Summer **2019** | Volume **33** | Issue 3

CorrectCare®

The magazine of the National Commission on Correctional Health Care

LGBTQ+ Detainees Find Community in Supportive Groups

Control of Measles in a Custodial Setting

NPs in Corrections: What Is Their Role?

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Deborah Ross Named Interim CEO

The National Commission on Correctional Health Care has appointed Deborah Ross as interim chief executive officer.

Deborah has worked for the National Commission for 21 years, most recently as the vice president of education and meetings. Throughout her career with NCCHC, she has developed strategic plans aimed at promoting growth and awareness within the correctional health care community. She has built relationships and partnerships with diverse stakeholders who share common interests. Through these efforts, she has expanded educational programming and outreach, leading NCCHC to be recognized as the premier educational provider in the field.

Deborah also serves on the board of directors for the Professional Convention Management Association, Greater Midwest Chapter. Earlier in her career, she served in leadership positions at the International Society of Traumatic Stress Studies and the Association of Behavioral Health Care Medicine.

"With her long tenure and extensive experience at the National Commission, the board is confident of Deborah's ability to continue the progress we've achieved to date," says Thomas Fagan, PhD, CCHP-MH, chair of NCCHC's board of directors.

Someone You Should Know

James Martin, MPSA, CCHP, has been promoted to vice president of program development for the National Commission. He had worked for four years as accreditation specialist and was involved in all aspects of the program. He has been highly visible at NCCHC conferences as a presenter and trainer, and speaks at other events around the country.

Jim is a deeply experienced and versatile career law enforcement professional, having served for 23 years at the Vanderburgh County (IN) Sheriff's Office as a lieutenant and assistant jail commander.

In this newly created position, he will focus on business development efforts to further the growth of accreditation, certification and other NCCHC programs and activities. Jim is the person to contact for information on how NCCHC can best work with your facility, system or program to improve your health care services. Contact him at jamesmartin@ncchc.org.

In Memoriam: Carl Bell

Carl C. Bell, MD, CCHP, a distinguished psychiatrist and longtime board member of NCCHC, died at his home in Chicago on August 2.

Dr. Bell's involvement with NCCHC dates to its beginnings. He was a founding board member and served for 33 years as the National Medical Association liaison, providing expertise on the relationship between poverty, violence, mental health, race and incarceration. He served as board chairman twice and chaired the accreditation committee for more than a decade. He played key roles in developing and updating NCCHC's jail, prison and mental health standards, as well as the seminal Health Status of Soon-to-Be-Released Inmates report to Congress. He also advocated for the CDC to broaden its mission to include correctional health care—a significant turning point for the field.

In addition to many other awards, in 2018 Dr. Bell received the Bernard P. Harrison Award of Merit, NCCHC's highest honor, for his long involvement with the organization and his groundbreaking work.

Calendar of events

October 3	CCHP exams, Newport, OR
October 8	CCHP exams, Alexandria, MN, and Atlantic City, NJ
October 12-16	National Conference on Correctional Health Care, Fort Lauderdale
October 13	Accreditation Committee meeting
October 13-14	CCHP exams, Fort Lauderdale
November 15	Accreditation Committee meeting

See the list of all CCHP exams at www.ncchc.org/cchp.

New! Prestigious Honor for Accredited Facilities

Correctional facilities that hold NCCHC accreditation in three service areas—health services, mental health services and opioid treatment—are eligible to receive the new NCCHC Pinnacle Recognition. For more information, contact traceytitus@ncchc.org.

Suicide Prevention Resources

Inmate suicide is a serious challenges in corrections. To help the field save lives, our website offers useful guidance, including full text of our standards on suicide prevention and intervention (jails/prisons and juvenile settings), white papers and a position statement—and soon, our forthcoming Suicide Prevention Resource Guide, developed in partnership with the American Foundation for Suicide Prevention.

For Better Outcomes, Let's Improve Coordination With Community Care

by Thomas J. Fagan, PhD, CCHP-MH

As correctional health and mental health services are more widely understood to be a piece of the larger public health system, the question many correctional health care providers ask is, "How can we more effectively transition individuals both into and out of our correctional facilities?"

Simply dropping an individual off in the receiving area of a prison or jail without detailed medical and/or mental health information where such information exists or releasing a medically or mentally challenged person with a bus ticket, a few days of medication and a little pocket money are just not viable options and may set the stage for a quick return to prison or jail. Transitions both into and out of correctional facilities are critical and essential for maintaining continuity of care.

Barriers to Continuity

Although there are a number of excellent court-based programs designed to divert individuals with serious mental health, substance abuse or psychological trauma, individuals who do not succeed in these programs often end up behind bars. How quickly and in what format health care information is transferred to correctional health care providers is important to ensure that medications and treatment are continued without interruption.

And yet, few localities have a well-defined mechanism for communicating this information effectively and efficiently. Surely in this age of advanced technology, there is a way to codify essential health care information and move it in a timely fashion throughout our public health care system while simultaneously safeguarding patient privacy.

Similarly, individuals whose medical, mental health and/or substance use problems have been stabilized while in prison or jail will need additional community support when they are released. Research suggests that without strong community support, the chance of recidivism among these individuals increases significantly. Clearly, they need ongoing medical and mental health support with community health care providers, and how efficiently and effectively their individual treatment needs are communicated to these health care providers is, once again, essential for continuity of care. While this is an obvious statement to make, the process is fraught with problems.

Many jurisdictions do not have effective communication mechanisms by which to transfer relevant treatment information from correctional to community health care providers. Additionally, releasees may not have the mental capacity to follow through with health care appointments or adhere to prescribed medication and treatment regimens. They may not have the financial ability to pay for health care services due to their lack of employment, nor have quick access to Medicaid benefits that were terminated with incarceration. They may not have access to the transportation needed to access this care.

In addition, community-based health care providers may be reluctant to treat individuals who were incarcerated. In many cases, postrelease adjustment for those with chronic medical, mental health and/or substance use disorders is further complicated by a lack of adequate housing and the family or community support needed to help these individuals navigate postrelease issues and problems.

Smoothing the Way to Successful Reentry

While these problems are significant, some jurisdictions are finding innovative ways to address many of these issues. For example, some correctional systems are implementing prerelease programs as early as six months prior to release. Through these programs, soon-to-be-released individuals are educated about common obstacles that others have found postrelease and how they overcame these obstacles. They are informed about community-based programs and services that may be of benefit to them and how to access these programs. Community health care providers are also brought into the correctional facility and introduced to their future clients and their treatment programs and individual needs. This "in-reach" approach gives the patient and the community-based provider an opportunity to establish a therapeutic relationship before release.

Other jurisdictions are using an extensive "out-reach" approach to managing releasees. These programs typically use a multidisciplinary team approach designed to aggressively address the various needs of each released individual. These programs, sometimes called assertive community treatment programs, assign each person to an individual "navigator" or team of individuals who assist with housing, employment, treatment and transportation needs and provide the community-based support and encouragement that is often lacking, but desperately needed for a successful community reentry. In some programs, navigators will pick the client up at the prison or jail gate and provide transport to community supported housing.

