Welcome to the inaugural issue of Correctional Health Connection, a newsletter of the Coalition of Correctional Health Care Authorities (CCHA). It has been our pleasure to serve as co-chairs of CCHA, and we are proud to present you with a new opportunity to network with each other, discuss the problems you face in your states and work together to find solutions.

In the past, correctional health care consisted of individual health care professionals fighting to find their voice within the confines of the prison walls. Health care professionals’ goals to provide appropriate and timely clinical services for inmates and promote policies that were consistent with “community standards of care” were sometimes in conflict with security policies put in place to ensure safe and secure institutions. During the last 10 years, significant work in areas of preventative services, rehabilitation and reentry have begun to take root in the nation, requiring all institutional employees to take stock in what their role should be in the areas of risk reduction and recidivism. Part of that risk reduction and reentry expansion includes advancing communication with medical and mental health services. By bringing health care to the table and including health care professionals in the conversation about preventative services, health maintenance, stabilization of the mentally ill and substance abuse treatment, we are beginning to see significant improvements in treatment outcomes for inmates within the correctional environment.

In correctional health care, sometimes challenges are many and solutions are few. Generally, the gap between the two is far stretched, leaving those of us who have committed our careers to this work feeling discouraged in the possibility of reaching positive outcomes. CCHA is helping to bridge that gap. Thanks to the commitment of Elizabeth Gondles, Ph.D., health care advisor to the American Correctional Association (ACA) president; Rear Adm. Newton Kendig, M.D., assistant director, Health Services Division, Federal Bureau of Prisons; and Lannette Linthicum, M.D., health authority, Texas Department of Criminal Justice, we are building momentum as a resource.
Co-Chairs’ Message continued

for finding solutions that work. These individuals didn’t just get
together to find solutions for a particular problem, but found a
way to connect 50 states, six large jail systems and the decision-
makers at ACA to work together on issues surrounding correc-
tional health care. Likewise, our CCHA members are actively
participating and making this a vibrant organization. Our con-
gratulations and appreciation to all of you for creating a forum for
us to build upon one another’s success. CCHA’s founding would
not have been as successful were it not for the support and as-
sistance of the National Institute of Corrections (NIC). Under
Morris Thigpen’s (director of NIC) leadership, NIC supported
the launch of CCHA’s first fall meeting and continues to support
CCHA today.

These are interesting times. On one hand, there are many
major reforms in corrections, and on the other hand, our na-
tion is witnessing one of the most significant changes ever in
the health care industry. Correctional health care sits in this
unique cusp, promoting these new ideas of managed care and
tying them to continuity of care while having a positive impact
on reentry efforts. In addition, there are significant develop-
ments with the Affordable Care Act, Prison Rape Elimination
Act, gender identity disorder classification, procedures for treat-
ing the mentally ill in segregation, providing effective substance
abuse treatment and developing practices for aftercare planning
(such as getting releasing offenders their social security benefits,
VA benefits, etc.). We must also test solutions that work in the
health care sector against the security scrutiny required to im-
plement them in our secure prison facilities.

This is why we believe that CCHA plays a critically impor-
tant role in correctional health care. Our coalition helps by
breaking down these barriers through team building. We are a
great resource to each other in these challenging times. As many
of our states face the worst fiscal crises in our history, appropri-
ate health care has to be delivered in a cost-efficient manner.
CCHA has provided coalition members with updates on cost
containment, information sharing and networking, which is
very beneficial to our objective of providing medically neces-
sary, cost-conscious health care.

CCHA also helps define correctional health care standards.
As states on our own, we face many challenges. Yet, as members
of CCHA, we soon realize that other states are facing many of
the same challenges and some of them have already found great
solutions. Citing research or a hypothesis may not convince the
sheriff, secretary, commissioner or director to accept a sugges-
tion, but proving that the idea is working well in another agency
may open the conversation for further discussion.

