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Subject:	CorrectCare
Date:	Thursday, December 3, 2020 7:26:00 AM
Attachments:	34-4_Fall-Winter_2020_CorrectCare_12-1-20.pdf

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Fall/Winter **2020** | Volume **34** | Issue 4

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NCCHC

The magazine of the National Commission on Correctional Health Care

Breaking the Chains of Human Trafficking in Incarcerated Populations

Caring for the COVID-19 Patient

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contents

Features

6 Breaking the Chains of Human Trafficking in Correctional Populations

10 Clinical Judgment, Critical Thinking, and the Correctional Nurse

12 Using Telehealth to Create a Virtual Safety Net and Ease Community Reentry

14 Clinical Care of COVID-19 Patients

16 Meet the 2020 NCCHC Award Winners

Departments

2 NCCHC News

3 Chair Notes: Coping with COVID

4 Legal Briefs: Deliberate Indifference? Yes and No

19 Journal Preview: HbA1c Levels and the Chronic Care Theory

21 CCHP Page: Movers, Shakers, and a New Trustee

22 Classified Ads and Ad Index

24 Standards Q&A: Your #1 Coronavirus Question, Answered

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Fall/Winter 2020 | Volume 34 | Issue 4

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NCCHC Announces New Logo and Brand

As part of a strategic rebranding initiative, NCCHC has modernized its 20+ year-old logo.

This fresh take reflects NCCHC's medical origins with a stylized caduceus and pulls together the NCCHC family of logos – NCCHC Foundation, NCCHC Resources, Accreditation, and Certification – in a stronger brand. All NCCHC materials will be updated on a rolling basis throughout 2021.

In this issue, you will see the new logos. When you visit ncchc.org, you'll notice the beginning of the brand refresh, with more website changes coming soon to enhance security, efficiency, and engagement.

Take Any CCHP Exam from Your Home or Work

Travel, time of day, and time out of the office are no longer barriers to taking the CCHP exam.

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Plus, with the adoption of a new testing network, more remote testing locations than ever before are available (in accordance with guidelines from local governments). Find out more at ncchc.org/CCHP/calendar.

Prepare for the CCHP Exam With a Webinar

Get the facts and the essential information you need to be prepared. The best exam preparation available! Take these courses online at your convenience.

- NCCHC Standards: An Essential Resource to Prepare for Certification (3.5 hours). Recorded October 2020.
- CCHP-RN Review: Meeting The Challenge of Correctional Nursing (3.5 hours). Recorded November 2020.
- CCHP-MH Review (2 hours). Recorded July 2020.

Register for these courses (and more!) at ncchc.org/ncchc-webinars.

Support the Foundation on Giving Tuesday

#Giving Tuesday was born in 2012 as a simple idea: a day that encourages people to do good. Over the past seven years, it has grown into a global movement that inspires millions of people to give, collaborate, and celebrate generosity. This year, #Giving Tuesday is December 1.

Help support the Foundation: Check out the NCCHC Facebook page, share our posts, and consider making a donation. Visit facebook.com/NCCHC or donate any time at ncchc.org/foundation.

Foundation Scholarships Awarded

The NCCHC Foundation awarded nine scholarships to the Virtual National Conference on Correctional Health Care. The Foundation distributed 25% of all funds raised since its launch in July to support the scholarships, which were given to students and early-career nurses, mental health professionals, administrators, and physicians.

- Sabreena Hassim, MSW, LCSW
- Helen Jack, MD, medical resident
- Kathryn McDowell, MPH candidate
- Meera Patel, PhD candidate
- Lisa Pickett, RN
- Kelly Podshadley, paralegal
- Jessica Robles, RN
- Kelly Ryun, RN
- Noor Taweh, undergraduate student

Calendar of events

Nov. 18	CCHP exams, Dallas, TX
Dec. 2	Last day to access National Conference on Correctional Health Care content
April 24-26	Spring Conference on Correctional Health Care
July 17-18	Correctional Mental Health Care Conference

New Publisher Tapped for *Journal of Correctional Health Care*

NCCHC's journal will be published by Mary Ann Liebert, Inc., effective January 2021. *The Journal of Correctional Health Care*, the only national, peer-reviewed scientific journal focusing on this complex field, now joins the company's strong portfolio of mission-driven journals such as *Health Equity, Transgender Health, LGBT Health*, and *AIDS Patient Care and STDs*.

"Correctional health is a vitally important component of public health, residing at the intersection of health care, mental health, and criminal justice. And yet it doesn't always get the attention it deserves," says Deborah Ross, NCCHC's CEO. "We appreciate Mary Ann Liebert, Inc.'s understanding of the role of correctional health care, the company's passion for cutting-edge topics and research."

NCCHC's New Board Chair Shares His Thoughts about Coping with COVID-19

by Joseph V. Penn, MD, CCHP-MH

I was recently asked how correctional health care has changed since the last time I was NCCHC chairman in 2008 and 2009. The truth is, in some ways it is very much the same, with similar challenges.

- Staff recruitment and retention remains a huge issue; it is particularly difficult to find and retain good people in corrections.
- We still battle misconceptions about our choice to work in corrections, although much has changed, thanks in no small part to you and the work of NCCHC.
- We still deal with those in the "Free World" who don't get it. They don't understand why we are dedicated to serving this patient population. Some people's attitude is, "Why should those people get health care?"
- We face everyday stressors in a difficult, restricted work environment. It's certainly not the cushy, well-heeled working conditions of our free-world colleagues.
- Every day, we may risk physical and emotional harm as well as vicarious traumatization; we see horrific things that can cause lasting emotional harm or damage.
- We continue to do more with less.
- We face budget cuts and reductions in force.
- We are subject to licensing board complaints, lawsuits, and litigation.
- And we care for greater numbers of more complex patients, people who are sicker, older, with significant acute and chronic medical issues, substance use disorders, serious mental illness and other challenges.

I would argue that we had a full plate well before the onset of COVID 19. Now, we must work with purpose to combat this threat to our patients, our families, our coworkers, and ourselves. We all feel the overwhelming responsibilities. We cannot escape the current civil unrest, racial tensions, and political upheaval. Many people are also dealing with hurricanes, flooding, wildfires, and COVID-related economic and unemployment problems.

Help Yourself

Those of us in the "helping professions" are used to diminishing our own mental health needs. We are accustomed to self-sacrifice and putting our patients first. We are less apt to recognize our own personal needs. And working in corrections, we have become experts at handling tough situations without acknowledging the full impact and toll those situations may take upon us.

It's not surprising that results of a recent survey sent to CCHPs emphasized the negative impact of today's stress and uncertainty on both staff and the incarcerated.

Obviously, stress can't be prevented, and most of us have chosen, indeed thrived, in this high-pressure profession. Given that, we absolutely must learn to recognize and manage our stress and build a supportive structure. We owe it to ourselves and everyone around us.

In subsequent columns, I will provide practical tips and strategies for taking care of yourself during this terribly challenging pandemic.

Joseph V. Penn, MD, CCHP-MH, is the 2021 chair of NCCHC's Governance Board and board liaison of the American Academy of Psychiatry and the Law. This column is an excerpt of a speech he gave at the 2020 National Conference.