Research suggests that these in-reach and out-reach programs can reduce recidivism. However, the obvious problem for many jurisdictions is that these programs are

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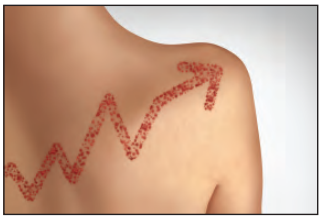
Control of Measles in a Custodial Setting

by Dharmapuri, Sadhana, MD, Karen Simpson, MD, MPH, and Kenneth Soyemi, MD, MPH, MBA

The recent U.S. measles outbreak is the largest since 1992. According to the Centers for Disease Control and Prevention, more than 1,000 infections have been reported from 28 states in 2019. It is just a matter of time before measles is introduced into a custodial setting. Are we prepared?



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Measles is a contagious disease with a high attack rate in vulnerable populations, with one infected person having the potential to infect 17 to 20 susceptible people. When measles is introduced into closed settings such as jails, prisons or juvenile detention centers, the number of potential new infections will rise exponentially depending on the immunization status of the residents. Therefore, closed settings have to be prepared to rapidly identify, isolate and vaccinate vulnerable residents.

This article presents steps to take to prevent the spread of measles in a custodial setting.

Outbreak Prevention

Measles will most likely be introduced from external sources such as staff, visitors and vendors. Screening for immunity (staff and residents) ahead of an outbreak during this high-alert period is cost-effective and necessary to prevent measles introduction. The goal of screening is to identify potential vulnerable residents and staff and, in the event of an outbreak, exclude them from work or isolate them to prevent disease transmission.

Steps to take in the event of an outbreak are as follows:

1. Immediately isolate the suspected resident or inmate and implement contact precautions and postexposure prophylaxis (PEP).
2. Call your local health department upon suspicion; confirm disease using clinical and laboratory parameters (see definitions).
3. Staff, visitors and vendors exposed to measles who cannot readily show that they have evidence of immunity against measles should be offered PEP or be excluded from the facility.
4. To provide protection or modify the clinical course among susceptible residents, staff or vendors, either administer the MMR vaccine within 72 hours of initial exposure or immunoglobulin (IG) within six days of exposure. Do not administer the MMR vaccine and IG simultaneously, as this practice invalidates the vaccine.
5. If the MMR vaccine is not administered within 72 hours as PEP, the vaccine should still be offered in order to offer protection from any future exposures. Those who receive the MMR vaccine or IG as PEP should be monitored for signs and symptoms consistent with measles for at least one incubation period (7-21 days).
6. Infected residents or inmates should be isolated for four days after they develop a rash.
7. Work on logistics such as getting security clearance to enable local health department staff to enter the facility.
8. Stop the transfer of residents or inmates in and out of the facility to reduce the risk of spreading measles to other parts of the facility.

According to the Federal Bureau of Prisons immunization guideline, during a measles outbreak in an adult custodial setting, it is recommended that one dose of MMR vaccine be given to anyone identified to be at risk and to those who have no evidence of immunity to measles within 72 hours of exposure.

Discussion

To the best of our knowledge, no measles outbreak has been reported in a juvenile custodial setting, and a search of databases revealed few reported outbreaks in adult settings. In the United States, the receipt of two or more MMR vaccines is documented in more than 90% of adolescents aged 13 to 17 years across all ethnic groups, metropolitan statistical areas, rural and non-rural counties and states, according to the National Immunization Survey. The MMR vaccine update trend in these birth cohorts remains high from 2008 through 2017, and we postulate that this high MMR vaccine uptake might contribute to the paucity of the measles outbreak in juvenile custodial settings.

Previous mitigation efforts during prison outbreaks demonstrated that mass vaccination following an outbreak is not always likely to prevent new infections among susceptible individuals. Favorable mitigating factors include implementing opt-out testing, vaccination and requiring full immunization of staff, contractors and vendors.

Case Definition of Measles

Source: Council of State and Territorial Epidemiologists

A measles outbreak is defined as three or more cases.

Clinical Description: An acute illness characterized by:
- Generalized, maculopapular rash lasting ≥ 3 days
- Temperature ≥ 101°F or 38.3°C
- Cough, coryza or conjunctivitis

Probable: In the absence of a more likely diagnosis, an illness that meets the clinical description with (a) no epidemiologic linkage to a laboratory-confirmed measles case, and (b) noncontributory or no measles laboratory testing.

Confirmed: An acute febrile rash illness with at least one of the following:
- Isolation of measles virus from a clinical specimen
- Detection of measles-virus specific nucleic acid from a clinical specimen using polymerase chain reaction
- IgG seroconversion or a significant rise in measles IgG antibody using any evaluated and validated method
- A positive serologic test for measles IG M antibody
- Direct epidemiologic linkage to a case confirmed by one of the methods above

The authors are with the Department of Pediatrics, John H. Stroger Hospital of Cook County, and Cermak Health Services at Cook County Juvenile Temporary Detention Center, both located in Chicago. Contact Dr. Soyemi at KSoyemi@cookcountyhhs.org.

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LGBTQ+ Detainees Find Community in Supportive Groups

by Lenny Gallo, LCSW, LCADC, ACT, and Kristina Oyarzun, LPC

I first encountered Carlos, a 36-year-old male from Colombia, in August 2018 when he requested to speak with mental health. He stated that he was being discriminated against on his unit because of his sexuality. He was being detained by Immigration and Customs Enforcement following a DUI conviction from two years prior.

After an initial meeting with Carlos, an out-and-proud member of the LGBTQ+ community, I started meeting with him on a regular basis and he slowly began to open up to me about his background and story. He spoke about the struggles and fears he felt regarding his sexuality in jail, the sexual abuse he faced throughout the course of his life, and the fears he faced at the thought of being deported back to a village that would be intolerant of his sexuality.

There was a real opportunity to help him—and others like him—process through their sexuality in the confined environment of jail. It was then that I proposed an LGBTQ+ support group to our clinical director. He was not sure what to expect from the jail's population, given the sensitive nature of sexuality and the environment, so he told me to survey the jail to see if there was any interest in this idea. I enlisted the help of my colleague and coauthor, Kristina Oyarzun. Soon, my individual sessions with Carlos turned into a bilingual group that supported the LGBTQ+ immigration detainees of the Bergen County Jail in Hackensack, NJ. – L.G.

Despite the challenges, the group has produced great outcomes. It has created a sense of community.

Confidentiality and safety of potential group members was the utmost priority and special care was given to finding participants. To determine interest, we posted signs in each housing unit to announce the group. The signs asked that prospective participants fill out a mental health sick call slip with their name and "LGBTQ+" written on it. Initially we received three slips. Together, we brought individuals out of their unit to interview them and get their thoughts on such a group and their interest in participating.

The facility is a hybrid of local people facing criminal charges and ICE detainees who are housed based on their classification and statuses. We decided to offer the group to both populations. To our surprise, however, not a single legitimate request came from the general population. Every request came from the immigration detainees.

Our biggest advocate during the exploratory phase of the program was Carlos. He wanted the group to transpire and knew of people who wanted to participate. These individuals, however, were too afraid of being outed to contact us. At our request, he informed prospective participants that we would maintain confidentiality by interviewing them outside of their housing unit without disclosing the meeting's purpose to other staff members.

Kristina and I soon learned that an underground LGBTQ+ community existed in the shadows of the jail's immigration population. We found eight brave individuals from other units who were willing to speak with us. After interviewing them, we reported back to our clinical director, who green-lighted the project based on interest and expressed need.