Our success is made possible by the strong support we have
received from ACA’s leadership, sheriffs, commissioners, direc-
tors and secretaries who have supported our efforts. We thank
you from the bottom of our hearts, knowing that success can
only be achieved with support from the top down. We hope that

you can find your voice and a home within CCHA. Regardless
if you are reading this newsletter as a secretary, director, health
authority or staff member, we welcome you to reach out to
CCHA for guidance and assistance in developing policies and
procedures in the future.

We hope you enjoy this new publication, and we wish you a
very happy holiday season.

Sincerely,

Viola Riggin, HIT, CCNM
Director, Healthcare Services
Kansas Department of Corrections
Kansas University Physicians Inc.

and

Raman Singh, M.D.
Medical/Mental Health Director
Louisiana Department of Public Safety and Corrections

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“America is the land of the second chance, and when the gates of prison open, the path ahead should lead to a better life.”

- President George W. Bush, State of the Union address, U.S. Capitol, Washington, D.C., Jan. 20, 2004

When former President George W. Bush stated those words in the annual State of the Union address, he called all Americans to respond to the call of giving offenders another chance at a successful, law-abiding life. An important component of “the path ahead … to a better life” is a healthy life. Indeed, the health of our nation partially depends upon releasing healthy offenders back into society. It is incumbent upon corrections professionals to do our part in ensuring that those offenders who become our neighbors, and often times our co-workers, are healthy. No one group in our nation knows better than you the tremendous opportunity we have as health care professionals to affect the positive outcome of releasing women and men back into our communities who pose little or no health risk to society. You are doing a public service for your fellow Americans when you respond to the needs of those incarcerated in our institutions. The path ahead for these women and men must include healthy lives, which will lead to better lives overall.

As health care authorities, you work day in and day out to lead your state or county in the elimination of health disparities. That is why the Coalition for Correctional Health Care Authorities (CCHA) was founded. Corrections, the community and public health working together hand-and-glove builds on positive outcomes of correctional health care in ways that benefit everyone — offenders and free-world Americans alike. By forming collaborations and networking, CCHA has been able to focus on building effective correctional health care delivery systems during these challenging times, which is no easy task.

With correctional systems coping with increasingly complex inmate populations, there has never been a time in history where professional correctional health care authorities were needed more. As correctional health authorities, you must, and you do, continue to learn and to embrace the latest strategies to deliver quality health care to the incarcerated populations. One of the greatest increases in correctional budgets in the last decade has been due to health care costs. With federal court rulings guaranteeing the constitutional right to adequate health care for offenders in our jails, prisons and juvenile facilities, you have faced ever-escalating costs to deliver this health care while continuing to ensure that the care delivered is responsive to the patient and meets the needs of society.

For those of you who are new, CCHA was founded at ACA’s 2007 Winter Conference in Tampa, Fla. During the conference, which was themed “Corrections, Community and Public Health,” ACA also launched its first-ever Healthcare Professional Interest Section (H-PIS). CCHA was initiated and dedicated to improving correctional health care. Both the new H-PIS and CCHA were called to action to bring together correctional health professionals and security professionals to examine important health care issues relevant to the field of corrections, and to improve communication and operations for all facets of corrections.

At that conference, James A. Gondles Jr., executive director of ACA said, “The association is deeply committed to improving correctional health care and ensuring that this initiative is a success.” He added, “I have always been troubled that the treatment side of corrections and the security side of corrections have met separately for training and for other reasons. We all know that success is achieved through team efforts. Treatment and security must work together for effective operations within the corrections profession. By creating the initiatives of H-PIS and CCHA we will drastically improve corrections in our country.”

Health care is an ever-growing and ever-changing field. Correctional health care is growing and changing just as it is everywhere else. Growth and change are not only the concern of health care professionals, they affect every single corrections professional — from line officers to wardens to agency directors. It was agreed by everyone at that initial meeting that an excellent venue for training, exchanging ideas, and solving problems confronting health care providers would be to form a group using the National Institute of Corrections (NIC) training model that the Association of State Correctional Administrators (ASCA) uses. NIC and the Federal Bureau of Prisons assisted ACA in launching a successful CCHA.