At A Glance
Joseph V. Penn, MD, CCHP-MH, Board Chair

Current Positions
- Director, Mental Health Services, University of Texas Medical Branch Correctional Managed Care, Conroe, TX
- Clinical Professor, UTMB Department of Psychiatry, Galveston, TX

Education
- Medical degree: UTMB School of Medicine, Galveston, TX
- General psychiatry residency and chief resident, Warren Alpert Medical School/Brown University
- Child and adolescent psychiatry fellowship, Warren Alpert Medical School/ Brown University
- Forensic psychiatry fellowship, Yale University
- Triple board-certified in general psychiatry, child and adolescent psychiatry, and forensic psychiatry, American Board of Psychiatry and Neurology

NCCHC Career Highlights
- American Academy of Psychiatry and the Law board liaison, 2016-present
- American Academy of Child and Adolescent Psychiatry board liaison, 2003-2016
- Board chair, 2008-2009
- Accreditation Committee chair, 2014-2016
- *Journal of Correctional Health Care* editorial board, 2011-2019
- Juvenile Committee chair, 2010-2013
- Task force member, jail, prison, mental health, and juvenile standards revisions
- Physician surveyor
- Technical consultant

Deliberate Indifference? Yes and No

by Fred Cohen, LLM

Case #1: Yes

Kevin Briggs, a Michigan state prisoner, suffers with diabetes and requires insulin. He had been taking 48 units when suddenly, without apparent explanation, the dose was reduced by PA Westcomb to no more than 40 units.

As a result, Briggs suffered high blood sugar levels, cysts, constant urinating, and kidney pain. After about two months a physician increased the insulin to 50 units. Prior to the doctor's intervention, Briggs had "complained for months of ill effects" caused by the dosage being too low.

Claiming deliberate indifference by the PA, plaintiff Briggs sued in federal (district) court. His case was dismissed. He appealed, and the lower court's decision was reversed and the case remanded in *Briggs v. Westcomb* (6th Cir. 2020).

At the legal heart of this claim, based on the Eighth Amendment, is that ubiquitous term "deliberate indifference." To prove deliberate indifference, there must be a serious condition at issue – and that is conceded – and a culpable state of mind. Medical malpractice does not qualify as the requisite deliberate indifference. While the alleged culpable party need not be accused of rejoicing at the patient's pain, the charge is that the PA acted "maliciously and with sadistic intent."

Courts are much more disposed to find deliberate indifference when the claim is "I received no treatment at all." That is not the case here. The crux is the allegation that the plaintiff developed cysts, increased blood sugar, discomfort, and pain, and that the PA refused to alleviate this by simply enhancing the units of insulin.

Reversed, reinstated.

Comment: This is not the "mere disagreement" that courts use to clarify that this is not a matter where inmates may elect the type of care they receive when a medical professional prescribes a different approach.

Case #2: No

Inmate Slaughter experienced a steeplechase-like series of health problems before it was determined during an ER visit that he had "meningitis, probably viral."

He does not claim there was deliberate indifference in the sense of being totally ignored. Rather, he claims he suffered from incorrect diagnosis (stomach virus); that the delay in seeing a physician resulted from the diagnostic error; and that the wrong diagnostic tests were used.

The district court entered summary judgment for defendants (a prison nurse and a health services manager), and that decision is upheld in circuit court.

The defendants followed the prison's abdominal virus protocol, which directs that the inmate be provided antidiarrheal medicine, avoid spicy foods, and drink more water. Two days after the prescription was provided, Slaughter reported blood in his stool, but no doctor had yet entered the treatment picture.

Days later, plaintiff still complained of pain, and the only difference in care was to provide acetaminophen. Two days later, Slaughter told a CO his whole body ached. This led to a doctor's appointment, the ER referral, the proper diagnosis (meningitis), and the proper treatment followed by relief within six days.

The Seventh Circuit notes that a misdiagnosis alone is not the basis of the requisite deliberate indifference. The evidence showed that the nurse responded to all of the plaintiff's complaints and gave him relevant information about his care.

The nurse's decisions were based on her diagnosis (albeit wrong) and were appropriate for the diagnosis. The administrator essentially was not involved in the care complained about. Lower court is affirmed.

Comment: Mistake after mistake was made here, and the plaintiff paid a price in pain and psychological concern. But it is not a good case for deliberate indifference, which is a virulent form of recklessness.

Fred Cohen, LLM, is editor of the Correctional Law Reporter. *This article is reprinted (with minor modifications) from CLR with permission of the publisher. All rights reserved.*

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"Insight into the most significant issues in correctional health."

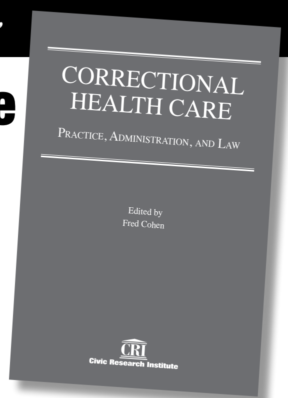
Correctional Health Care

Practice, Administration & Law

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

We live in an era of unprecedented promise and uncertainty in health care—nowhere more so than in America's prisons and jails. New drugs and devices for treating infectious and chronic conditions are revolutionizing care, but often at very high costs. Courts are mandating better levels of service, while the resources available to correctional agencies are increasingly subject to severe budget constraints. The work can be incredibly rewarding—yet burnout is a constant threat to the well-being of caregivers and patients alike.

Written to help professionals meet these challenges, this contributed volume brings together the insights and experiences of thirty of the nation's top experts to provide a comprehensive working guide designed to benefit every correctional health care provider, from specialist physicians to GPs, PAs, nurses, and the correctional administrators who are responsible for the overall well-being and care of their residents.



Format: Casebound Book
Leather, Gold Foil Stamp
© MMXVII 416 pp.
ISBN 978-1-939083-07-4
List Price: $135.95
Title Code: CHCPAL
http://www.civicresearchinstitute.com/chcpal.html

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Breaking the Chains of Human Trafficking in Incarcerated Populations

by Tom Serridge, MSW, LSW, CCHP-MH

Amelia was in her early 20s when she was incarcerated in a large state prison for drug possession. Her cellmate, Randi, befriended Amelia and offered her a place to stay upon release, which she gladly accepted. Amelia didn't know that her new "friend" was actually a sex trafficker. After moving in with Randi's associates, Amelia was coerced into prostitution, and over the next 10 years cycled in and out of jail or prison 23 times on prostitution and drug-related charges. Finally, a chaplain in the correctional system recognized that she was a trafficking victim and offered her support and a way out.

Stories like Amelia's are all too common (although the happy ending is not). Justice-involved individuals, particularly women, are easy targets for traffickers, and correctional settings are popular recruitment spots. Traffickers can work from the inside, offering their recruits housing, employment, love, and stability once they're released – false promises that can be almost impossible to resist.

That cycle of victimization and incarceration can be broken, however. Working together, health care and custody staff can implement interventions to identify victims, recognize recruitment techniques, and significantly improve outcomes for people like Amelia.

Human Trafficking: Scope and Definition

Human trafficking is the second largest and fastest-growing illegal activity worldwide and in the United States, surpassed only by drug trafficking. The International Labour Organization, a United Nations agency, estimates that it is a $150-billion-a-year industry, with approximately 40 million victims worldwide. According to the Polaris Project, a nonprofit organization that works to combat and prevent human trafficking, there are hundreds of thousands of victims in the United States alone, most of them involving sex trafficking.

The Trafficking Victims Protection Act, passed by Congress in 2000 to address this growing problem, defines human trafficking as the use of force, fraud, or coercion to compel a person into commercial sex acts or labor or services against his or her will. Any inducement of a minor into commercial sex is considered human trafficking regardless of the presence of force, fraud, or coercion.

Correctional health care and custody staff are much more likely to encounter victims of sex trafficking than any other type of human trafficking in their facilities because prostitution is illegal in most U.S. states and jurisdictions. It is imperative that all staff members who work with inmates – custody staff, health care professionals, and mental health professionals – understand what to look for and how to identify victims.

Victim Vulnerabilities

Anyone can become a victim of human trafficking. Individuals of all races, genders, ages, social and economic classes, and nationalities, from rural, suburban, and urban settings in all countries, have experienced victimization.