Unfortunately, we were not permitted to bring in the "L" part of our LGBTQ+ group due to strict policies regarding mixing male and female populations. Since the jail generally has a small female population, and we did not receive any requests from their units, group members were male or transgender (biological male to female).

The Core Philosophy

Next came all of the logistical concerns. One of the biggest was the language barrier. Many of the detainees who wanted to participate spoke little to no English. To overcome this barrier, we made it a bilingual group whereby Kristina would interpret between English and Spanish.

We decided that the safest place to meet would be the chapel. We went to each member and notified them of the time and place. Two weeks later, on a Wednesday morning in September 2018, the first eight members were called down from the housing units for a one-hour "mental health group." We sought their feedback on what to talk about, expecting topics such as marriage equality and information about Truvada. However, we were met with quiet and uncertainty.

To break the ice, we simply asked the men to share their country of origin and what brought them to the United States. This prompted discussion for the LGBTQ+ theme naturally. Every participant stated that their reason was related to discrimination based on their sexuality or gender identity in their home country. Many of our members came from countries where sexuality and gender issues are taboo and gay culture is still developing. As people became comfortable with each other, they were more willing to delve further into their stories.

We mostly discussed issues that LGBTQ+ activists in the United States have been addressing for years—and in some cases have resolved. The biggest concern was people's fear of being deported back to a country where their sexuality would not be tolerated and, in some cases, was even criminal. Week after week we would process through concerns about what it was like to live in countries where their sexuality could cost them their lives. Many said that their initial reason for coming to the United States was to seek asylum and freedom from the persecution they faced.

Relationship issues was another common topic. Many of our members were married with children and leading a double life in secrecy. A great deal of time was spent discussing whether or not coming out to family members was appropriate. Others struggled with how to reconcile their sexuality and religious beliefs, and some openly stated that they felt their "lifestyle was a sin."

The groups always had some element of a psychoeducational component, and one of particular interest was sexually transmitted infections and HIV. Many had wrong information on how viruses are contracted and the types of treatment options available. While participants wanted a lot of information on this topic, those with HIV were not as willing to disclose their status for fear of stigmatization and how disclosure might negatively impact them on their units.

The ICE detainees have relatively long stays in the jail—some have been with us for a year—and so as the group solidified over several months, the topics started to evolve. There were challenges, however. The biggest unexpected issue was inmates who purported to be a part of the LGBTQ+ community, solely in an effort to help their legal cases. Unfortunately, several of these people made it into our group, which was upsetting to legitimate members who were struggling to obtain asylum status. On several occasions passive-aggressive verbal fights broke out and had to be addressed. We removed these individuals from the roster once their true motivations were uncovered, and tailored our screening interview techniques to identify and exclude people who did not belong in the group.

Another hurdle came from facility staff who resisted the idea of an LGBTQ+ group. Many were skeptical and uncertain about the process. The importance of maintaining confidentially was discussed with the nurse and officers to ensure the safety of the group members, and our clinical director worked with correctional administration to ensure that the staff was aware of our meetings in the chapel.

Unexpectedly, we even received some pushback from inmates. On certain units, the signs announcing the formation of the group were mocked and ridiculed. Some detainees and inmates even tore them down moments after they were posted. Everyone wanted to know what was going on in the chapel on Wednesday mornings. Onlookers from across the hall would gawk and laugh as the group was being conducted. On numerous occasions, we had to ask an officer to remove these individuals from the multipurpose room. Over time this became less of an issue.

A Sense of Community

In its first nine months, the group has had more than 20 participants and, despite the challenges, has produced great outcomes. It has created a sense of community. The detainees use one another as a resource for legal issues and connect each other to organizations that assist with asylum. They also provide emotional support for each other and look out for one another on the units. Some detainees have become more comfortable with their sexuality, so much so that they were able to tell their families.

As we gained the group members' confidence, they also became comfortable informing us about PREA-related difficulties they were having, such as bullying and discrimination. This enables us to respond faster, before they are hurt. Other participants provided our best marketing—other referrals. Some of our Spanish-speaking members even used the group as a jump-start to help themselves learn English.

Sadly, one day in group, Carlos reported that he had lost his appeal and would be returning to Colombia. Rather than feeling upset, he said that he had come to terms with the outcome of his case and was ready to "start living again." He reported that the group had helped him feel a sense of normalcy while being detained and that he learned a great deal about being able to advocate for his sexuality. His hope

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Nurse Practitioners in Corrections: What Is Their Role?

by Tom Rowley, DNP, FNP-BC, Jennifer Clifton, DNP, FNP-BC, CCHP, and Leissa Roberts, DNP, CNM

This article is the first of a three-part series on NPs.

Nurse practitioners are board-certified advanced practice registered nurses who are trained to assess, diagnose, order diagnostic tests, prescribe, counsel and manage a patient's overall care autonomously or in collaboration with other health care providers. With their previous training as registered nurses, NPs place an emphasis on holistic medicine by recognizing the importance of health promotion, disease prevention, health education and counseling in addition to physical and mental health care. More than 72% of nurse practitioners work in primary care clinics, but many care for patients in specialty settings including corrections, according to the American Association of Nurse Practitioners.

History of the Nurse Practitioner

The first nurse practitioner training program was created in 1965 at the University of Colorado by a nurse, Loretta Ford, and physician, Henry Silver. They hoped to train registered nurses to perform routine testing, examination and immunizations to meet the increasing demand on primary care providers. Today, all NPs must complete a master's or doctoral degree program that includes advanced clinical education above their initial RN preparation.

For more than 50 years, demand for NPs has been increasing, especially in rural and underserved areas. There are currently more than 270,000 NPs across the United States caring for patients.

The Nurse Practitioner's Role

NPs are educated to "assess, diagnose, treat and manage acute episodic and chronic illnesses" as well as "order, conduct, supervise, and interpret diagnostic and laboratory tests; prescribe pharmacological agents and non-pharmacologic therapies; and teach and counsel patients, among other services," according to AANP. Research consistently shows that NPs provide high quality, safe and affordable care when compared to other providers.

Learn More at aanp.org

The American Association of Nurse Practitioners offers information geared toward consumers as well as health professionals.

- NP Fact Sheet
  aanp.org/about/all-about-nps/np-fact-sheet
- What's a Nurse Practitioner (NP)?
  aanp.org/about/all-about-nps/whats-a-nurse-practitioner
- Scope of Practice for Nurse Practitioners
  aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners

Nurse Practitioners in Corrections

The scope of the nurse practitioner in corrections is regulated the same as in other settings, by the state board of nursing. In some states, the NP may be required to work with a consulting physician. In other states, NPs are independently licensed health care providers.

Many specialty care settings require specific training for differing patient populations, and corrections is no different. The correctional NP must adapt to the risks unique to corrections; when treating patients it is essential to consider the safety of the patient, staff and health professionals. The NPs need to be aware of the laws concerning confidentiality when it comes to communicating the health care needs of the patient to facility staff and outside entities.

Successful correctional NPs recognize that there are differences in health literacy among inmates and adapt their vocabulary to assist and encourage understanding. They also may use motivational interviewing techniques to help patients achieve their health goals.

Correctional NPs are expert in diagnosing and treating infections, diseases, injuries, mental health disorders and other health conditions that are more prevalent in the incarcerated population, as well as creating protocols for health professionals and staff to assist in treating these patients.