The Listserv is for CCHA Members Only.

CCHA list members can access the listserv by visiting the following address:

http://www.aca.org/ccha

If you need assistance with your account or to reset your password, please email Kathleen Bachmeier at KathleenB@aca.org or call (703) 224-0076.
Much has happened since we were formed in January 2007. As correctional health advisor to the last eight presidents of ACA, and as a corrections professional, I will never lose sight of the fact that as correctional health authorities, you help protect the health of the communities throughout our nation. You constantly address the health concerns of inmates by providing for their health care needs. You strive to be good stewards of the people's money while always trying to provide the best care for the individuals we serve. You make a difference every day in those people who are in our charge. As professionals, you constantly strive for excellence in health care services.

You are part of a unique group of dedicated public servants. Each of you represent one of the 50 states, the federal system and six large jail systems. You are the leaders who carry the responsibility of making sure that you deliver quality health services to almost 2 million people, and you have a tremendous responsibility advising and working with your director, secretary or commissioner. In your position you may sometimes feel alone and isolated. We hope that with the launch of this inaugural issue of our newsletter we are providing you another venue to connect with partners in your daily routines — other professionals who walk your walk and talk your talk. I hope you feel as I do that Correctional Health Connection is another way for CCHA members to have the opportunity to stay connected, network, explore exemplary practices, share issues, solve problems and pioneer new solutions together. I am appreciative and thankful that we have each other.

Elizabeth Gondles, Ph.D.
Health Care Advisor to the President
American Correctional Association

Federal Bureau of Prisons’ Report

The Federal Bureau of Prisons (BOP) is issuing two new clinical practice guidelines on food allergies and injectable medications in fall 2012. Inmates self-reporting food allergies often pose diagnostic dilemmas for clinicians and significant operational challenges for correctional food services administrators. The BOP Food Allergy Guidelines adapt recommendations from the National Institutes of Health to the correctional setting. The guidelines include practical appendices such as a food allergy assessment form, algorithms for diagnosing and managing food allergies and an outline of strategies for treating anaphylaxis. The focus of the guidelines is to assist correctional health care providers in counseling, evaluating and managing inmates with food allergies, with a particular focus on identifying those inmates at risk for anaphylaxis.

The second new BOP guideline on injectable medications includes a wealth of specific information for nurses, pharmacists and practitioners related to outpatient IV treatments. Covered topics include: managing intravenous lines, preparing pharmaceuticals for dispensing and dosages for commonly prescribed medications. Providing intravenous antibiotics and other parenteral treatments in the correctional outpatient setting can be safely done with the availability of appropriately trained staff, and can be a significant cost-containment strategy for correctional health care administrators.

Other BOP guidelines that have been updated in 2012 include Hepatitis C and Cirrhosis, Methicillin-Resistant Staphylococcus Aureus Infections and Diabetes. Check out the beginning of each guideline to see “what’s new” in the BOP.

Save the Dates

The next CCHA business meeting will be held Friday, Jan. 25, 2013, at 1 p.m. during the ACA 2013 Winter Conference in Houston. Many pertinent topics related to correctional health care will be discussed by CCHA members.

The CCHA All Health Authority Training will be held April 23-26, 2013, in Aurora, Colo. The National Institute of Correction (NIC) is sponsoring this year's training. The NIC Academy will host the event in the facility. This CCHA training will give correctional health care authorities from around the country the opportunity to reconnect, meet new health authorities and share pertinent information from the field. Many topics confronting correctional health care will be discussed, including: the Affordable Health Care Act, segregation, PREA and bisexual cross-gender issues.