There are, however, known vulnerabilities and profiles that put some groups at much higher risk of being victimized. A significant percentage of justice-involved individuals share these characteristics:

- Past trauma history: child abuse, sexual abuse, domestic violence

- Mental health issues
- Active substance use or history of substance use
- Lack of positive family and social support
- Poverty and/or lack of stable housing

Vulnerable populations include:

- Women and girls. Females have the highest risk of victimization, particularly if they have a past history of sexual abuse, as many incarcerated women and girls do.
- Sex workers. Studies find that up to 80% of women and girls serving as prostitutes were coerced or forced to engage in prostitution by pimps or traffickers.
- Girls and boys in foster care, particularly those that "age out" without a permanent family connection
- Gay, lesbian, bisexual, transgender, and gender-nonconforming youth and young adults
- Homeless and runaway youth and young adults. According to the National Center for Missing and Exploited Children, about one in seven youth runaways in 2018 were likely victims of sex trafficking.
- Undocumented individuals or immigrants without lawful status

Indicators of Being Trafficked

To identify potential victims, health care professionals must know key signs or indicators. While one indicator alone may not raise a red flag, a combination of signs, and the patient's presentation during health care encounters, can indicate victimization. Some general signs include:

- Evidence of controlling or dominating relationships
- Scripted or inconsistent history
- Signs of physical or sexual abuse
- Unwillingness or hesitancy to answer questions about injury or illness
- Fearful or nervous behavior; avoiding eye contact
- Lack of awareness of location, date, or time

Indicators specific to sex trafficking may include the following:

- Multiple or recent sexually transmitted infections
- High number of sex partners
- Trauma to vagina and/or rectum
- Signs of physical trauma
- Suspicious tattoos or branding, including bar codes, initials or nicknames, dollar signs, or a king's crown
- Use of lingo or slang relating to involvement in prostitution; referring to a boyfriend as "Daddy" or talking about "the life"
- For children or youth, evidence of abortion

Indicators relevant to admission to a facility include having large quantities of cash or condoms, as well as hotel receipts or key cards. Arrest charges are particularly relevant, as victim charges typically include prostitution, loitering, theft, and drug possession. Typical trafficker charges include trafficking and kidnapping.

Arrest and admission indicators are a good example of why it is important for health care and custody staff to share important information that could assist in making an assessment that an inmate may be a trafficking victim.

Health Impacts

Many trafficking victims have significant co-occurring medical and mental health conditions. Sex traffickers often inflict violence when victims do not meet daily financial quotas. Common abuses and control tactics include severe beatings and gang rape. Victims often endure being choked, burned, or threatened with weapons. They may be deprived of sleep, food, or clothing. Additionally, they are often forced to witness violence perpetrated against other trafficked victims as a means of intimidating them into compliance.

Since victims typically have not received routine health care services, they often enter correctional systems with health complications due to untreated injuries or other health conditions. Consequently, they may experience chronic medical conditions, reproductive and sexual health issues, as well as dental or oral health complications.

Even if a trafficking victim does not present with medical conditions, they are likely to meet criteria for several types of serious mental illness and substance use disorders. For example, victims experience complex trauma or post-traumatic stress disorder at much higher rates than other populations. Complex trauma involves exposure to severe and pervasive traumatic incidents. Symptoms can be more enduring and extreme than PTSD, and patients often require a lengthy, multidisciplinary approach to support recovery. These patients often have significant trust issues and have difficulty identifying and expressing their feelings.

> **"The needs of survivors of trafficking are among the most complex of crime victims, often requiring an interdisciplinary approach to address severe trauma and medical needs."**
>
> Polaris Project/National Human Trafficking Hotline

Interventions to Address Human Trafficking

Thankfully, a number of interventions can, if taken together, make a significant positive impact in combating human trafficking and supporting survivors.

Develop a human trafficking policy, working cooperatively between health care and custody staff. Policy development plays a foundational role in ensuring that all other planned interventions are coordinated, trauma-informed, gender-sensitive, evidence-based, and compliant with NCCHC standards or other best practices.

Conduct staff training. All staff members who come in contact with inmates should receive training to ensure understanding of and compliance with policies and procedures. Staff from all disciplines need to know how to identify

Continued on next page

possible victims and traffickers. Recommended resources include the National Human Trafficking Resource Center, the Polaris Project, and HEAL Trafficking (see "Resources" box, below).

Establish identification and assessment procedures. Appropriate screening questions and a trauma-informed approach are critical to effective identification and assessment. Consider the perspective of trafficking survivors when developing language to use, screening questions, and interview techniques. Keep in mind that traffickers routinely instill in their victims the idea that no one outside their circle of control can be trusted, including people in the criminal justice system – and that includes health care staff. Support provided to victims should minimize the risk of retraumatization or stigmatization that may result from acknowledging their victim status.

Develop educational materials for victims, such as a human trafficking flier that lists signs and indicators and the National Human Trafficking Hotline number. Educational materials can be used during the initial health care screening process or at subsequent health care encounters. Fliers can also be laminated and posted in custody-approved locations.

Establish health care referral and reporting procedures. If a suspected trafficking victim has acute medical needs, the first priority is, or course, immediate treatment. If health care staff believe a patient is a victim, the health services administrator or designee and custody staff should be notified immediately. Victims could then be referred to local agencies with experience working with this population. Those steps should be spelled out in policies and procedures.

Create relevant programming to address the needs of trafficking victims, individually and/or in groups. Some correctional systems take a direct approach by offering educational and support groups with titles such as Human Trafficking 101, The Johns, and Ethical Sex. Others take a more subtle approach, with groups on topics such as healthy relationships, boundaries, or other relevant trauma-sensitive topics.

Target discharge/reentry planning to educate and connect victims with local advocacy resources and/or safe home information. Some jurisdictions offer prostitution diversion programs as an alternative to incarceration, similar to drug and alcohol or mental health diversion programs.

An Opportunity

Correctional health care professionals have an opportunity to ensure that correctional systems approach human trafficking among incarcerated persons from a public health perspective that is patient-centered, evidence-based, and trauma-informed. It is critically important that victims do not face additional obstacles as they return to their communities and avoid further abuse as they recover.

Working together across departments and disciplines can stop the cycle of victimization and incarceration, and support survivors on their journey toward healing and restoration.

Tom Serridge, MSW, LSW, CCHP-MH, is director of clinical development for Centurion, LLC.

Resources

For further information, training resources, examples of victim education materials, sample screening questions, and more:

- National Human Trafficking Hotline: 888-373-7888, humantraffickinghotline.org
- HEAL (Health, Education, Advocacy, Linkage)Trafficking: healtrafficking.org
- The Polaris Project: polarisproject.org
- Correctional Anti-Human Trafficking Initiative: nicic.gov/correctional-anti-human-trafficking-initiative

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More Than Meets the Eye

Clinical Judgment, Critical Thinking, and Correctional Nursing

by Nicole M. Walker, MSN, RN, CCHP

One of the great things about working as a correctional nurse is the amount of autonomy our specialty gives us. With that autonomy comes the responsibility to engage in high-level critical thinking and apply sound clinical judgment in each patient encounter.

Nurses are like icebergs. At any time, people only see about one-fifth of what we are actually doing. Patients, families, and peers see the tip of the iceberg – our skills and the care we provide. They don't see everything occurring under the surface – our critical thinking and clinical judgment. When it comes to nursing, there is definitely more than meets the eye.

All nurses need solid critical thinking skills and clinical judgment, of course. But there are several reasons why those who work in corrections especially need those skills:

- Nurses are the backbone of correctional health services and are typically the entry point to health care for our patients.
- Due to frequent involvement in patient care and the large proportion of nurses practicing in correctional settings compared to other health care professionals, we are exposed to more opportunities to make errors.
- We work in an environment where the focus is on safety and security, not health care. That environment can get under your skin and lead you, consciously or unconsciously, to think less critically. Examples include labeling a patient as malingering or demanding, or refusing to see a patient because he or she has requested access to care for the third time that week. Attitudes like that can lead to disastrous patient outcomes.
- Conscious and unconscious biases can influence our practice; it is essential that our critical thinking skills and judgment are stronger than any biases we might have.
- Correctional nurses see it all. While no individual nurse can be an expert on all things, those who work in corrections must be knowledgeable about a wide range of issues, conditions, and illnesses. Many of our patients have not had regular access to health care services and come into the system with complex needs.

