
- Enhances feelings of personal accomplishment
- Provides evidence of professional commitment
- Enhances professional credibility
- Indicates professional growth
- Validates specialized knowledge
- Enhances personal confidence in professional abilities
- Indicates mastery of professional standards

CCHP Exam Dates

June 4	Regional sites
July 16	Boston, MA
August 20	Regional sites
October 23-24	Las Vegas, NV

We are seeking sites for regional exams as well as CCHPs to proctor the exams. To participate, contact the certification assistant at 773-880-1460 or cchp@ncchc.org. See the complete calendar at www.ncchc.org/cchp/calendar.

Readerresponse

Making a Difference

As a surveyor for NCCHC's opioid treatment program accreditations, I typically interview OTP patients to gather information. Generally, patients in OTP and on methadone want to tell you more than you want to hear about their drug abuse issues, but during a recent survey, I had a remarkable interaction. I asked a patient, who has been incarcerated for 11 months and was on long-term detox, if she was pleased with the program and did she have anything to add. She looked at me directly, then said, with intensity, "It saved my life."

At the exit conference, which was very positive, I used her comment to close the meeting. As I left the facility, it struck me that beyond the documentation, policies, procedures, credential reviews, training requirements, screenings, assessments, meeting minutes, health record reviews and my own desire to be sure I covered everything required by the 47 OTP standards, the real bottom line is this: Does all of this make a difference in the lives of incarcerated patients? This opioid treatment program certainly made a difference in the life of this young woman!

Peter Heffernan, MBA, CCHP
NCCHC Lead Surveyor

New Standards for Opioid Treatment Programs Hot Off the Presses

NCCHC's standards for OTPs have been updated to reflect the 2015 revision of the Federal Guidelines for Opioid Treatment Programs, published by the Substance Abuse and Mental Health Services Administration.

The *OTP Standards* manual presents NCCHC's requirements for corrections-based opioid treatment programs seeking accreditation. Importantly, it takes into account the issues unique to providing OTP services in a correctional facility.

Expanded to more closely align with NCCHC's *Standards for Health Services* for jails and prisons, this second edition has 47 standards (vs. 43 in the 2004 edition). New standards address emergency response plans, patient and staff safety, inmate workers, mental health screening and evaluation, and patient escorts.

Like NCCHC's other *Standards*, the manual is divided into nine general areas: health care services and support, patient care and treatment, special needs and services, governance and administration, personnel and training, safety, health records, health promotion and medical-legal issues.

The revision was undertaken by a task force of experts chaired by Kevin Fiscella, MD, MPH, who serves on NCCHC's board of directors as liaison of the American Society of Addiction Medicine. Other task force members were Jeffrey Alvarez, MD, CCHP, Barbara Mariano, RN, CCHP, Carolyn Sufrin, MD, PhD, Wilma Townsend, MSW, James Voisard, BS, CCHP-A, and Katie Wingate, MSN, RN, CCHP.

The *OTP Standards* may be purchased online at www.ncchc.org/ncchc-store or call 773-880-1460.

New From SAMHSA

Medication-Assisted Treatment of Opioid Use Disorder Pocket Guide (free PDF) — available for download at <https://content.govdelivery.com/accounts/USSAMHSA/bulletins/13fdf0e>

Legal Affairs (continued from page 8)

Conley deserves the right to show this is beyond mere negligence and that providing something resembling care does not itself escape the reach of deliberate indifference. Conley's medical expert opines that the appropriate treatment for a probable fracture would have been to immobilize Conley's hand using a splint and to promptly order X-rays, to be taken within three to five days. Dr. Birch, of course, did not recommend immediate immobilization and, although she ordered an X-ray approximately five days after learning of Conley's injury, the X-ray was not slated to be performed for an additional eight days (Jan. 6, 2010). There is no suggestion that Dr. Birch herself scheduled the X-ray; it is reasonable to infer—based on the prison's standard practice of releasing inmates for X-rays only twice per week (and less frequently over the holidays)—that Dr. Birch knew that it would be some time before Conley received his X-ray.

Thus, Conley survives summary judgment and is afforded a chance to settle or make his considerable case to a jury.