ACA’s 143rd Congress of Correction will take place Aug. 9-14, 2013, in National Harbor, Md. (Washington, D.C. metro area).
**Delaware**

This is an exciting time for the Bureau of Correctional Healthcare Services. It has hired a new medical director, Dr. Vincent Carr, M.D., who started on Oct. 9, 2012, as well as a new mental health/substance abuse contractor, Connections CSP, which began work on July 1, 2012. The ending of their memorandum of agreement with the Civil Rights Division of the Department of Justice is anticipated in the near future. All these changes will help the Bureau of Correctional Healthcare Services to move forward with some of the programs and changes that have been in the works for a few years now. During the next few cycles, it will be reporting on its Trauma Informed Care, Motivational Interviewing and Cognitive Behavioral Therapy programs. All these are in the infancy stages of implementation.

**Maryland**

The Maryland Department of Public Safety and Correctional Services (DPSCS) has begun using an information-sharing program known as Data Point. This system runs a match against the community-based mental health providers to newly received arrestees on a daily basis. A match is when a new arrestee matches the community based mental health data. When a match is confirmed, the system automatically downloads information into the DPSCS electronic health record. The data that is downloaded into the electronic health record consists of a primary diagnosis, current medication, Medicaid number and identification of the community mental health provider. This process if fully automated and improves continuity of care in several areas:

- When mental health staff are processing a newly received detainee into the system they can cross-reference self-reported data with data as provided by the community-based mental health provider;
- Medication verification is automated; and
- When conducting release planning, the case worker can identify the community provider in one easy automated pathway within the electronic health record.

DPSCS has also rolled out a new telemedicine program that:

- Adds peripherals to the 11 existing telemedicine units;
- Adds several new clinics, cardiology, oncology, general surgery and trauma units;
- Provides linkages with the University of Maryland Medical Center; and
- Provides linkages to Bon Secours Hospital.

These upgrades are being deployed to improve access to care, as well as limit the number of outgoing trips. A database has also been developed in order to review monthly statistical information and perform an analysis, thus monitor the success of this new initiative.

**New York**

The New York State Department of Corrections and Community Supervision’s (NYSDOCCS) Division of Health Services is currently working to finalize its HCV Triple Therapy Addendum to its HCV Primary Care Practice Guideline. Some of the changes involving triple therapy will be the elimination of a liver biopsy, which was previously required prior to treatment and substituting fibrosure testing in addition to a liver ultrasound. NYSDOCCS is adhering to FDA limitations and not using protease inhibitors for patients co-infected with HIV or hepatitis B. This will be reconsidered if FDA approval is given in the future. Telaprevir is NYSDOCCS’ preferred agent, but Boceprevir is available for specific scenarios, especially for patients with pre-existing rashes or skin conditions.

NYSDOCCS has established a multidisciplinary committee to address gender identity disorder (GID). The committee will be addressing issues related to GID including diagnosis, hormonal therapy, ongoing supportive therapy, housing, clothing issues and PREA requirements, to name a few. NYSDOCCS is currently referring patients for GID diagnosis and providing hormonal therapy for patients previously on hormonal therapy prior to incarceration, as well as appropriate newly diagnosed cases.

NYSDOCCS is progressing toward the initiation of a central pharmacy robotic automation program. Currently, integration of the pharmacy management software with the automation system is ongoing. When operational, hub-based pharmacies will fill initial prescriptions and refills will be "pushed" electronically to the automation center. Refills will be filled robotically and...
North East Report continued

then checked and released by pharmacists and shipped to the facility where the patient is housed for distribution. The centralized automated pharmacy is designed to optimize the use of technology to reduce cost by utilizing less staff and provide greater oversight and clinical management of medications. When automation is complete, it will provide prescription refills to facilities statewide and allow for even greater economies of scale and better overall management of resources.

The year 2011 heralded the first year of no cases of active tuberculosis (TB) infection diagnosed in NYSDOCCS. This follows a steady trend of declining incidence. This is attributed to aggressive TB screening of offenders and staff combined with aggressive treatment of latent TB infections. The NYSDOCCS Infection Control Unit oversees the TB screening and treatment program and performs contact tracings when necessary.