Critical thinking and clinical judgment lead to creative problem solving, an important skill when working with limited resources. For example, we had a patient who returned to our infirmary with multiple post-operative drains following a mastectomy. She wanted to ambulate by herself but was unable to manage the drains. Instead of insisting she have a CNA with her to walk, the nursing staff used materials they had on hand to create pouches in which she could hold and conceal the drains. Thinking creatively enabled our patient to be independent and freed up the CNA to assist other patients.

Benner and Tanner, Nursing Theorists

Patricia Benner, PhD, RN, and Christine Tanner, PhD, RN, are two well-known nurse theorists who developed and studied concepts of critical thinking and clinical judgment.

Prompted by a recognition of the increasing complexity in acute care settings, Benner first set forth her theory and model of how nurses develop critical thinking skills in her 1982 book, "From Novice to Expert: Excellence and Power in Nursing Practice."

According to Benner's theory, critical thinking is a nonlinear process in which a nurse gathers objective information and puts those data pieces together to form a nursing plan of care. Critical thinking directs clinical judgment, a deliberative process that develops through practice, experience, and knowledge.

Benner's seminal work continues to provide an excellent tool to measure what stage any nurse is at in his or her career. The novice level best describes individuals such as prelicensure students who have no professional experience. At the beginner level, the individual can recognize and note recurrent situations and themes but cannot necessarily prioritize them. Nursing students are expected to graduate at the advanced beginner level moving into the competent

level, in which they begin to understand their actions in relation to setting long-range goals. At the proficient level, the nurse can perceive patient situations as a whole, rather than in single aspects. Finally, at the expert level, the nurse has developed an intuitive grasp of patient care situations and can easily zero in on an issue or problem.

According to Benner, it generally takes a nurse five years to progress from novice to expert. Benner also posits that when a nurse changes specialties, he or she will start the new specialty at the novice level but will generally progress quickly through the stages. That is especially true for correctional nursing, as nurses enter our specialty at all different levels.

Tanner was a student of Benner who looked more closely at the development of clinical judgment. In 2004, Tanner published her model of clinical judgment and posited the idea that nurses think differently. She defines clinical judgment as a process that includes deliberatively generating alternatives, weighing them against the evidence, and noticing patterns when making practice decisions. When nurses reach that stage of development, judgment occurs consciously and unconsciously at the same time. For instance, some nurses can walk into a patient's room with no information and immediately know something is going on that needs immediate attention.

Pattern recognition, which Tanner describes as "an intuitive grasp of the situation," is key to sound critical thinking and an essential skill for correctional nurses. A nurse who has developed his or her intuition can quickly perform an initial patient assessment and know when something is "off."

That skill is important because many of our patients have not developed the initial trust needed to engage in the therapeutic nurse–patient relationship. Pattern recognition enables the correctional nurse to know when to dig deeper. Take, for example, the patient who puts in multiple health service requests. The experienced nurse knows to ask more questions and dig deeper to find the root of the concern, whereas a less-experienced nurse may only address the symptoms listed on the health service request.

Tanner's model describes four phases of clinical judgment: interpreting, responding, noticing, and reflecting. According to Tanner, there are two types of reflection: Reflection in action (the ability to read a patient and evaluate data) and reflection on action (what the nurse learned from the experience). Prelicensure students begin to develop the skill of reflection during clinical lab sessions, and debriefing of patient care situations hones it. We can build on that and apply it in the correctional setting by doing case reviews, sharing experiences with one another, and doing root cause analyses when we have poor patient outcomes.

Tracy Levett-Jones' Clinical Reasoning Cycle model outlines a systematic process for the development of critical thinking and clinical judgment skills that incorporates some of Tanner's key principles. The nurse starts with considering the patient situation, collects cues and information, processes the information, identifies problems and issues, establishes goals, takes actions, evaluates outcomes, and, finally, reflects on the process and what has been learned.

In addition to individual use, the nurse manager can apply that model in the creation of clinical ladders or performance evaluations, and it can also be used in case studies to break down what went well and identify areas for improvement.

A Mountain Worth Climbing

Among our goals in correctional health care are for patients to be healthier when they leave than when they came in, and to teach them how to access health care in the community. At times that feels like climbing a mountain and never quite getting to the top. We work in an environment where safety, not health care, comes first.

Our duty is always to preserve and protect patient autonomy, dignity, and rights by acting as patient advocates while remaining aware of our unique environment. We are a voice for a disenfranchised group. We can help friends, family members, and community members to see our patients the way we do – not as "inmates" but as human beings.

Nicole M. Walker, MSN, RN, CCHP, is the nurse educator and an assistant health services manager at the Taycheedah Correctional Institution in Fond du Lac, Wisconsin.

Attitude Adjustments

The development of critical thinking and clinical judgment in nursing is essential for professional accountability, patient safety, and quality care. To develop those skills, correctional nurses need to be:

- **Independent thinkers.** Independent thinking is essential to expand the profession of nursing and move it forward. It opens the door to exploring nursing-based theories and research and helps solidify the profession.
- **Responsible and accountable for their decisions**. Those attitudes go hand in hand.
- **Creative.** Nurses may need to look for various different ways to implement an intervention, often with limited resources.
- **Curious.** Curiosity involves research, lifelong learning, reflecting, and asking questions.

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Using Telehealth to Create a Virtual Safety Net and Ease Community Reentry

by Rita Torres, CCHP

When it comes to providing health care, county jails in rural Colorado and New Mexico, as in many parts of the United States, face distinct challenges including provider shortages, long distances, a revolving door of patients, and recidivism. Thanks to a Health Resources and Services Administration grant, at Health Care Partners Foundation, a nonprofit organization that provides medical and mental health services in county detention facilities, we are using advanced telehealth tools to create continuity of care – and a seamless transition to health care services after discharge – for incarcerated individuals in several local jails. And we're hoping to reduce recidivism in the process.

We began to explore the idea of delivering services via videoconference and phone consultations several years ago as a way to expand provider resources and increase access. But as the revolving door continued to turn, concerns grew about the lack of a safety net to ensure continuity of care for those individuals being released into the community. The HRSA grant, awarded in 2018, promised to bridge that gap.

The focus of the grant: development of advanced technology tools to expand the existing virtual network into the community, thus providing recently discharged individuals, especially high-risk patients with mental health and substance abuse issues, continuity of care as they reintegrate and develop relationships with their own community providers.

The ultimate goal of the jail-to-community program was to reduce recidivism by identifying root causes in the areas of health, mental health, and substance abuse as well as social, environmental, economic, and educational realities.

The first year of the grant was dedicated primarily to building a dual-state, multicounty network to identify common issues and develop workable solutions, while also recognizing individual state and county government systems. County detention centers in New Mexico, for instance, are run by county administrators recommended by the county managers and approved by the county commissioners, while in Colorado, they are run by elected sheriffs. Despite local differences, all four participating counties – Las Animas and Huerfano counties in Colorado and San Miguel and Colfax counties in New Mexico – were committed to working together to reate bridges to the community.

During a strategic planning process, the four-county consortium identified common and individual issues, created a vision statement and a statement of purpose to encompass the global essence of the program, developed a road map to solutions, and put together priorities and strategic action plans.

The next step was identifying an electronic telehealth system that could realize those priorities. To be successful, the system needed to be flexible and easily accessed by patients and providers, include tools for assessing patients and developing treatment plans, and interface with other electronic systems.

HRSA pointed us to a Jail-to-Community Transition initiative launched in 2007 through a partnership between the National Institute of Corrections and the Urban Institute, which included a detailed assessment form focused on the well-being needs of individuals within the jail systems. This tool held great promise, if we could find a partner to expand the NIC/UI form into a digital tool that would work together with telehealth and EHR systems.