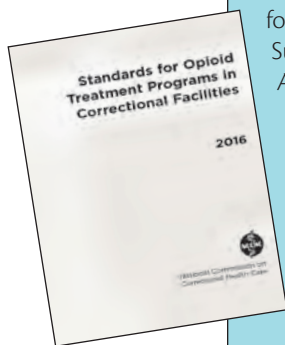
Comment

Dr. Birch was the only physician available to this injured inmate. While Dr. Birch did something, expert testimony strongly argues it was well below the relevant standard of care and as a result a permanent injury ensued.

Doing something, we learn again, is not the equivalent of doing what is minimally needed. While this may seem self-evident, there is some earlier federal case law suggesting that virtually any medical intervention negated deliberate indifference, but this is less and less the case.

Fred Cohen, LLM, is executive editor of the Correctional Health Care Report. This article is scheduled for a future issue of CHCR, ©2016 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicrosearchinstitute.com.



Connecticut to Expand Opioid Treatment for Prisoners

The Connecticut Department of Correction is planning to roll out what may be the nation's first statewide methadone treatment program for inmates. This program will expand on two successful pilots at two of the state's jails (the DOC operates a combined system of jails and prisons). The aim is to help inmates avoid painful withdrawal symptoms and overdoses, including overdose after release, when their tolerance is lower. Over the next year, the program will be expanded to the state's other three jails to treat addicted inmates, and in prisons will be offered to opioid addicts six to eight weeks before release. The program also includes counseling. The DOC's goal is to treat 1,000 inmates a year at an estimated cost of \$4 million.

- www.nhregister.com/20160417/connecticut-to-expand-methadone-treatment-in-prisons

OJJDP to Help States Eliminate Solitary for Juveniles

The federal Office of Juvenile Justice and Delinquency Prevention has announced the agency's goal of eliminating the use of solitary confinement for juvenile offenders at the state and local levels. Solitary for youth in the federal prison system was recently banned by President Obama. In an April 19 blog, OJJDP administrator Robert Listenbee stated the importance of "creating an environment where [confined youth] can heal and thrive. We are committed to working with states to develop effective policies to limit the practice and adopt alternatives," he wrote. "We encourage states, localities, and tribal communities to follow the

guiding principles and policy recommendations" made in a Department of Justice report on restrictive housing. The agency's Center for Coordinated Assistance to States provides cohort-based training and technical assistance.

This effort aligns with NCCHC's new position statement, which says that juveniles, mentally ill people and pregnant women should be excluded from solitary confinement of any duration, and calls for an end to prolonged (more than 15 days) solitary confinement for others.

- www.justice.gov/opa/blog/ojjdp-supports-eliminating-solitary-confinement-youth
- www.justice.gov/dag/file/815551/download
- www.ncchc.org/solitary-confinement

HCV Deaths Hit Record High in U.S.

Deaths associated with hepatitis C reached an all-time high of 19,659 in 2014, according to data released by the Centers for Disease Control and Prevention in May. In 2013, HCV-related mortality surpassed the total combined number of deaths from 60 other infectious diseases reported to the CDC. These data likely understate the true picture since hepatitis C is often underreported. Baby boomers—those born from 1945 to 1965—account for most cases of hepatitis C, often acquired during medical procedures that were less safe than they are today. Unaware of their infection and without treatment, they may unknowingly transmit the disease to others. Since 2010, acute infections have more than doubled, mainly among young, white injection drug users.

"Why are so many Americans dying of this preventable, curable disease?" asked Jonathan Mermin, MD, director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The CDC recommends implementing comprehensive prevention programs to avert drug-related HCV transmission. These programs should include regular testing for hepatitis C (as well as hepatitis B and HIV); rapid links to medical care for people who test positive; and access to substance abuse treatment, sterile injection equipment and other services.

- www.cdc.gov/media/releases/2016/p0504-hepc-mortality.html

HIV May Accelerate Aging

HIV infection seems to cause people to prematurely age by an average of 4.9 years, according to a study published in *Molecular Cell* in April. The study, which used a "highly accurate biomarker" to measure epigenetic changes in cells, determined that this aging increases the risk of early death by 19%. The 137 study participants were being treated with combination antiretroviral therapy and had no other health conditions that would skew the results. The study found no difference in aging between those infected within five years and those with chronic (more than 12 years) infection. The researchers advise people with HIV to make healthier lifestyle choices to diminish their risk for age-related diseases.