NPs in corrections quickly learn to collaborate with facility staff and management in order to provide the most appropriate care to patients. NPs partner with nurses and other health care providers to achieve successful outcomes. The NPs must consider the capability and caliber of the health services department as well as the health literacy of the staff to determine if the patient would be best served in the facility or should be transferred to the local hospital for continuous monitoring.

There are few formal trainings provided for health care providers in correctional settings, which makes it necessary for the NP to rely on networking and organizations like NCCHC to identify up-to-date correctional care practices. To provide the best care for the unique patients in a correctional setting, the NP should obtain knowledge in prevalent medical conditions, public health opportunities, ethical issues and medical-legal issues, and understand the correctional health administrative structure.

Autonomous and Collaborative

Nurse practitioners are providing safe, efficient and high-quality care and have been for more than 50 years. They work autonomously and in collaboration with other health professionals to manage their patients' needs. Their emphasis on holistic medicine has helped NPs to thrive in diverse health care settings, including correctional health care systems.

The authors are affiliated with the University of Utah College of Nursing, where Tom Rowley, DNP, FNP-BC, is an assistant professor, Jennifer Clifton, DNP, FNP-BC, CCHP, is an associate professor and Leissa Roberts, DNP, CNM, is a professor and the associate dean of faculty practice. Clifton also serves on the NCCHC board of directors as liaison of the American Association of Nurse Practitioners and is a member of the juvenile health committee.

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Surviving Your Job With Style

Rule #3: You Are What You Write

by Susan M. Tiona, MD, CCHP

In her upcoming book, "Correctional Health Care: Twenty Rules for Surviving With Style," Dr. Tiona offers sage and practical advice on forging your way through a smart, successful and satisfying career in correctional health care. Applicable to a range of health care disciplines and experiences, these rules encapsulate the emotional, professional and cognitive complexities of the worst job you'll ever love.

Legally defensible documentation forces you to be knowledgeable and thorough

In the old days, the country Doc might scribble a few lines in a paper log to close out an appointment—after all, payment may have been made in chickens, and multiple generations of families came to the same one-Doc clinic for years—and oftentimes Doc followed up at church the next Sunday with a congenial, "How's your back today, Tom?"

It was a personally professional relationship, and documentation served mostly to remind Doc of what he did the last time you came in, and to act as a running record of ailments and treatments for Doc to regale to the newcomer who would eventually take over the practice when Doc got too old to carry on.

Even as medicine became much more sophisticated—with specialists, hospitals, insurance companies and large clinics—the quantity and quality of documentation was still a matter of personal preference, and handwritten cursory notes were often still the norm. The advent of the Dictaphone transformed documentation 50 years ago, with clinics and hospitals hiring transcriptionists to put verbal notes into easily readable form.

Still, content was largely controlled by the one doing the dictating until those clinics and hospitals began making rules about dictation contents, and insurance companies started auditing charts to make sure documentation was to specification. At that point, documentation was no longer viewed as an afterthought, but a necessary forethought and integral part of the patient encounter.

And that is how we must view the documentation process in correctional health care. It is not an afterthought to be carelessly completed just to get it done, and it is not about another provider's failures or shortcomings.

On the contrary, documentation reflects your ability to completely and correctly articulate your encounter with your patient. It reflects your genuine interest in providing excellent medical care to your patient, your genuine consideration for health care givers who will come after you in the patient's ongoing management, your genuine understanding and support of company policy and procedure, and your genuine confidence as a health care provider to execute patient care to the fullest of your scope of practice.

Just as you should not take shortcuts with your physical patient encounter, so, too, should you not take shortcuts with the written record of that interaction.

'How Will This Look to a Judge?'

I know what you are thinking: "I don't have time to document well!" Au contraire! You cannot afford to *not* document well!

Like it or not, Rule #2—you will be sued for doing the right thing—is a reality. And there is no more intimidating and befuddling scenario than the intense critique experienced at deposition or court testimony. No peer review, audit or quality assurance process comes close to the scrutiny of the legal process. Trying to explain or defend your own mediocre documentation is something you never want to experience. Equally disheartening is when your documentation must be interpreted and explained by an expert witness trying to defend your medical care on your behalf.

If you can master documentation to legal specification, then the rest is a cakewalk. Every chart entry—whether it is to document a medication dispense, a nurse sick call encounter, an Accu-Chek, an ear lavage, a history and physical, a chronic care appointment—must be done with one tiny thought in the back of your head: "How will this look to a judge?" Even if you manage to breeze through your correctional health care career unscathed by a legal situation, if you document to this standard, you will never go wrong.

Legally defensible documentation forces you to be knowledgeable and thorough. Within your scope of practice, you must know the condition you are evaluating and treating, and you must know policy and procedure pertaining to that situation. Lacking knowledge will lead to bad documentation.

You've heard it said, "If it isn't written, it didn't happen." But equally true is, "Everything that happens must be written." You cannot defend "HEENT = normal" to anyone—not to your peers, not to your administrative superiors, not to the auditors and certainly not to opposing counsel. Stop using those little checkboxes and option buttons on your paper chart or electronic health record. You must get in the habit of writing out exactly what you mean by "normal" exam.

Being thorough with your documentation forces you to practice excellent medicine (whatever your scope). As you learn to document defensibly, it will reflect in better patient care, because you will be preparing your documentation mentally as you conduct your encounter.

Advanced Tips for Foolproof Documentation

So, what does that foolproof, high-quality, legally defensible documentation look like? Beyond the basics of SOAP, SOAPE and SOAR, here are some advanced documentation tips to get you started.

1. Know what you don't know, and learn it ahead of time. If you continuously update your professional skills, it will spill over into the content of your documentation.

2. In the subjective portion of your note, never refer to your patient as "I/M" or "detainee" or "offender." He or she has a name—use it. In the community, you wouldn't begin your note with "Free person comes to clinic today complaining of back pain," so why should your correctional patient be afforded any less dignity?

3. The subjective portion of your note should tell a story. If prior historical documentation is readily available in the chart, it's fine to say "refer to excellent review by provider so-and-so on such-a-date," and then add interim details as needed. But, as is more often the case, if you are faced with previous inadequate chart documentation, *you need to fix it.*

   For every typical complaint you might see in your clinic, you should have a Word document with a template of necessary and relevant historical questions, questions that will show that you have adequately assessed your patient, that you care about his/her problem and that you are knowledgeable about that condition. Nursing protocols and EHRs with checkboxes do not cancel your obligation to know what you are assessing! Use "text" spaces whenever they are available on your prefabricated note to expand on the history and make the story complete.

4. Do not use made up or nontraditional abbreviations in your documentation. Your facility (or department) should have a list of approved medical abbreviations—if it's not on that list, it should not appear anywhere on the chart. Do not make other providers (or lawyers) guess what you mean.

5. Objective exam documentation is absolutely critical. If you performed a detailed examination the previous visit, and you do not believe that repeating such an exam is needed for the follow-up visit, then say so. Do not just say "exam deferred." Give a reason: "Prior exam completed in detail on such-a-date. No further examination needed at this time for completion of this follow-up appointment." Use a cut and paste if you need to, but don't skimp.