Pennsylvania

The introduction of rapid HIV testing in the Philadelphia Prison System (PPS) three years ago increased the (entirely voluntary) testing rate from 6 percent to 60 percent. Blind sero-reivalence testing showed that the 40 percent who refused testing had an HIV infection rate four times greater than the 60 percent who agree to be tested. Changes in Pennsylvania regulations last fall allowed PPS to introduce Center for Disease Control guideline compliant opt-out testing, and the testing rate has risen to 85 percent. As a result, PPS expects to treat 1,000 HIV-positive individuals this year.

PPS and the City of Philadelphia Department of Health are implementing a common electronic medical record (EMR). Approximately 40 percent of PPS’ inmates are seen in city health centers before or after incarceration. This common EMR will facilitate arrangements for continuity of care. The city expects to complete implementation of the EMR in 2013.

PPS contracted with InterMedHx Inc., a year ago for a service that, given inmate consent, allows PPS clinicians to see what prescriptions were filled by an inmate prior to incarceration. This is called Electronic Verification of Prescription Use Prior to Incarceration. During medical screening, intake clinical staff enter an inmate’s name, birthdate, etc., in a secure website, and in less than a minute receive a faxed history of up to two years of prescription fill data. This data is particularly useful when inmates cannot or will not report medication histories accurately. The data is far more readily available than the usual verification method, which has been calling pharmacies or prescribers. Currently, PPS enters into the secure website the name provided by the inmate at the time of incarceration, and histories are found about 28 percent of the time. Shortly, aliases will be submitted (automatically) as well, and the expectation is that the number of histories will then double.

Rhode Island

Accidental drug overdose is the leading cause of accidental death in Rhode Island. There are approximately three per week, and the Health Department has made this a priority. To that end, the Rhode Island Department of Corrections now has two projects. One study educates substance abusers with a DVD and personal instruction, and provides them with a nasally administered Narcan kit upon release. The cohort is 100 inmates who will then be followed up on the outside. In addition, all inmates are being shown the DVD with an in-house campaign. All outside providers and community health centers are in the loop as well, and offered information about prescriptive Narcan.

Similarly, Rhode Island is assessing the inmate population for hepatitis C (HCV) prevalence and testing all inmates for HCV. Positives are informed and seen by a staff provider. Dr. Newton Kendig’s treatment guidelines are being used, which is working out very well.

Fleet Maull is running several yoga and mindfulness programs for both staff and inmates, and that is most welcome and well-received. He spent 14 years in federal prison and offers a very effective presence. For more information, visit www.fleetmaull.com.

The Rhode Island Department of Corrections is working hard on the Medicaid problem trying to get released and eligible inmates back on Medicaid as soon as possible, which has proven to be a daunting problem in Rhode Island.

A new course has been started at Brown University’s new School of Public Health (still in the developmental phase) called Prison Health Inside and Out. It is a 12-week, 2 1/2-hour course at the graduate level looking at all aspects of correctional health care, the history of penology, the prison/industrial complex, epidemiology, mental health, gender issues, women’s issues, substance abuse, courts, parole and probation. The Center for Prisoner Health and Human Rights at Brown is very involved, as well as the Urban-University-Correctional Complex.

The Rhode Island Department of Corrections recently had an inmate undergo a liver transplant while incarcerated — the first one within the department. This will be discussed in a workshop in Houston in January 2013.

West Virginia

The West Virginia Department of Corrections (WVDOC) has established a Mental Health Unit at its women’s facility. This is an eight-bed unit that is used mainly to treat behavioral issues. The program utilizes both individual and group therapies, as well as various activities. Privileges are gained in phases, which are assigned according to behaviors. This has been a very successful program since it began in July 2013. It is also the first program of its kind available to women in the WVDOC system.
North East Report continued

Implementing a hospice program in three of the WVDOC facilities is currently in progress. With the aging population, there is an increasing need for end-of-life services. CCHA members shared great ideas and information that has been incorporated into West Virginia’s hospice program. The plan is to have the hospice program fully functioning by Jan. 1, 2013.