Introducing the Dream Team

We reached out to Soraya Abad-Mota, PhD, in the computer science department at the University of New Mexico, who put together a "dream team" of graduate students with expertise in software development and reporting systems. Their mission: to develop virtual screening, assessment, and treatment tools and an electronic care coordination system for follow-up and tracking to establish a seamless continuity of care structure.

The first electronic tool developed was a prescreening instrument, which collects demographic data about the population coming into the facility, including age, gender, race, ethnicity, any substance abuse and/or mental health issues, and past incarceration history, as well as anticipated length of stay and severity of charges. This tool is installed on each booking officer's desktop computer and takes only two

Purpose and Vision Statements

Purpose: Our collaborative partnership serves individuals transitioning from detention centers to the community by using telehealth connectivity, local care coordinators/advocates, and local support systems to provide responsive and high-quality care to improve their responses to behavioral health crises, reduce health care costs and recidivism, and support them in their recovery.

Vision: All county residents released from detention centers have access to primary and behavioral health services and other community support services for successful integration back into their communities.

minutes to complete. The information collected helps to identify individuals who are appropriate for the program.

Monthly reports are generated for the four counties, including information such as the percentage of detainees with substance abuse and/or mental health issues; their ages, ethnicities, and genders. The counties appreciate being able to clearly identify the demographics and high-risk needs of their jail populations, which is helpful for budget negotiation and grant-seeking.

A key to the program's success are our telecounselors, licensed professional counselors who are trained to evaluate, assess, and treat the total person for all areas of well-being. For each individual, the telecounselor develops a short- and long-term plan, coordinates care, and makes appropriate referrals to community programs and systems to support that individual's specific needs. They also work closely with telehealth providers.

Once the booking officer completes the prescreening assessment, a report is sent to the telecounselor who begins the Transition Assessment Tool. The TAT includes drop-down boxes and comment sections along with referral and case management sections. "This is the easiest and most complete electronic assessment tool I have ever worked with," says Christina Wick, lead telecounselor for the project. "Working with the dream team allowed providers like me to test it, give input on use and simplicity, and make recommendations. It makes my job so much easier!"

We also worked with CORHIO, a health information exchange for securely sharing clinical information among multiple providers and patients. That information identifies any community services or resources the recently discharged individual may have utilized. Armed with that information, the telecounselor begins the referral and care coordination process for whatever is needed, such as telemed services, tele-addiction specialty care, community-based resources, medication-assisted treatment, transportation, housing, and continued counseling. Upon discharge, the patient receives a summary of the final TAT report. Telecounselors follow up within 36 hours for up to 90 days or until the individual has successfully transitioned into community resources and provider network systems.

Capt. Rick Mangino from Las Animas County reports that two individuals called the jail after being discharged to request copies of the summary transition plan. "They feel this program is really trying to help them get back on track and actually cares about them," he says.

What Happens Next? Back to the Future

The funding for this program will end in 2021. We have been working on several initiatives to ensure the program can continue after the end of the grant.

As a result of the COVID-19 pandemic, telehealth in all sectors of health care has become more widely used and accepted, and billing systems for telehealth have also expanded. With over 95% of detainees eligible for Medicaid and/or Veterans Administration benefits, processes for ensuring those benefits are in place upon discharge allows for billing systems to continue the needed medical, mental health, and substance abuse programs for continuity of care.

New Mexico passed legislation requiring that insurance payors contracted with Medicaid provide transitional services to individuals being discharged from jails, and county detention centers have established insurance representative contacts who are coming into the facilities to ensure compliance with the legislation.

In Colorado, an innovative state-funded jail-based behavioral health services program (called Criminal Justice Services for Community Behavioral Health) has improved access to behavioral health treatment in jail while also supporting continuity of care after release.

State Rep. Donald Valdez, who represents the Colorado counties in the program, says, "Legislative leaders need to support these programs to address the substance abuse and behavioral health issues within rural communities. Telehealth is proving to be a solution for expanding access to provider and community resources."

Our advanced technology jail-to-community program has begun to produce a key outcome measure that all county detention centers would like to achieve – a reduction in recidivism. Compared to a recidivism rate of 68% in the four counties prior to the program, among those individuals who have completed the program, the rate is only 20%. Now that is a program worth keeping!

Rita Torres, CCHP, is founder and chief executive officer of Health Care Partners Foundation based in Julesburg, Colorado.

Success Stories

Success story #1: A 45-year-old man with a history of multiple incarcerations and a medical history of asthma, mental health issues, and alcohol abuse reported being non-compliant with medications and unmotivated to manage his health care, although he reported having a primary care physician. Prior to discharge, the TAT assessed his needs and identified provider and community resources. Seventeen days post-discharge, the patient was still using telehealth services, maintaining telehealth follow-up visits, complying with medication use, and using community-based health care providers.

Success story #2: A 54-year-old woman with a history of multiple incarcerations and a medical history of asthma, COPD, fibromyalgia/chronic pain, depression, and PTSD reported difficulty managing her health care needs and remembering medical appointments. After using the TAT, the telecounselor scheduled community referrals and a primary care appointment. Within one week of discharge, the patient had followed through with the scheduled appointments and was maintaining medication compliance. She completed requested postrelease drug tests and attended court-ordered recovery meetings. Initially she had difficulty making it to community counseling appointments, so she continued with telecounseling until transition to a community mental health provider was achieved.

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Clinical Care of COVID-19 Patients: Monitor, Manage, and Move Out

by James Grigg, MD, Ross MacDonald, MD, and Rachael Bedard, MD

A significant amount of national attention has focused on the risks of coronavirus in correctional settings. Coverage in the media, public health guidelines, and academic writing have emphasized mitigation strategies to prevent the virus's spread, such as testing procedures, isolation strategies, quarantine protocols, and decarceration efforts.

The "how-to's," however, have been given less attention thus far – specifically, how to safely and effectively provide clinical monitoring and medical care for people who develop COVID-19 while in jail or prison.

Monitor, Monitor, Monitor

Actively monitor confirmed or suspected COVID-19 patients for worsening symptoms during the course of their illness. In some individuals, symptoms that start off mild can worsen over the first week, and shortness of breath, low oxygen saturation, weakness, or confusion may develop. Screen patients at least daily for worsening symptoms and monitor vital signs, including oxygen saturation level and heart rate.

The oxygen level is especially important as COVID-19 has been known to present with "silent hypoxia," wherein patients have low oxygen levels but do not feel or look as sick as would be normally expected, so hypoxia is not suspected. Hypoxia is considered a key measure for severe disease. Given the various challenges inherent in working with incarcerated patients – language barriers, serious mental illness or cognitive impairment, lack of trust, logistical hurdles, and more – a pulse ox of ≤ 94% is a reasonable level at which to consider escalation of care.

Symptom surveys and observation should also always be considered. Ask patients specifically about worsening shortness of breath and confusion, and look for symptoms or signs of other potential complications such as stroke, heart attack, or pulmonary embolism.

Pay Special Attention to High-Risk Populations

Those patients with risk factors for severe disease, including advanced age and relevant chronic conditions, require even closer monitoring.

Incarcerated individuals should be considered at risk for serious disease at an earlier age than the general population due to premature aging and higher rates of mortality from COVID-19 in this population. People of color, significantly overrepresented in jails and prisons, are also generally at higher risk for hospitalization and death due to the disease.

The CDC lists specific chronic conditions that are known to increase risk for severe disease: diabetes, heart disease, kidney disease, severe obesity, lung disease, cancer, and other weakened immune system problems. Those higher-

risk patients may need to be monitored in a setting with an increased level of skilled nursing and receive monitoring more frequently than daily, as well as chest X-rays early in the course of illness. They should also be given greater consideration for therapies beyond supportive care, depending on current treatment guidelines.