6. Again, if you are clicking "normal" on that checkbox, you might want to rethink that practice. "Lungs WNL"—what does that mean, exactly? Did you listen both anteriorly and posteriorly, or only posteriorly? Did you listen in four fields or six? Did you check for vocal fremitus (which is almost never needed, but maybe you do that on a regular basis)? Did you percuss the lungs or just auscultate? Did you check for diaphragmatic excursion? If you have to explain in deposition or testimony what you meant by that checkbox, could you do it with confidence? Doubtful. And you will appear incompetent and unprofessional.

   If your exam was normal, use the text box to say what you mean: "Lungs clear in all fields with good air movement throughout; no wheezing, rales or rhonchi; normal respiratory effort." If your EHR requires you to check something (many do, which is why I am opposed to most EHR formats, but that's an argument for a different time), then check the box *and* type your complete personalized exam in a text box. Have a cut and paste ready for what you consider to be your normal exam, in your own words, and then adjust it if needed for each patient's case. If all you need to do is a quick heart and lungs, then document that, with a comment to the effect of, "No further exam required to meet the goal of this appointment."

7. If you are still doing paper charting, shame on your employer! Even if you don't have a formal electronic health record, it is inexcusable not to have Word or PDF fillable forms. No one should be hand writing in a chart except under unusual or extenuating circumstances. If your department still uses paper forms, insist on having a typewritten option. If your department doesn't have the technological savvy to accomplish that, have them contact me and I will be happy to show them how to do it.

8. When you think you are done with your note, take a few seconds to proofread it. Make sure you didn't say "did" when you meant to say "did not", make sure you could tell a judge exactly what you did for your patient that day and why (should the need ever arise) and make sure it is a note that you would be proud to have another provider read on another day—what goes around comes around.

A Work of Art

If you start thinking of documentation as a work of art, you will start thinking of patient care as a work of art, too. Both are skills to be mastered, and are inseparable in content, form and execution. Eventually, your finely crafted notes, which took laborious time to complete until practice made perfect, will transform your patient care into something efficient, relevant, compassionate and complete—and no lawyer, judge, administrator or auditor will be able find fault. Plus, you will have the satisfaction of a job well done. After all, correctional health care is a work of art.

Next up, Rule #4 – Be an artist first and a scientist second.

Susan M. Tiona, MD, CCHP, has practiced medicine in the correctional setting since 2004. She is the former chief medical officer for the Colorado Department of Corrections and is currently a telemedicine provider for CoreCivc, as well as providing expert witness services and pursuing a master's degree in forensic psychology.

Meeting the Continuing Education Needs of Correctional Nurses

by Sue Smith, MSN, RN, CCHP-RN

The NCCHC Nurse Advisory Council is a subcommittee of the multidisciplinary education committee; its primary function is to support nursing education and to advise the committee, through the nurse planners, of the continuing education needs of correctional nurses. Council members represent various aspects of correctional health care: They work in prisons and jails; they are nurse administrators, nurse educators, direct care nurses, advanced practice nurses and a nurse attorney. They all care passionately about correctional nurses and are dedicated to sharing their insights and knowledge about the practice of correctional nursing so that the educational programming provides the CE activities that are most needed.

The NCCHC nurse planners have conducted several learning needs assessments since 2013; the results of some of these surveys have appeared in *CorrectCare*. At their October meeting during the 2018 National Conference, the council decided to develop a cohesive educational plan that combines the results of the needs assessment surveys, data gathered from conference attendee evaluations and educational needs that the council members have noted within their correctional systems. Keeping in mind that correctional nurses come to educational activities with varying levels of knowledge and expertise, the lead nurse planner used Patricia Benner's novice-to-expert model to organize the topics into three levels: basic (novice), intermediate (competent) and advanced (expert).

This table is meant to inform nurse presenters and nurse educators of education needs that have been identified and to provide some organization of those needs. This is not to say that potential presenters should only select topics from the table—the needs and interests of correctional nurses are far too diverse to be that limiting.

Sue Smith, MSN, RN, CCHP-RN, is a correctional nurse educator. She served as lead nurse planner for NCCHC educational activities and directed the Nurse Advisory Council from 2014 to 2019. Contact her at nsuesmith48@yahoo.com.

Knowledge/ Competency Level	Administration/Management	Clinical Topics	Professional Development
Basic (novice/ advanced beginner)	1. Level 1 nurse supervision: shift supervision; charge nurse 2. Orientation/onboarding 3. Facilitating legal and regulatory compliance 4. Supervision: delegation, employee management 5. Managing core processes: health assessment, intake, sick call, chronic care, medication administration 6. Professional behavior 7. Basic health care budgeting/ resource management; budgeting at the unit level 8. Interviewing 9. Scheduling 10. Retention strategies	1. Head-to-toe health assessment in correctional settings 2. General nursing education a. Diabetes b. Hypertension c. Seizure disorders d. Skin disorders e. Asthma f. Strains and sprains 3. Triage/emergency procedures 4. Managing difficult patients 5. Basic infection control 6. Social media for correctional nurses 7. Care of patients in restrictive environments 8. Care of patients in physical restraints 9. Documentation 10. Basic mental health issues: emergent assessment for medical nurses 11. Opioid and other withdrawal protocols; medication-assisted treatment	1. Correctional Nursing 101, including safety/security issues a. Professional/therapeutic boundaries (patient and correctional colleague) 2. Critical thinking 3. Scope of practice, working within and to full extent of licensure 4. Review of the ANA Scope and Standards of Correctional Nursing Practice 5. Effective communication: advanced providers (SBAR communication), coworkers, patients, custody staff 6. Working with difficult people (patients, staff) 7. Use of nursing protocols 8. Applying the ANA code of ethics in correctional nursing 9. Staff well-being: stress management; healthy habits for shift workers
Intermediate (competent)	1. Level 2 supervision: departmental/ unit management 2. Monitoring core processes: using monitoring procedures to drive process improvement 3. Fiscal management: managing a department budget. 4. Staff professional development 5. Hiring	1. Critical thinking 2. Advanced physical assessment (with abnormals and red flags) a. Respiratory system b. Neurological system c. Cardiac system d. Gastrointestinal system e. Genitourinary system 3. Withdrawal syndromes: why signs	1. Medication administration: legal/ regulatory issues, how to apply the 10 "rights" of medication administration in correctional settings 2. Delegation, supervision of licensed and unlicensed staff 3. "Verbal judo"/de-escalation techniques, negotiation, conflict resolution

Knowledge/ Competency Level	Administration/Management	Clinical Topics	Professional Development
Intermediate (competent) *(continued)*	6. Fostering healthy environments 7. Creating a culture of quality and safety 8. Nurturing staff: mentoring, coaching, staff well-being 9. Medical/behavioral health interface 10. Handling employee challenges; having difficult conversations 11. Identifying community and educational resources	and symptoms occur as they do (alcohol, opiates, benzodiazepines) 4. Intermediate mental health issues a. Suicide assessment and intervention for correctional nurses b. Nursing care of patients with personality disorders c. Psychopharmacy for nurses d. Role in mental health promotion in correctional settings	4. Professional behavior 5. Coaching/precepting new staff 6. Correctional nursing research; evidence-based practice 7. Common legal issues: court orders, mandated medication, DNR, refusal of treatment 8. Moral reasoning, moral resilience 9. PREA topics
Advanced (expert)	1. Level 3 supervision: systems administration, executive leadership 2. Creating collaborative partnerships with correctional colleagues, community health resources, academia 3. Leading change 4. Managing ancillary services: dental, laboratory, pharmacy, optometry, podiatry, etc. 5. Implementing new programs: MAT, electronic health record, preceptor 6. Financial: future planning, articulating and justifying the health care budget	1. Clinical judgment, decision making 2. Leadership roles in correctional nursing 3. Research implementation 4. New medications for chronic diseases 5. Nursing ethical dilemmas 6. Advanced mental health topics a. The emotional labor of correctional nursing b. Primary, secondary and tertiary mental health interventions c. Trauma-informed nursing care 7. DNP project presentations	1. Clinical reasoning and clinical decision making 2. Emotional intelligence 3. Patient advocacy behind bars 4. Reconciling ethical dilemmas 5. Cultural/spiritual sensitivity in corrections 6. Professional networking, collaboration

NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE

FORT LAUDERDALE FLORIDA

October 12-16, 2019

Come to the Sunshine State...