The Electronic Medical Records System (EMRS) is being planned with another state agency building EMRS from start to finish. This will provide a better way to keep and share records. PREA is at the forefront of the Medical Department operations to ensure that WVDOC is compliant with these new standards. WVDOC has not made too many major changes in order to remain in compliance.

Midwest Report

Midwest
James Greer, RN
Wisconsin Department of Corrections

The Midwest regions of CCHA held a conference call to discuss topics such as electronic medical records (EMR), 340 B medication programs, gender identity disorder issues, PREA guidelines, and Medicaid reimbursement. They also discussed the agenda for the next All Health Authority Training. Members on the call were from Illinois, Iowa, Minnesota, Ohio and Wisconsin. Illinois indicated that it signed a contract with BCA software Pearl to implement EMR for the DOC Medical Department. Minnesota is working on Medicaid reimbursement for hospitalized inmate patients. The following are key updates from the remaining states.

Michigan

Michigan issued a request for proposal (RFP) in July for all of correctional health care, and it is not a foregone conclusion that Michigan will privatize. A five-year plan for the Michigan Correctional Health Services Bureau was turned in the same day as the RFP bids, which was Sept. 27, 2012. This plan contains metrics and cost-savings projections, and the intent is to share this with state leaders so they have something to use to compare what the Michigan Department of Corrections can do versus the private sector.

Ohio

• Ohio awarded a contract to E-Clinicalworks for development and implementation of a comprehensive electronic health record. The Department of Rehabilitation and Correction is currently working with the Ohio statewide Health Information Exchange to develop parameters to upload offender information upon release from the correctional system. Ohio has targeted implementation for June 2013.
• Due to legislative sentencing reforms in Ohio, the prison population has slowly declined. During the past 18 months the population has decreased from 51,258 inmates to 49,497. This reduction has led to satellite camp closures.
• Under Gov. Kasich, Ohio formed the Governor’s Office of Health Transformation. This office has taken ownership of several statewide health care initiatives which include the modernization of Medicaid, streamlining health and human services and improving the overall health system performance. The Department of Rehabilitation and Correction is one of several cabinet-level agencies that participate as a member of the Health Transformation team. Ohio is currently developing plans to begin Medicaid reimbursement for inpatient care in July 2013.

Wisconsin

• Wisconsin recently viewed electronic medical record presentations by three vendors and are working on a request for proposal to send out in October.
• The department set up a new committee for implementation of the new PREA guidelines.
• The Bureau of Health Services is implementing the GID guidelines in all Wisconsin prisons. This is part of a federal court settlement that was signed at the end of 2011. It will have about 20 offenders on hormone medications in the next month.
• The Wisconsin Department of Corrections (DOC) is meeting with two organizations to see if the department can receive 340 B pricing for its HIV and hepatitis C patients.
Arkansas

Arkansas has seen new faces from Corizon with new VOP for Operations Rhonda Almanza. Corizon is searching for a permanent medical director, so the position is currently being handled by Drs. Renee FallHowe and Gregory McKinney. The Arkansas Department of Corrections (ADC) staff remain constant, but are busy drafting a request for proposal to be issued in February 2013 for a start date of Jan. 1, 2014. ADC has expanded its Medicaid applications beyond the pregnant offenders, and have saved more than $89,000 so far on nonpregnant offenders who have been approved for Medicaid coverage.

Florida

Florida has a lawsuit challenging their selection of private vendors filed by the Florida Nursing Association, et al.

Louisiana

Louisiana continues to face budget cuts, prison closures and hurricanes. The state continues to work on challenges such as improving continuity of care for offenders upon release by ensuring that medical and mental health appointments have been scheduled, they have an adequate supply of medications and contact information, and are enrolled for eligible benefits by collaborating with the Office of Behavioral Health, health care providers in community and the Social Security Office.