- www.sciencedaily.com/releases/2016/04/160421133642.htm

Spotlight *(continued from page 7)*

shared with all health staff. To document this review, it is recommended that staff members who are not present during a drill later review and initial the written critique.

New to the 2014 jail and prison standards and 2015 juvenile standards is the requirement that recommendations for health staff be acted upon. For example, if during a drill the health staff find that the emergency response equipment was missing or not in working order, the written critique should state how this problem was resolved and the steps to ensure it doesn't occur again.

Are You Ready?

Practicing the emergency response plan improves health staff's ability to respond to disasters when they occur, and drills help to identify weaknesses in the plan. The scenario described at the beginning of this article could happen at any time. Are you ready to respond?

Tracey Titus, RN, CCHP-RN, is NCCHC's vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org. Find the complete Spotlight series at www.ncchc.org/standards-explained.

National Conference on Correctional Health Care

October 22-26 • Gaylord Opryland Resort, Nashville



The National Conference celebrates 40 years in 2016! Join us at one of the world's largest gatherings of correctional health professionals. Attendees come from all segments of the correctional health care community—administrators, medical and mental health directors and managers, physicians, nurses, mental health professionals and more—to share insights, find solutions and identify best practices. Connect with more decision makers than you can in months of cold calling. Sign up for a cost-effective exhibition booth today!

Who Attended in 2015?

Nurse/nurse practitioner	38%
Physician/physician assistant	25%
Administrator	15%
Psychiatrist/psychologist	8%
Social worker, therapist, counselor	6%

Decision Makers With Authority

State/facility medical director or director of nursing	25%
Health services administrator	10%
Department manager/supervisor	15%
Health services, dental or mental health staff	19%

Who Do Attendees Represent?

Jail facility	44%
Prison facility	21%
State DOC/agency	11%
Private corporation	10%
Juvenile detention or confinement facility	4%
Federal agency	4%

Categories Attendees Recommend or Buy

• Dental care and supplies	• Dialysis services
• Disaster planning	• Education and training
• Electronic health records	• Health care management
• Health care staffing	• Infection control products
• Information technology	• Laboratory services
• Medical devices and equipment	• Medical supplies
• Optometry services	• Mental health services
• Pharmacy services	• Pharmaceuticals
• Substance abuse services	• Safety equipment
	• Suicide prevention

Draw Qualified Customers to Your Booth

NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and outreach to local facilities and agencies.

- Three days of exhibit hall activities
- Two free full conference registrations per 10' x 10' booth
- Discounted full registration for up to three additional exhibit personnel (per company)
- Access to nearly 2,000 attendees for premium face time
- 50-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and postshow marketing
- Discounts on advertising in the conference programs
- Opportunity to participate in raffle drawings
- Continuing education credits for all sessions attended
- Exclusive opportunity to become a sponsor or advertiser

Amplify Your Brand Through Sponsorship

Enhance your exposure to conference attendees and provide a memorable conference experience. Sponsors receive extra recognition in conference materials and pre- and post-conference promotion. Ask the NCCHC sales representative to help you maximize your marketing exposure.

- Conference app
- Exhibit hall reception, lunch or refreshment breaks
- Product Theater events
- CCHP lounge host
- Conference portfolio
- Hotel key card
- Exhibitor lounge
- Keynote speaker
- Premier educational programming
- Internet kiosks
- Meeting message board
- Conference bags
- Show bag insert
- Exhibit hall aisle drop

Become an Exhibitor Today!

Make a cost-effective impact! This high-profile event is where you can meet with key contacts and enhance your standing, so reserve your space now. Standard booth sizes are 10' x 10'; double-size and premium spaces are available. For details and a reservation form, download the prospectus at www.ncchc.org, or contact Carmela Barhany at sales@ncchc.org or 773-880-1460, ext. 298. Be sure to ask about sponsorships and advertising.



WHERE WILL YOU FIND YOUR NEXT GREAT HIRE?