And dive in to five days of the field's best continuing education and networking at the National Conference on Correctional Health Care. This unparalleled event comes to Fort Lauderdale, known as "the Venice of America" for its expansive network of canals, where the average year-round temperature is 75.5 — in other words, perfect. Close to 2,000 correctional health professionals will gather in this oceanside location to learn, exchange ideas, talk shop and get energized, returning to work with fresh energy and inspiration. Won't you join them?

Why Attend?

- Targeted education and excellent networking with peers and experts from every segment of the correctional health care field: clinicians, administrators, staff and management
- Up to 32.25 hours of continuing education credits, with 100+ sessions and 8 preconference seminars to choose from — including all-day seminars on the NCCHC standards for jails and prisons
- Comprehensive coverage of all aspects of correctional health care: chronic care, infectious disease, mental health, suicide prevention, oral health, crisis intervention, liability challenges, risk management and more
- NCCHC is the nation's leader in correctional health care education, accreditation and certification. Learn from respected authorities with years of experience in health care delivery in jails, prisons and juvenile confinement facilities.
- The conference is the perfect place for networking. Coffee breaks, lunches and exhibit hall breaks are among the built-in networking events that attendees enjoy. Take advantage of these opportunities to learn how others are handling the challenges you face every day.

Timely Informational Topics

Enjoy three full days of top-notch educational programming with an all-star lineup of correctional health care speakers, leaders and colleagues. These are some of the 100+ sessions on offer:

- Psychopathy: Treatment and Risk Management in a Correctional Setting
- Care, Control and Collaboration in the Correctional Environment
- The Jail Is on Fire! Disaster Preparedness Beyond Stop, Drop and Roll
- Preventing and Managing Wound and Soft Tissue Injury Infections
- Autoimmune Conditions, Triggers and Associated Chronic Pain: Diagnosis and Treatment
- Prison Pumping: Development, Implementation and Evolution of a Breast Milk Program
- Dental Treatment of the Medically Complex Patient
- Dementia: Identification, Evaluation and Management
- Treating All Genders: Building a Competent Transgender Mental Health Practice
- Suicide Prevention: Filling in the Gaps Through Continuous Quality Improvement

Exceptional value! In addition to the low cost per credit hour, the invaluable face-to-face networking is free! The registration fee also includes two breakfasts, three lunches, beverage breaks and a reception.

Meeting Location

All conference activities will take place at the Fort Lauderdale/ Broward County Convention Center, 1950 Eisenhower Blvd.

Room blocks have been reserved at the Hilton Marina (across from the convention center) and the Marriott Harbor Beach Resort and Spa (2.5 miles away). See see the conference website for details.

Continuing Education Credit

The National Conference offers up to 32.25 hours of CE credit: 18.25 for the conference and 14 for the preconference seminars.

- Certified Correctional Health Professionals: Category 1 credit
- Dentists: American Dental Association (ADA CERP)
- Nurses: American Nurses Credentialing Center
- Physicians: Accreditation Council for Continuing Medical Education
- Psychologists: American Psychological Association
- Social Workers: National Association of Social Workers

Learn more and register at https://national-conference.ncchc.org

San Francisco County Jail Aims to Save Lives Through Opioid Overdose Prevention

Opioid users are at high risk of overdose death after release from incarceration. This risk stems from reduced opioid tolerance while incarcerated and limited access to substance use disorder treatment and other support services during reentry to the community.

To reduce these deaths, the San Francisco County Jail implemented an overdose education and naloxone distribution program. Lisa Wenger and colleagues describe this OEND program and results after four years in the October issue of the *Journal of Correctional Health Care*.

The program is a collaboration among several county agencies and community partners. Jail Health Services (JHS) staff members are trained to provide OEND services by the Harm Reduction Coalition's Drug Overdose Prevention and Education (DOPE) Project, which coordinates distribution of naloxone in community settings. The DOPE Project pays for the OEND naloxone and assembles the kits. JHS and the DOPE Project are funded by the San Francisco Department of Public Health.

In 2013, a pilot OEND program was launched as a supplement to the JHS HIV testing program. It began in one male housing unit, then added a female unit, and in 2016 received city funding to hire a dedicated staff member and to expand the program's reach. The jail system has five individual jails, and the program is based in the one with reentry housing units for men and women serving the last 30 to 90 days of their sentence. The later expansion of the program identifies candidates in all five jails via review of intake records and medical staff referrals.

OEND program eligibility is extended to people who are within 30 days of their release date and have not already participated in the jail program, and includes those who use opioids and are thus at risk for overdose as well as those who have peers who use opioids.

Participants attend a group training in the housing unit. They first view a 19-minute video on postrelease overdose prevention: risk factors, how to reduce risk and how to respond to an overdose. The JHS staff member then discusses the subject matter, including California's "Good Samaritan" law, and answers questions. (Participants in other units receive a brief one-on-one training.)

Training participants are then asked to indicate, on a paper slip, whether they would like a naloxone kit to be placed in their personal property, to be received upon release. Those who opt in meet with JHS staff one-on-one to review how to administer naloxone and to ask questions.

Ready to Respond

Between March 2013 and April 2017, 637 program participants watched the OEND training video and 26 people received one-on-one training from JHS staff. Overall, 453 people opted to receive naloxone in their property. Of these 453 people, only 3.5% had previously received OEND training in the community.

Of those who received the kits, 25% had experienced an opioid overdose at least once; of this subgroup, 47% had been revived with naloxone at least once, either by a bystander or a first responder. Furthermore, 63% of those who received the kits reported having witnessed at least one overdose; and 39% of this subgroup said that either they or someone else had administered naloxone at the time of the last witnessed overdose. When asked why they wanted to receive naloxone upon release, 87% said that their friends, partner, neighbor or people in their community were at risk for overdose.

The study also determined that 44% of participants who received naloxone in their property later received a naloxone refill in the community for a variety of reasons, with 32% reporting it had been used to reverse an overdose.

The study authors conclude that having OEND programs in jails is feasible and reaches people who have not already been trained, as well as those willing to act as overdose responders.

Standards Review + CCHP Exam + Your Location = Convenience & Expertise

For the best training and CCHP exam preparation, turn to the organization that "wrote the book" on correctional health care!

Let NCCHC bring the full-day *Standards* review and Certified Correctional Health Professional exam to your facility. Your employees will benefit from the same in-depth review generally offered at the fall and spring conferences and an opportunity to take the exam, without having to travel.