South East Report

South East
Wendy Kelly, J.D.
Arkansas Department of Corrections

Louisiana continues to collaborate with the Louisiana Medicaid office to ensure that eligible offenders receive coverage for inpatient stays, as well as making sure that eligible offenders are enrolled in the program before they are released to ensure an efficient reentry plan. Louisiana has expanded the Medical Release program and released 38 offenders in the last two years. A new mental health intake process uses a revised screening form and criminogenic assessment tools, along with an in-depth substance abuse screening to identify offenders with addiction disorders that play a role in criminality and to identify those most receptive to treatment.

Oklahoma

Oklahoma is working from a stand-still budget, an improvement over recent years. The Oklahoma Department of Corrections (DOC) has implemented an e-MAR to its electronic health record. It is acquiring video conferencing equipment, and planning to expand telehealth services at all clinics. The DOC has partnered with a major medical center and hepatologist for assistance in the management of hepatitis C, and is partnering with a University Infectious Disease Clinic for assistance in the management of HIV. It has recently completed a total digitization of medical radiographs, and will soon have all dental radiographs digitized. Radiographs will be stored in a PACS system easily available for viewing. The provider is relocating its Oral Surgery Clinic, and has added digital panography at that facility and the Assessment and Reception Centers. The DOC is scanning old paper medical files and will soon have completely digital records. About a year ago, it partnered with a federally qualified community health clinic to provide care for the halfway house offenders who are housed in one of Oklahoma’s major cities with great success. The clinic provides primary care, dental, vision, medications, mental health and transportation services. Oklahoma continues to consider housing options for its aging population, and continually faces the challenge to recruit and retain quality health professionals.

Midwest Report continued

- The department was under budgeted by $25 million due to under estimating prison population by more than 650 inmates.
- The DOC has revised its C PAP program due the increase number of inmates using C PAP and BI PAP machines. We are having a much better patient compliance rate and are insuring the equipment is working properly.
South East Report continued

South Carolina

John Solomon retired from the South Carolina Department of Corrections on July 9, 2012, to do some teaching at Winthrop University. He sends his best wishes.

Tennessee

Tennessee selected Marina Cadreche, Psy.D., as its health authority on June 5, 2012. Cadreche is now the director of clinical services for the Tennessee Department of Correction, having previously served as the department’s mental health director. In her new role, she oversees medical, mental health and substance abuse services provided to the inmate population.

Virginia

The Virginia Department of Corrections’ Fluvanna Correctional Center for Women, near Charlottesville, is replacing its old mammography film technology with a digital system for enhanced images, improved diagnoses, less radiation, efficiency/speed of transfer and elimination of chemical processing. UVA radiology and OB/GYN provide their clinical services to the Fluvanna female offenders, and the mammography service is accredited by the American College of Radiology.

West Report

A tragic incident recently occurred at the Arkansas Valley Correctional Facility, a medium-custody facility in Crowley, Colo., that resulted in the death of one staff member, and caused serious injuries to another. This lethal assault on corrections staff that Colorado experienced cannot be ignored.

History demonstrates the changes in the management of correctional systems, and thankfully, the incident Colorado experienced is the rare exception, and not the everyday occurrence. The incident took place in the food service area and remains under investigation. The nursing staff at the Arkansas Valley Correctional Facility took appropriate action and certainly contributed to saving the life of the second staff member who was injured. While health care professionals are trained to respond and manage emergencies, it is somehow different when it is one of our correctional professionals.

It is critical for us to remember that in these types of situations, all staff need support. The staff at the affected institution are the ones that we initially and understandably focus on, however, we should not forget how interconnected we are as an organization. This connection is not only within our organization, but across the country. It is important to touch base with staff in your organization and acknowledge the risk we face as corrections professionals.

I would challenge you to look at your own organization and assure that critical response teams that can assist in debriefing and peer support are ready and able to activate. You most likely have behavioral health staff who participate on those teams. Are those teams in adequate numbers to manage a department-wide response? What role can you as the health authority play in assuring the teams are adequately trained and ready?