Find your next lead with the **National Commission on Correctional Health Care mailing list**, a proven tool to reach over 30,000 physicians, nurses, mental health care providers, medical directors, nurses and other allied health professionals and administrators. Pinpoint your audience by job title, work setting and demographics. No other marketing channel allows you such a targeted marketing opportunity.

www.InfocusLists.com/Datacard/NCCHC

Contact INFOCUS Today!
Kerry Tranfa
ktranfa@infocuslists.com
 800.708.LIST (5478), ext 3247

INFOCUS
THE ASSOCIATION LIST SOURCE

www.InfocusLists.com

EMPLOYMENT

Physician – Correctional Health

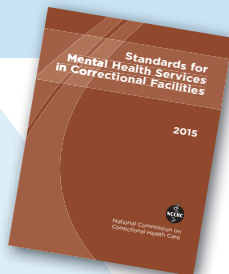
Santa Clara Valley Medical Center, a public teaching hospital, affiliated with Stanford University School of Medicine, located in the heart of Silicon Valley in San Jose (San Francisco Bay Area in Northern California) is seeking BC/BE Family Medicine or Internal Medicine Physician for a small group practice in Custody Health. We offer competitive compensation, comprehensive benefits and paid malpractice. Please submit a letter of intent and CV to roya.rousta@hhs.sccgov.org. SCVMC is an Equal Opportunity employer.

2015 STANDARDS for Mental Health Services in Correctional Facilities

Newly revised, the 2015 Standards present NCCHC's latest recommendations for managing mental health services delivery in adult correctional facilities.

This second edition represents the **culmination of hundreds of hours of careful review** by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain **the most authoritative resource for correctional mental health care** services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women's health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.



To order or to see a list of all NCCHC publications, visit www.ncchc.org.



SIMPLIFIND

Tap into the incredible network of the National Commission on Correctional Health Care with the NCCHC Buyers Guide. Powered by MultiView, the Guide is the premier search tool for correctional healthcare practitioners. Find the suppliers and services you need, within the network of the association you trust.

Simplifind your search today at www.ncchc.org.



About CorrectCare®

CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

Subscriptions: *CorrectCare* is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, create an account online at www.ncchc.org or email us at info@ncchc.org. The magazine is also posted at www.ncchc.org.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, email editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

Advertising: Contact Carmela Barhany, sales manager, at sales@ncchc.org or 773-880-1460, ext. 298.

ADVERTISER INDEX

AmeriHealth Administrators.....	9
California Correctional Health Care Services.....	6
Centurion	13
Correctional Mental Health Report.....	8
GEO Group.....	24
InFocus Lists.....	22
Medi-Dose/TampAlert.....	IFC
NCCHC Resources, Inc.	17
PowerDMS.....	BC
Standards for Health Services in Juvenile Facilities.....	5
Standards for Mental Health Services.....	23
Wexford Health Sources.....	IBC

Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

COs and Confidential Health Information

Q Would it be considered a HIPAA violation if a correctional officer looked at the information in an inmate's medical records? Does NCCHC have standards that address this topic?

A Standard H-02 Confidentiality of Health Records requires that the confidentiality of a patient's written or electronic health record, as well as orally conveyed health information, is maintained. The responsible health authority should control access to the health records and health information. The RHA should maintain a current file on the rules and regulations covering the confidentiality of health records and the types of information that may or may not be shared.

Standard C-08 Health Care Liaison requires that a designated trained liaison coordinate the health services delivery in the facility on those days when no qualified health care professionals are available for 24 hours. The health care liaison may be a correctional officer or other person without

a health care license who is instructed by the responsible physician in limited aspects of health care coordination. The health care liaison generally carries out the following duties: reviews receiving screening forms for follow-up attention; reviews nonemergency health care requests as instructed by the responsible physician; helps to carry out clinicians' orders regarding such matters as diet, housing and work assignments; and maintains patients' rights to privacy. The health care liaison does not deliver health care.

Naming Policies and Procedures

Q In our jail's accreditation survey report, the findings for standard J-A-05 Policies and Procedures stated that a procedure with the title "Patient Safety" was not found, but that all components of standard J-B-02 Patient Safety are addressed in several of our policies. Do we need to have "Patient Safety" in the title of one or more of the policies if the content of the policies meets the standard?

A Although the policies do not need to be numbered or titled to match NCCHC standards, we do need to see that they contain the wording for each compliance indicator along with a description of how each compliance indicator is met. If the policies you mentioned clearly outline compliance indicators #1 and #2 of standard B-02, along with a description of how each indicator is met, then it should satisfy the requirements of the standard.