The CCHP credential is the premier professional certification to recognize the unique skills and knowledge required to be a correctional health professional. CCHPs have demonstrated mastery of the NCCHC standards and a comprehensive understanding of this specialized field. The exam is open to both administrators and health care professionals.

Collaborative Learning Experience

The intensive *Standards* review is taught by NCCHC experts. Participants are encouraged to ask questions and discuss specific challenges to create a truly collaborative learning experience.

This extraordinary value includes a copy of the relevant *Standards* book (jails, prisons or juvenile facilities) sent to each participant in advance for self-study, a full day of on-site training and administration of the CCHP exam.

To arrange for standards training and on-site CCHP exams for your employees, please contact Matissa Sammons, MA, CCHP, vice president of certification, at matissasammons@ncchc.org.

Chair Notes *(continued from page 3)*

very labor-intensive and, therefore, costly. Furthermore, such programs are lacking in many jurisdictions, particularly in rural settings. However, given the high cost of multiple incarcerations, along with the fact that people with chronic medical and mental health problems recidivate more often and spend more time incarcerated than those without such problems, it may be time to consider innovative approaches that invest resources to address these problems as early as possible and in the least restrictive environment required.

To accomplish these objectives would require better coordination between individual law enforcement and community health care agencies, more effective sharing of health care data, possible tweaking of HIPAA laws and better integration of correctional health care into the larger public health care system.

Thomas J. Fagan, PhD, CCHP-MH, is the chair of the NCCHC board of directors. He is the liaison of the American Psychological Association.

LGBTQ+ *(continued from page 7)*

is to take what he learned in the United States back to his country and become a voice for change.

While it is hard to quantify the success of a group like this, it is for those like Carlos that we wanted to make this group a reality—to give confidence and a voice to the voiceless and to afford participants the opportunity to speak freely in an environment that is too often associated with the persecution of LGBTQ+ individuals. For us, this group demonstrates the need for these types of programs to exist and to be available in facilities everywhere.

Lenny Gallo, LCSW, LCADC, ACT, is a mental health and substance abuse clinician and Kristina Oyarzun, LPC, is a mental health clinician at Bergen County Jail, Hackensack, NJ. Contact Gallo at LennyGallo@aol.com.

CCHP-A Reaches Quarter-Century Mark

by Erin Kabot, CCHP

1994 was a year to remember. The North American Free Trade Agreement was adopted; the "Chunnel" opened connecting England and France by train; Major League Baseball went on strike for 232 days, effectively canceling the 1994 season; and the world population reached 5.6 billion people. Of those 5.6 billion people, seven were in the first group to earn CCHP–Advanced certification.

When the flagship CCHP program began in April 1990, the board of trustees announced that it would have an advanced component, to begin in 1993. The board decided to offer two separate exams: the basic CCHP exam and a more advanced exam for those who had held the CCHP credential for three years.

In March 1992 at their semiannual meeting in Chicago, the trustees discussed how to implement advanced certification, soon to be known as CCHP-A. Those present were Jaye Anno, PhD, Carmelita Walton, AN, Bernard Harrison, JD, Kenneth Moritsugu, MD, Scott Chavez, MPA, PA-C, Robert Burmeister, PhD (ex officio), and the staff liaison, LeAnn Schmidt. They agreed to gather information and develop proposals to review in the fall.

The Framework of the Program

At the September board meeting, Chavez presented a proposal establishing the program's core elements. Advanced certification would be an elective process, and the CCHP must decide to apply for it. Unlike the basic CCHP process, applications for CCHP-A would be reviewed by the CCHP board of trustees. Similar to the approach used by organizations such as the American Society of Association Executives and the American College of Healthcare Executives, the proposal set criteria for approval of applicants. These included personal achievements, commitment, accomplishments and contributions to correctional health, as well as education and scholarly activity.

Accepted applicants would be informed that they are approved to take a proctored exam. It would be a closed-book, essay-based examination administered over a four-hour period. The exam would be crafted to measure and interpret the candidate's knowledge necessary for professional practice in correctional health care. It would not seek to measure clinical competency. The CCHP board would grade the exams on a pass/fail basis, and each essay question would be evaluated by at least two readers. For the candidate to achieve CCHP-A status, six of the eight essay questions needed a passing score.

In 1993, invitations to apply for the CCHP-A exam were sent to eligible CCHPs who had been certified for at least three years. After careful deliberation, the trustees chose 11 candidates for the first exam, which was administered at the 1993 National Conference on Correctional Health Care in Orlando, Florida. Two of the 11 examinees were CCHP board members, John Clark and Jaye Anno.

Seven of the 11 candidates passed the exam and became CCHP-A in January 1994: Jaye Anno, PhD, Thomas Bellavia, MD, John Clark, MD, MPH, Katherine Heinen, RN, Janice Hill, RN*, Jeffrey Metzner, MD*, and James Voisard, EMT-P* (credentials are shown as they were in 1994).

* Special recognition goes to the three CCHP-As who have maintained their Advanced status for 25 years, continuing their commitment and passion to correctional health care: Janice Hill, Jeff Metzner and Jim Voisard.

"This was an opportunity to join a select group, to reach a pinnacle in the profession," Voisard said. "I am honored to be associated with the huge names in correctional health that are also CCHP-As. Becoming a CCHP-A, I was challenged to broaden my understanding of topics that affect our work on a daily basis."

Confirmation of Your Accomplishments

Within two years, the CCHP-A program had grown to 25, and interest in holding this credential continued to climb. "Adding the 'advanced' to CCHP status means not only well-deserved recognition by your peers," said Betty Hron, RN, CCHP-A, who was a CCHP board member during this time. "It is also a personal confirmation of the accomplishments, accumulated knowledge and contributions made to the advancement of correctional health care."

In 2010 the flagship CCHP program celebrated its 20th anniversary and was flourishing, and the number of CCHP-As had risen to 41. Today the CCHP-A program continues to attract individuals who demonstrate excellence, commitment and contribution to the field. And that probably means you!

CCHPs are eligible to apply for Advanced Certification after being certified for three years. CCHP-A exams are offered three times a year, at NCCHC's spring, summer and fall conferences. Applications are accepted on an ongoing basis, and must be submitted at least three months before the desired exam date. See the CCHP-A brochure and application to learn what is involved: www.ncchc.org/cchp-a.

Erin Kabot, CCHP, is the certification assistant for NCCHC.

Let's Make a Date to Celebrate!

The CCHP-Advanced credential, NCCHC's highest certification, will celebrate its 25th anniversary at the National Conference in October with special events and fun surprises. Watch your email for details!

The National Conference is something special. Widely renowned as the premier annual meeting in correctional health care, this year's event features standout programs and activities that will attract the movers and shakers in this field. This is your opportunity to meet with nearly 2,000 professionals who influence or make purchasing decisions. And they spend significant time browsing the conference exhibits to learn about the latest medical supplies and pharmaceuticals, information technology, contract services, staffing services and more. If you exhibit at only one meeting in 2019, this has to be it!

Who Attended in 2018?

Nurse/nurse practitioner	38%
Physician/physician assistant	20%
Administrator	14%
Psychiatrist/psychologist	10%
Social workers/therapists	8%
Other	10%

Who Do Attendees Represent?