Manage Symptoms

Currently, no medications are proven to improve outcomes in COVID-19 patients who are not hospitalized. As with many other viral illnesses, supportive care is the goal in COVID-19 treatment in correctional settings. That includes hydration and symptom management for cough, body aches, fever, and other symptoms.

Generally, acetaminophen may be preferred for fevers and body aches. NSAIDs may be used for COVID-19 symptoms, however, especially if acetaminophen fails. When using those medications, remember they may mask fevers when applying protocols that include fever resolution to help decide when to end a patient's quarantine.

When caring for patients suspected to have COVID-19, remember that diseases that may be treated with other medications, such as influenza, bacterial pneumonia, and strep pharyngitis, should still be considered. For asthma and COPD patients, nebulizers should generally be replaced with inhalers due to the potential for nebulizers to spread the coronavirus. Similarly, BiPAP and CPAP machines may also spread the virus. A case-by-case review of their use and possible temporary suspension should be considered or used with protocols in place for infection control.

Transfer to Hospital

To ensure adequate capacity for a potential surge of patients, have a predetermined partner hospital ready to accommodate transfers from your facility if necessary. Given the course of this disease, patients should typically be identifiable before becoming critically ill and should be transferred to the hospital early if showing signs of instability or worsening.

If your partner hospital is a small community hospital that may not be equipped to care for an influx of incarcerated patients, work together to create a plan of action in the event of an outbreak at your facility or in the community.

Develop – and Update – Protocols

Develop protocols that take into account the many considerations and challenges of caring for people with COVID-19 in a correctional setting. Protocols should include guidance on monitoring symptoms and vital signs for the development of severe disease, when to escalate the level of care, and which high-risk populations will receive closer monitoring and additional care. Evolving community guidelines should be incorporated and adapted to the incarcerated setting and population as they are updated.

Protocols for minimizing coronavirus transmission in correctional settings remains a very high priority; monitoring and clinical care are also essential to ensuring that patients receive appropriate treatment and decrease their risk of developing critical illness.

The authors are affiliated with New York City Health + Hospitals Division of Correctional Health Services.

James W. Grigg, MD, is director of clinical education and a clinical assistant professor in the department of medicine at NYU Grossman School of Medicine; Ross MacDonald, MD, is chief medical officer and senior assistant vice president; Rachael Bedard, MD, is director of geriatrics and complex care services and an assistant professor at the Icahn School of Medicine at Mount Sinai.

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2020 Award Winners Honored at Virtual National Conference

NCCHC's annual awards pay tribute to leaders and innovators who have enriched the correctional health care field. We applaud this year's recipients of the most prestigious awards in this field. The awards were presented Nov. 2, during a virtual opening ceremony of the National Conference on Correctional Health Care.

Bernard P. Harrison Award of Merit

NCCHC's highest honor, this award is presented to a group or individual who has demonstrated excellence and service to advance the correctional health care field through an individual project or a history of service. The award is named after NCCHC's cofounder and first president.

Jim Voisard, CCHP-A

Since becoming an accreditation surveyor in 1986, Jim Voisard has been an integral part of NCCHC and its consulting arm, NCCHC Resources, sharing his correctional health care expertise as a senior lead surveyor, trainer, and consultant.

Before his retirement, Mr. Voisard was director of the Correctional Health Care division of TeamHealth/Premier Physician Services, overseeing health care management and staffing at 23 facilities. Prior to that, he was director of medical services at the Montgomery County Jail in Dayton, Ohio.

His nominators describe him as honest, ethical, calm, patient, professional, and tireless. One called him "the ideal representative of NCCHC." He is known as a leader, teacher, colleague, friend, and someone who enjoys a good laugh.

Mr. Voisard was one of the first CCHPs and also one of the first to become a CCHP-Advanced. He is chair of the Surveyor Advisory Committee and the OTP standards revision task force, and a longstanding member of the accreditation and standards committee.

B. Jaye Anno Award of Excellence in Communication

This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. It is named after NCCHC's cofounder and first vice president.

Anne Spaulding, MD, MPH, CCHP-P

As one of the nation's foremost experts on infectious disease in corrections, Anne Spaulding's work is always important. But it is especially significant now, during the coronavirus pandemic. As COVID-19 gripped the country's correctional system, Dr. Spaulding quickly emerged as an authority. In a situation that called out for guidance, she provided it, generously sharing her unique expertise and knowledge through interviews, webinars, articles, and more.

In nearly 25 years of focusing on correctional health, Dr. Spaulding has authored more than 100 publications and lectured widely. She is associate professor of epidemiology at Emory University's Rollins School of Public Health in Atlanta. Previously, she served as medical director for the Rhode Island Department of Corrections and associate medical director for Georgia Correctional Healthcare.

She earned her medical degree from the Medical College of Virginia and her master's in public health from Johns Hopkins University

R. Scott Chavez Facility of the Year

This award is presented to one facility selected from among nearly 500 jails, prisons, and juvenile facilities accredited by NCCHC. It is named after NCCHC's longtime vice president.

Atlantic County (NJ) Justice Facility

When health staff, custody staff, and leadership work together to provide their best, along with numerous community partners, the results go above and beyond the requirements of the NCCHC jail standards. That is what surveyors found at the Atlantic County Justice Facility in Mays Landing, NJ.

Because health administrators make themselves available to listen to and address patient concerns, health-related grievances are minimal. Mental health coverage is comprehensive, and staff and volunteers lead a variety of groups. Suicide prevention training and drills occur monthly on each shift, and staff report feeling well-prepared for real-life situations.

In addition to required rounds by medical and mental health staff, inmates in the segregation unit meet weekly with medical and mental health providers in a nearby exam room. Through community partnerships, the facility provides on-site medication-assisted treatment, along with counseling and linkage to continued treatment upon

release, and a comprehensive reentry program provides assistance with housing, health insurance, and case management services.

Department heads meet weekly and the health services vendor meets monthly with the Atlantic County Department of Public Safety, which operates the facility. This all leads to exceptional cooperation and coordination of services.

NCCHC Program of the Year

This award recognizes programs of excellence among thousands provided by accredited jails, prisons, and juvenile facilities.

Complejo Correccional de Bayamón, Puerto Rico, Transformative Education Institute

At this recently accredited prison in San Juan, the Transformative Education Institute gives a select group of men the opportunity to learn and practice a variety of arts and crafts. The program is designed to promote rehabilitation by instilling positive values and ethics – not to mention hands-on, marketable skills. Creative activities such as woodworking, leather crafting, soap making, and theater arts are taught, along with plumbing and other trades. The program also operates a shop where the men sell their work and earn a portion of the proceeds, allowing them to support their families while strengthening bonds and further preparing them for reintegration. Upon release they receive assistance, connections with potential employers, and loans for small-business start-up.

To qualify for the program, the men must have at least 3 years remaining on their sentence and a record of good behavior, including no substance use. Surveyors noted the strong sense of teamwork, fulfillment, and pride among the participants

Surveyor of the Year

This award was created in 2019 to recognize a surveyor who is an exemplary representative of NCCHC and demonstrates extraordinary dedication.

Barbara Mariano, RN, CCCHP

Barbara Mariano has been an NCCHC surveyor for close to 30 years and a lead surveyor for more than 20, with special expertise as a lead surveyor for Opioid Treatment Programs. While she describes herself "an invisible part of the system" and "a tiny cog in the wheel of change," she has had a big impact on the hundreds of facilities she has surveyed and on her fellow surveyors.

As one of her nominators said, "She educates with laughter and maintains leadership with a generosity of spirit" and "conveys to all members of a survey a pure joy in recognizing each site's accomplishments."

Ms. Mariano says she entered the field of correctional health care "by accident" when, as a visiting public health nurse, she was sent to the local jail to administer TB tests.

A quarter of a century later, she retired from the Monmouth County Correctional Institution, an NCCHC-accredited facility in Freehold, New Jersey, to devote herself to consulting and surveying.