Medication Administration Training

Q Our jail is preparing for initial health services accreditation. Can you tell me what the training requirements are for medication administration?

A NCCHC Standard C-05 Medication Administration Training requires that all personnel who administer or deliver prescription medication are permitted by state law to do so, and are appropriately trained as needed in matters of security, accountability, common side effects and documentation of administration of medicines. Other issues that should be discussed during the medication administration and delivery training are hoarding of medications, selling of drugs, overdoses and adherence to therapeutic regimens. Psychiatric staff should review the training materials with regard to psychotropic medications. A clinician designated by the responsible health authority and facility administrator or designee should approve the training. The standard also recommends that posttraining evaluation be conducted. Documentation of completed training and testing should be kept on file.

Tracey Titus, RN, CCHP-RN, is NCCHC's vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460.

— GEO IS HIRING — Medical Professionals Nationwide



Apply Online at www.jobs.geogroup.com

The GEO Group Inc. is the world's leading provider of diversified correctional, detention, community reentry, and electronic monitoring services to government agencies worldwide.



Questions? Contact Michele Dobos
Toll Free: 866 301 4436 ext 5863

Equal Employment Opportunity



When it comes to innovative ideas in correctional health care, we've taken the shackles off.

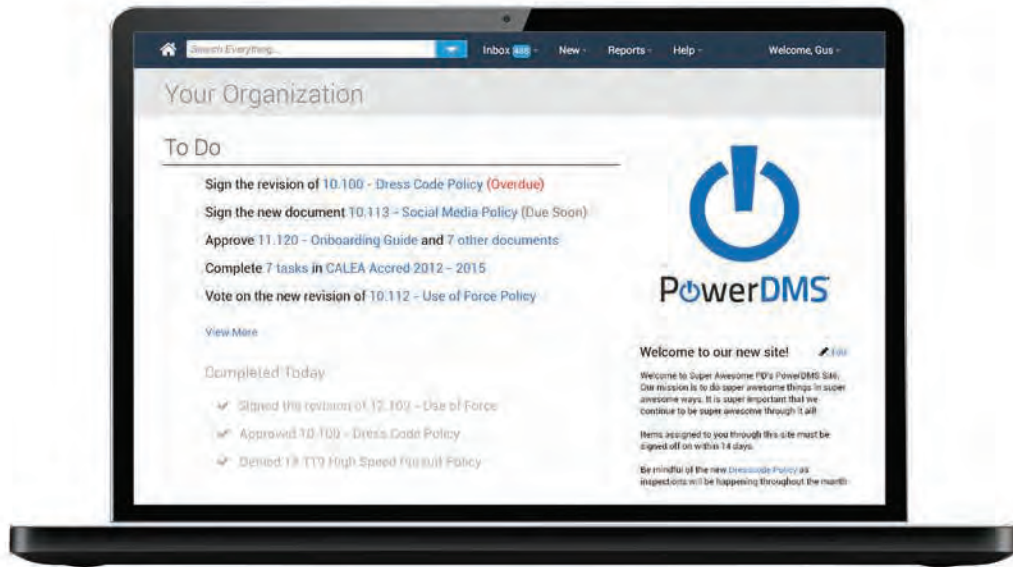


Wexford Health is stretching the boundaries of innovation to bring you more efficient, safer, and smarter health care. Our 340-B pharmacy, re-entry, and Medicaid reimbursement programs are at the forefront of the industry. And with our telehealth services and electronic medical records, we can speed up care, improve outcomes, and save you money. For ideas that break out of the box, but don't break the bank, visit wexfordhealth.com.



QUALITY CARE | EXPERIENCED MANAGEMENT TEAM | PROVEN STAFFING EXPERTISE | TECHNOLOGICALLY ADVANCED SERVICES | COST CONTROL

Join the Fight Against Paper! Go Electronic...NCCHC Did!



Subscribe electronically to NCCHC Jail and Prison Standards. This is a 12 month pilot program between PowerDMS and NCCHC.

PowerDMS provides a secure, web-based software subscription that provides delivers tools to organize and manage critical content – reducing risk, improving workflow and allowing you to focus on improving safety and quality patient care.

Visit PowerDMS.com/NCCHC to sign up for a 14-day Free Trial.

PowerDMS® Benefits



Central Location



Workflow



Training



Accreditation

To learn more, visit PowerDMS.com