Jail facility	40%
Prison facility	21%
State DOC/agency	13%
Private corporation	9%
Federal agency	6%
Juvenile detention or confinement facility	5%
Other	6%

Categories Attendees Recommend or Buy

- Contract management
- Dialysis services
- Education and training
- Emergency preparedness
- Health care staffing
- Information technology
- Medical devices, equipment
- Mental health services
- Pharmaceuticals
- Safety equipment
- Suicide prevention
- Dental care and supplies
- Disaster planning
- Electronic health records
- Health care management
- Infection control
- Laboratory services
- Medical supplies
- Optometry services
- Pharmacy services
- Substance abuse services
- Treatment programs

Draw Qualified Customers to Your Booth

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

- Three days of dedicated, expo-only activities
- Three free full conference registrations per 10' x 10' booth
- Electronic attendee lists for pre- and postshow marketing
- 75-word listing in the Final Program and conference app
- Discounts on advertising in the conference program
- Opportunity to participate in raffle drawings
- Exclusive opportunity to become a sponsor

Pump Up Your On-Site Presence

Give your company marketing power and increased visibility! Gain added exposure through sponsorships that support and enhance the conference. Recognition is given through additional signage, sponsor ribbons and listings in the final program and other NCCHC publications.

- Conference mobile app
- Exhibit hall reception, lunch or refreshment breaks
- Product Theater events
- CCHP lounge host
- Conference padfolios
- Wi-Fi
- Relax & Recharge Lounge
- Phone chargers
- Keynote speaker
- Educational programming
- Wellness center
- Ice cream social
- Photo booth
- Conference bags
- Twitter wall
- Exhibit hall aisle sign
- Badge lanyards

Become an Exhibitor Today!

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Classified ads

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County Of Los Angeles, Sheriff's Department invites applications for Assistant Director of Bureau Operations. One of the nation's largest county jail Gender-Responsive System!

$118,905.84 - $179,973.12 Annually

The Sheriff's Department runs the largest women's jail in the country, which requires dedicated, centralized leadership with decision-making power to lead all aspects of the programs and services provided to incarcerated women.

Your role will oversee gender-responsive services at all County jail facilities, which house low-to-medium security women. You will lead the Gender Responsive Advisory Committee, which provides recommendations to the Board of Supervisors and County Departments.

You will receive an annual salary commensurate with qualifications and excellent benefit program:
• Retirement Plan - A Contributory Defined Plan
• Cafeteria Plan
• Flexible Spending Accounts
• Matched Savings Plan (401K)
• Deferred Compensation Plan
• 12 paid Holidays per year
• 10 paid leave days (option to buy 1-20 more paid leave days)

What you will do:
• Oversee gender-responsive programs and services at all County custody jail facilities
• Serve as a liaison and advisor to County leadership, Departments, internal Divisions, Bureaus, and units responsible for gender-responsive program services, elected officials, partnering agencies, and County Counsel on all issues related to gender-responsive and trauma-based incarceration.
• Resolve gender-responsive program issues
• Supervise the work of subordinate managers and supervisors.
• Act as the Bureau Director during their absence, as needed.

Requirements: A Bachelor's degree* from an accredited college/university –AND– Two years bonafide supervisory experience over a unit of professional-level staff, including one year management experience directing a section composed of multiple units responsible for providing administrative services which directly impact gender-responsive system implementation, operations, or compliance.

We are accepting applications starting July 16, 2019 at 8:00am. Use the following link for further information and to submit your application: https://www.governmentjobs.com/careers/lacounty

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MARKETPLACE

Standards for Opioid Treatment Programs
These standards present the requirements for OTPs seeking NCCHC accreditation. This second edition adheres to the Substance Abuse and Mental Health Services Administration's 2015 Federal Guidelines for Opioid Treatment Programs and takes into account the issues unique to correctional settings. The OTP Standards address the general areas of patient care and treatment, clinical records, governance and administration, personnel and legal issues. 2015. Softcover, 141 pages. $69.95. Order at www.ncchc.org/ncchc-store or call 773-880-1460.

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 Certified Correctional Health Professionals, key personnel at accredited facilities, members of the Academy of Correctional Health Professionals and other recipients at our discretion. To see if you qualify for a subscription, create an account 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.

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ADVERTISER INDEX

Standards Q & A

Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Can We Earn Three Accreditations? Sure!

Q *Our jail is accredited by NCCHC for health services and a survey is scheduled for our opioid treatment program. We know that NCCHC also offers a mental health accreditation. Is this an additional accreditation that our facility can attain?*

A First, thank you for participating in NCCHC's accreditation program for health services and soon-to-be for OTP. Yes, we do offer mental health accreditation for facilities that have a more robust mental health program in place. It is based on the 2015 *Standards for Mental Health Services in Correctional Facilities*. The survey for this program can take place at the same time as the surveys for health services and/or the OTP, or it can be conducted at a separate date or time. Facilities that attain all three types of accreditation will be awarded NCCHC's Pinnacle Recognition.

Health Record Review: How, and How Many?

Q *NCCHC's standards for jails and prisons require that health record reviews be done under the guidance of the responsible physician or designee (A-06 Continuous Quality Improvement Program). Could you provide guidelines as to the number of health records to be reviewed each month and how the review should be conducted?*

A These systematic reviews of the health record use a standardized form or audit tool to determine whether specific elements related to the quality of care provided are adequately documented. Although the standards are silent on the number of charts to be reviewed, a generally accepted guideline is 5% to 10% of the average daily population. Specific areas for review should be selected each month (e.g., documentation, access to care, chronic diseases), and criteria should be developed to evaluate each area.

The intent of the standard is that facilities have a continuous quality improvement program to monitor and improve the health care delivered. Health record reviews are only one component of the overall CQI program.

Customized Policies and Procedures

Q *Our facility is about to contract with an organization to provide health services. The contractor has its own policies and procedures that we would be using. Will we meet the requirements of standard A-05 if we use the contractor's policies and procedures, or must we develop our own?*

A You may use the contractor's policies and procedures only if they meet your facility's unique needs. For example, the policies and procedures must address infirmary-level care if your facility houses these types of patients and they must address prenatal care if it houses female inmates. In other words, if the policies and procedures are to perform their function of providing guidance to staff, they must be tailored to fit the needs of your facility and to address each applicable NCCHC standard.

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. For an archive of Q&A topics as well as the Spotlight on the Standards column, visit www.ncchc.org/standards-explained.

For in-depth instruction on the standards for health services and mental health services, attend one of the preconference seminars at the National Conference on Correctional Health Care. Visit national-conference.ncchc.org for details.

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Accreditation provides public recognition that correctional facilities are meeting NCCHC's nationally recognized standards for quality health services. Accreditation reduces exposure to costly liability and recognizes the institution's commitment to meeting quality goals and using best practices.

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The Certified Correctional Health Professional program provides formal recognition for individuals who have engaged in a process of ongoing, focused and targeted professional development.

STANDARDS AND PUBLICATIONS

NCCHC's highly respected *Standards* serve as a framework to ensure that systems, policies and procedures are in keeping with nationally recognized best practices. NCCHC also publishes *CorrectCare* and the *Journal of Correctional Health Care,* the leading periodicals in the field.

EDUCATION

NCCHC conferences are renowned for their exceptional educational programming, abundant networking and the best commercial exhibitions in this field.

Spring Conference on Correctional Health Care

Correctional Mental Health Care Conference

National Conference on Correctional Health Care

For more information, visit **www.ncchc.org.**