Liz Piatek, NCCHC's accreditation logistics specialist and last year's Surveyor of the Year, says, "Barbara's commitment to NCCHC is unparalleled."

NCCHC Young Professional

This award recognizes new and upcoming leaders in the correctional health care field. It is presented to an outstanding correctional health professional, 45 years of age of under, who leads by example, takes initiative, demonstrates a strong work ethic, and inspries others through his or her commitment to quality health care.

Lalita Bhandari Gautam, MSN, RN, CCHP

In the many nominations and glowing reviews Lalita Gautam received, two words showed up repeatedly: passion and compassion. She is described as a strong, approachable leader who creates "a healthy and positive environment" and "goes above and beyond to support new staff."

Correctional nursing does not exist in Nepal, Ms. Gautam's native country, and when she heard the term several years ago she became intrigued. She took her curiosity and her nursing experience to California Medical Facility, the California prisons system's flagship health care facility, where she quickly rose from newcomer to emergency room supervising nurse. In the process she gained the respect and admiration of coworkers and supervisors alike.

She earned a master's in nursing from Grand Canyon University in 2019 and became certified as a CCHP in 2017.

Watch the Awards Ceremony (and more) at youtube.com/NCCHC.

CALIFORNIA

CAREERS | LOCATIONS | LIFESTYLES

Executive

Chief Medical Executive

$333,048 - $501,744

(Depending on assignment)

- Chuckawalla Valley State Prison – Blythe

Mental Health

Psychiatrists

$266,844 - $320,640

(Board Certified)

$260,004 - $311,592

(Board Eligible)

Senior Psychologists

$129,996 - $139,164

Primary Care

Physicians

$282,216 - $296,328

(Time-Limited Board Certified)

Physicians*

$324,540 - $340,776

(Time-Limited Board Certified)

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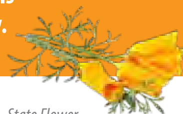

California Poppy – Eschscholzia californica – State Flower

As a correctional health care professional,

you're already well-versed in the skills needed to provide care for this diverse and unique patient population. Now imagine taking your skills to the California State Prison System!

Together, the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) provide medical, dental, and mental health care to patients in our State-operated correctional facilities. Here, you'll find robust mutidisciplinary teams with like-minded professionals dedicated to providing patient-centered primary care. And with locations throughout California, you're sure to find your perfect fit.

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EOE

Effective July 1, 2020, in response to the economic crisis caused by the COVID-19 pandemic, the Personal Leave Program 2020 (PLP 2020) was implemented. PLP 2020 requires that each full-time employee receive a 9.23 percent reduction in pay in exchange for 16 hours PLP 2020 leave credits monthly through June 2022.

Journal preview

HbA1c Levels and the Chronic Care Theory

Since integrating the chronic care theory in 2008 and the complete care model in 2015, the California Department of Corrections and Rehabilitation has seen steady improvement in health care-related mortality. However, one area where outcomes have not changed significantly is in glycemic control among diabetes patients, according to a study in the October issue of the *Journal of Correctional Health Care*. Study authors Diane O'Laughlin and Jordan Rose of California State University say that the CCM needs to incorporate additional components of the theory to achieve CDCR's goal of 90% of diabetes patients with glycated hemoglobin (HbA1c) levels below 8%.

A Model for Improving Health Care

The chronic care theory is an evidence-based framework to improve health care outcomes for patients with chronic conditions. It has six main concepts: team-based patient-centered care, patient self-management support, information technology, evidence-based clinical guidelines for patients and providers, community programs, and a health system with leadership support.

The complete care model is the health care delivery model designed by California Correctional Health Care Services (established in 2008 to oversee CDCR's health care). It is based on the six concepts of the chronic care theory.

The HbA1c level is a known key indicator for a competent implementation of the chronic care theory. A rigorous review of studies relating to chronic care and diabetes concluded that when all six of the concepts of the chronic care theory are implemented, the result is improved patient involvement in self-care, reduced HbA1c, and better adherence to standards of care.

Findings and Recommendations

The study compared diabetes patients' HbA1c levels during the two years before the CCM was implemented (2013–2014) to the two years after (2016–2017). Data came from the CCHCS website's dashboard and are at the population level, indicating what percentage of the total diabetes population (approximately 8,000 patients) is in glycemic control each month at each of 33 prisons. The data cover patients who have been incarcerated in CDCR continuously for 12 months. Most of the study population is male as only two of the 33 prisons are for female. As of the 2010 census, inmate ethnicity in California prisons was 9% White, 14% Hispanic, 58% Black, and 19% other.

Date analysis found that post-CCM, 78% of the statewide diabetes population was in glycemic control compared to 77% pre-CCM, a change that was not statistically significant. The study authors note several factors that could influence the data outcomes include the aging population, prison reforms, the implementation of the electronic health record in 2015 and 2016, and prison diet. They also observe that the average percentage of patients in glycemic control in CDCR was superior to the 50% to 65% reported in the private sector during the same time period.

Among their recommendations for better implementation of the chronic care theory are assigning patients to consistent multidisciplinary primary care teams; offering healthier dietary options; broader use of self-monitoring of key indicators such as blood sugar and dietary choices; and enhanced use of community services such as weight management resources and exercise programs.

JCHC Vol. 26, Issue 4: October 2020

- Clinician Experiences of Care Provision in the Correctional Setting: A Scoping Review – *Lisa Simon, David Beckmann, Martha Stone, Rachael Williams, Marya Cohen, & Matthew Tobey*
- The Emotional Burden of the Correctional Health Advance Practice Nurse – *Scarlett L. Hancock*
- Differences in Sexual Health Outcomes between Adolescents in Public Schools and Juvenile Correctional Facilities – *Meagan Thompson, Laurel Davis, Virginia Pendleton, & Rebecca Schlafer*
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- Influences of Antenatal Smoking Cessation Education on Smoking Rates of Incarcerated Women – *Robin McCormick & Sherry L. Seibenhener*
- A Systematic Review of Literature: Alternative Offender Rehabilitation—Prison Yoga, Mindfulness, and Meditation – *Dragana Derlic*
- The Complete Care Model and Glycemic Control in California State Prisons – *Diane M. O'Laughlin & Jordan Rose*
- An Outcome Study on the Naloxone Education/Dispensing Program for Departure Patients at Cermak Health Services of Cook County – *Tony C. Leung, Stefanie Colyer, & Svetozara Zehireva*

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Correctional Medicine's Movers and Shakers

The CCHP-P program was launched in 2015 to give correctional physicians (the second P in CCHP-P) an opportunity to earn a credential that acknowledges their unique expertise in this specialized field. CCHP-Ps have demonstrated that they recognize the medical needs of the incarcerated and understand the challenges, legal issues, and policies and procedures specific to practicing in corrections.

"Correctional physicians can feel like they are out there by themselves," says Eileen Couture, DO, RN, CCHP-P, who serves on the CCHP-P Subcommittee. "CCHP-P recognizes them as a specialty, acknowledges their body of knowledge and says to their counterparts, 'I've taken the next step and I'm recognized as a correctional physician'."

An Impressive Cohort

Since its inception, close to 100 physicians have become certified as CCHP-Ps. And their contributions to the field are impressive.

Notable CCHP-Ps include: Jeffrey Keller, MD, CCHP-P, author of the "Jail Medicine" blog and "Health Care Behind Bars" column in MedPage Today and medical director of Badger Medical; Nader Sharifi, MD, CCHP-P, medical director of correctional health with the Provincial Health Services Authority of British Columbia; Kenneth Soyemi, MD, MPH, CCHP-P, medical director, Cook County (IL) Juvenile Temporary Detention Center; executives from several correctional health care companies; and many chief medical officers, medical directors, staff physicians, consultants, and professors from as far away as Guam.