We need to examine what is the adequate response of the health services staff. While they are trained and highly skilled at responding to emergencies, this type of staff injury is different. Our staff are often resistant to debriefing activities since they view themselves as being prepared and expected to handle emergencies. However, we must not forget that they may be experiencing secondary trauma and may need services from employee health systems. We have a responsibility to ensure that they will be able to cope with future traumatic events.

The support that Colorado has experienced from other states and law enforcement agencies is truly gratifying. It is clear that the corrections profession is a family of those who genuinely care and will be there for others.
CHA has established an annual award named the Correctional Health Care Leadership Award. This award will be an honor bestowed by CCHA and is given to recognize an outstanding CCHA member who is a leader in correctional health care.

Requirements:

• Correctional health authority for three years or more;
• Current active member of CCHA; and
• Demonstrates outstanding leadership, contributions, accomplishments and services to CCHA, his or her jurisdiction, community and the field of corrections.

Nominations for the award may be submitted by:

• A current active CCHA member; or
• The supervising authority (agency correctional administrator, governor or a senior staff person who reports directly to the nominee).

Nominations should include the following information:

• Letter signed on official agency letterhead by the principal nominator;
• Supporting letter(s) from other individuals who supervise and/or report to the nominee; and
• The nominating letter should contain a minimum of the following on the nominee:
  • Education/formal training;
  • What the nominee has accomplished in his or her current job;
  • Nominee contribution to the CCHA mission; and
  • Why the nominator(s) believe the nominee deserves this award.

An awards committee will make the decision from the nominations. The Awards Committee members are as follows:

• The last four CCHA Correctional Health Care Leadership Award awardees; and
• The correctional health care advisor to the president of ACA.

Until such time as the Awards Committee consists of four previous awardees, the committee shall be made up of the health care advisor to the president of ACA, ACA’s executive director and any awardees who have received CCHA awards. The committee membership shall be no less than five, and no more than six members.

The deadline for submitting nominations will be Feb. 1, 2013, eight weeks before the All Health Authority Annual Training in April.

Happy Holidays from CCHA and ACA!
The CCHA business meeting was held during ACA’s 142 Congress of Corrections in Denver, on July 20, 2012. ACA’s executive committee was in attendance when Morris Thigpen, director of the National Institute of Corrections (NIC) was presented with an award of recognition from ACA’s Executive Director, James A. Gondles Jr. Thigpen was recognized for NIC’s financial support of CCHA activities such as the annual All Health Authority Training and new health authority trainings in years past. His leadership was key to the establishment of CCHA, the success of CCHA’s mission and the importance of the role of health care in corrections.

Topics discussed during the CCHA business meeting included the Affordable Health Care Act and implications for correctional health care. Eric Schultz, ACA’s director of Government and Public Affairs, presented a timeline regarding universal health care. Electronic medical records and the importance in correctional health care were discussed. Anita Pollard presented an NIC update. Topics on heat restriction policies and segregation regarding seriously mentally ill offenders were also discussed.

Kathleen Bachmeier received the 2012 CCHA Correctional Health Care Leadership Award at the CCHA All Health Authority Training in May 2012. Bachmeier retired from the North Dakota Department of Corrections as director of medical services for 17 years. She contributed to the field of correctional health care in many ways, including serving on several ACA committees, and as being a correctional health care auditor, contributing to publications such as Corrections Today, and being a founding member of CCHA. She is currently employed in ACA’s Office of Correctional Health Care. Other past CCHA award recipients include:

- Rear Adm. Newton Kendig, M.D., assistant director, Health Services Division, Federal Bureau of Prisons, recipient of the 2011 CCHA Clinical Award of Excellence;
- Lannette Linthicum, M.D., director, Health Services Division, Texas Department of Criminal Justice, recipient of the 2011 CCHA Award for Correctional Administration; and
- Elizabeth Gondles, Ph.D., health care advisor to the ACA president, recipient of the 2011 CCHA Award for Correctional Medical Leadership.