CCHP-Ps make an enormous contribution to NCCHC. In 2020, 13 were conference or webinar presenters, 13 acted as physician surveyors, and six served on the board .

The exam covers clinical management, mental health, public health, security, legal and ethical issues, and administration.

A detailed study guide is available at ncchc.org/cchp-p.

CCHP-P Subcommittee Members

- Jeffrey Alvarez, MD, CCHP-P, CCHP-A, chief medical officer, NaphCare
- Eileen Couture, DO, RN, CCHP-P, medical director, South Suburban Council for Alcohol & Substance Abuse
- Brent Gibson, MD, MPH, CCHP-P; chief health officer, NCCHC
- Charles Lee, MD, JD, CCHP-P, retired
- Ilse Levin, DO, MPH, CCHP-P, Mid-Atlantic Permanente Medical Group
- Rebecca Lubelczyk, MD, CCHP-P, Wellpath
- Robby Morris, MD, CCHP-P, professor emeritus, UCLA
- Juan Nunez, MD, CCHP-P, medical director, Duval County Jail
- Esmaeil Porsa, MD, MPH, CCHP-P, CCHP-A, CEO, Harris Health System
- Matissa Sammons, MA, CCHP, vice president, certification, NCCHC (staff liaison)
- Steven Shelton, MD, CCHP-P, CCHP-A, consultant
- Anne Spaulding, MD, MPH, CCHP-P, associate professor, Emory University
- Todd Wilcox, MD, MBA, CCHP-P, CCHP-A, medical director, Salt Lake County Metro Jail
- Johnny Wu, MD, CCHP-P, chief, clinical operations, Centurion

An Old Friend in a New Role on the CCHP Board

"When I began my career in correctional health care in 1994, I sought out any information I could find to help in my learning about this exciting new field," says Tracey Titus, RN, CCHP-RN, CCHP-A, senior director of policy and accreditation for Centurion, LLC. "Naturally, I turned to NCCHC and the CCHP program."

Fast forward 26 years, and Titus brings that same excitement and passion for learning to all she does, including serving on the CCHP Board of Trustees. She was recently elected by her peers to serve a three-year term, prevailing over several widely recognized and well-established correctional health professionals for the seat.

Before joining Centurion in 2019, Titus spent seven years as vice president of accreditation for NCCHC, where her responsibilities included oversight of the accreditation program for hundreds of facilities nationwide, development of the NCCHC surveyor program, and revisions to NCCHC standards. She is a popular conference speaker and trainer.

Previously, she was nurse manager at the Vanderburgh County Sheriff's Office in Evansville, Indiana, for nearly 20 years. Her career is a family affair; her mother, Lavon Wood, LPN, CCHP, is also a jail nurse and medical educator.

"Titus accepted her appointment with all the enthusiasm and graciousness her peers and colleagues know her for," says Matissa Sammons, MA, CCHP, vice president of certification. "Her energy will be a great asset to the board."

Tracey Titus and her mother, Lavon Wood

When asked about reasons for wanting to be part of the CCHP Board of Trustees, Titus says "The development of the CCHP program over the years has been phenomenal, with numerous specialty certifications and now the availability of remote testing and proctoring. Those developments will open doors for continued growth, and challenge the Board of Trustees to continue its mission to be the foremost correctional health care certification program available. It is my honor and privilege to be part of the board's continued mission, and I'm looking forward to the hard work in store over the next three years".

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For information on how to participate, go to ncchc.org/national-conference.

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ADVERTISER INDEX

California Correctional Health Care Services 18
CCHP – Physician 20
Centurion 9
Corr.l Health Care: Practice, Administration & Law 4
Harvard University/NCCHC 23
Medi-Dose EPS .... Inside front cover
Medi-Dose Tamper Evident Products 24
Medi-Dose Tamper Evident Syringe Bags 15
NCCHC Foundation .... Back cover
Swisslog Healthcare 25
Wexford Health Sources 5

HEALTH CARE BEHIND THE BARS

Facilities needed for a research study on health care in jails

The National Commission on Correctional Health Care has partnered with researchers at Harvard University to learn about the effects of health care accreditation in jails.

We all know that health care problems don't disappear behind bars.

Even in the best of times, providing health care to inmates is challenging despite having a disproportionate number of people with serious chronic health issues.

NCCHC's accreditation program is dedicated to improving the quality of correctional health care services and helping jails provide effective and efficient care.

This study will assess the impact of accreditation on jails' health care systems and how accreditation affects the care of the incarcerated. The NCCHC *Standards for Health Services in Jails* will be utilized as the basis for assessing proper management of care services.

NCCHC and researchers at Harvard University are working with jails that have an ADP of 500-3,000 inmates.

Participation involves:

- Commitment to complete surveys about facility characteristics and effects of accreditation process on health care system
- 2-3 virtual and/or on-site visits by the study team

Facilities receive:

- $500 award for each on-site visit
- Reduced fee if become accredited during study
- Confidential facility assessment of health care delivery system

Benefits of participating:

- Become accredited at a reduced fee
- Improve health care processes
- Improve inmate health
- Limit occurrence of adverse events
- Reduce lawsuits related to inmate health care

Please respond by February 1, 2021.
For more information, contact
accredstudy@hks.harvard.edu

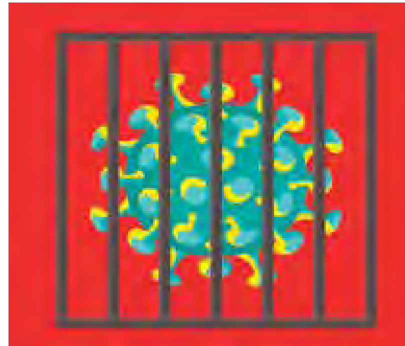
Expert Advice on NCCHC Standards: Your #1 Coronavirus Question, Answered

by Amy Panagopoulos, MBA, BSN, and Jim Martin, MPSA, CCHP

Q *I am concerned about maintaining our facility's accreditation status because, in response to COVID, we have made some changes in the way we provide health care that might not be in alignment with the NCCHC standards. Can you clarify?*

A Over the past months, NCCHC has received many similar questions about compliance with standards during the pandemic. Many accredited facilities share your concerns.

While we understand the challenges of providing health care during this time and know that care may have been interrupted during the pandemic, there are a few keys to success when thinking about the future and getting beyond the coronavirus crisis.



Here's how correctional leaders can begin navigating what's next as you think about accreditation or reaccreditation.

1. Decisions about resource allocation should be made at the system level in alignment with your emergency response plan.
2. Standards are the backbone of a health services delivery system; therefore, no standards are "waived." The key to success is to document the reasons for all deviations to health care plans and resume normal operations as soon as safely feasible.
3. Document your response to the crisis in a thorough and thoughtful manner. Be clear when services deviated from the plan and when they are anticipated to get back on track. Document your triage plan when providing care: who can wait, and why? Document, document, document.
4. Document your contingency plans when needing to provide emergency medical or dental care.
5. Follow national guidelines like those of the CDC for guidance on care protocols during a pandemic. Keep these guidelines as part of your documentation to support your rationale.
6. Think beyond coronavirus and what the path to normal looks like. Document when services resumed and how you went about assessing patients and addressing the backlog of health service needs.

NCCHC surveyors are experienced correctional health care professionals who know what you are going through; many have been through similar crises themselves. They will consider the unusual circumstances you are facing and the adjustments you are having to make.

We understand the changes made to your health care delivery system were in order to respond to vulnerable populations while also actively working to reduce potential exposure to the virus.

Thank you for the amazing patient care you are delivering during these challenging times.

Amy Panagopoulos, MBA, BSN, is NCCHC's vice president of accreditation. Jim Martin, MPSA, CCHP, is NCCHC's vice president of program development.

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Let's end 2020 on a positive note by helping the Foundation enter 2021 with the means to make a difference.

With your help, we can expand and do more in 2021 and beyond.

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