“This is a great organization!” is a comment we hear at every gathering of the Coalition of Correctional Health Authorities (CCHA) — and it is true. It has been an honor for us to serve this group of professionals as co-chairs. We have fantastic doctors who share their clinical knowledge with the group; administrators who know how to administer a program with minimal resources; and nurses and psychologists who know how to provide care to a very difficult population. We all have the same goal: to improve the health of the offenders in our custody so that they have every opportunity to be productive citizens.

For those of you who missed the training in Colorado, we covered topics such as standards and rules developing from important federal legislation, including the Patient Protection and Affordable Care Act and the Prison Rape Elimination Act. We started with a presentation on how three state systems are caring for ill, aging and impaired inmates. We also had an excellent presentation on electronic health records. There was a presentation on how other systems have managed to contract for health care services that included the pitfalls of which to be aware when navigating requests for proposals, contracts and implementation. The presentation on mental health issues in corrections reminded us of the challenges we all face as mental health hospitals are closing and patients become our responsibility after they become involved in the criminal justice system. Rear Adm. Newton Kendig, M.D., led the working group on clinical practice updates and joined us via video conferencing to present on that topic. Our new working groups made strides by presenting on electronic medical records, exemplary practices resulting in positive outcomes, correctional health workforce, recruitment and retention, and correctional mental health. Viola Rigginn received the Correctional Healthcare Leadership Award on Saturday night following an address by Colorado Department of Corrections Executive Director Rick Raemisch. We concluded on Monday morning with a session titled “Taking Care of Ourselves and Our Employees.” It was a great ending

Mission Statement

The mission of the Coalition of Correctional Health Authorities is to preserve, promote and improve the health and well-being of the correctional population. CCHA is committed to leadership and excellence in correctional health care. CCHA offers members the opportunity to stay connected through educational programs, networking, sharing exemplary practices, identifying issues, solving problems and pioneering new solutions together.
Co-Chairs’ Message continued

to a packed training event. Elizabeth F. Gondles, Ph.D., and the ACA staff did an excellent job of taking care of all the details.

We need you! This group has a wealth of knowledge, but we will never be as strong as possible unless we all contribute and participate. We have to consider medical ethics, legal issues, risk management and how to cover these theories in our agency/department policies and procedures to provide medically-necessary health care. Whether you are dealing with the use of restraints, telemedicine, privacy issues or a provider practicing defensive medicine, CCHA members provide advice to each other regarding issues — whether it involves access to care or questions of which services are medically necessary. When you have an issue, question or potential crisis, this group is there to help you see these as opportunities for improvement.

The next CCHA meeting will be in the sunny city of Tampa, Fla., at the end of January. We hope to see as many attendees as possible at our business meeting, where we will continue to chart the course to improve health care. We can only do this with you as our colleagues. Your participation produces the wonderful work from this group. Aside from the help we give each other, we produce information that is shared with the correctional community from every area of corrections with our publications and presentations. Thanks again for the work everyone does to make the lives of our clients better.

Sincerely,

James Welch, R.N., HNB-BC
Bureau Chief for Correctional Health Services
Delaware Department of Corrections

and

Wendy Kelley, J.D.
Deputy Director for Health and Correctional Programs
Arkansas Department of Corrections

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Upcoming Events

ACA Winter Conference
Tampa, Fla.
Jan. 31-Feb. 5, 2014

CCHA Business Meeting
Friday, Jan. 31, 2014
1:00 p.m. - 5:00 p.m.

Substance Disorders Committee Meeting
Sunday, Feb. 2, 2014
10:00 a.m. - 11:30 a.m.

Mental Health Committee Meeting
Monday, Feb. 3, 2014
10:00 a.m. - 11:30 a.m.

Health Care Committee Meeting
Tuesday, Feb. 4, 2014
7:00 a.m. - 8:00 a.m.

New Health Authority Training
Date and location to be determined.

144th Congress of Correction
Salt Lake City
Aug. 15-20, 2014

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As health authorities, we face many challenges in addressing the need for the use of restrictive housing. Restrictive housing has been referred to by many terminologies, such as administrative segregation, isolation, segregation, solitary confinement, “the hole” and other terms. As professionals in our field, and as experts in our discipline, we need to constantly examine and re-examine our practices to ensure we are doing the best job we can do in serving the public and in adhering to public safety.

At present, we are facing new challenges as legal action addressing the disproportionate number of inmates in restrictive housing is being tested throughout America’s correctional systems. The use of restrictive housing has come to the forefront of discussions on Capitol Hill, with hearings held in 2012 in the U.S. Senate, as well as several prisons and jail systems in the U.S. One of the leading challenges we face is that our correctional facilities have become major mental health facilities in our country — a purpose for which they were never intended. With that reality, we must continuously examine housing of the mentally ill in restrictive housing or high-security confinement units. The ACA Mental Health Committee has outlined its two primary goals for housing the mentally ill in restrictive housing or high-security confinement units:

- Goal I: The diversion of mentally ill to more appropriate settings; and
- Goal II: Modify treatment plans/care delivery for the mentally ill who must be in restrictive housing to include:
  - Addressing the patient’s added needs while in restrictive housing; and
  - Specific treatment modifications designed to reduce the patient’s symptoms that may have contributed to placement in a secure setting.

We must strive to examine the critical mental health issues of our inmates in restrictive housing. Questions that we must ask ourselves include:

- What is the science for who can be and who should not be placed in restrictive housing?
- What is the science for how we know who can stay in restrictive housing, and for what length of time?; and
- What is the science for how we know who needs to be removed, and for where to house them with continuity of treatment?

ACA’s Office of Correctional Health Care has worked closely with ACA’s 102nd president on one of the key initiatives of his presidency — the issue of restrictive housing. President Christopher B. Epps, commisioner of the Mississippi Department of Corrections, has moderated two national plenary sessions — one last January at ACA’s 2013 Winter Conference in Houston, and one at the 143rd Congress of Correction in National Harbor, Md. He is now addressing the next steps on restrictive housing with another plenary planned for ACA’s 2014 Winter Conference in January, titled “Essential Components of Administering Safe, Humane and Constitutionally-Sound Restrictive Housing Programs: Internal Assessment.”

The following are several of the questions for which we must continue to challenge ourselves to find better solutions:

- Does your agency follow national standards and sound agency policies and procedures for using restrictive housing?;
- Do you utilize restrictive housing for punishment or security, or both?;
- What level of staff are used, and how are reviews conducted, both internally and externally?;
- If you utilize restrictive housing for punishment, what are the alternatives beyond restrictive housing?;
- What measures does your agency have in place to train staff on all shifts and all levels involved in implementing a

The Listserv is for CCHA Members Only.

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

http://www.aca.org/ccha

Please use the listserv for all communications with CCHA members. For assistance on accessing the listserv with your account or to request your password, please contact Doreen Efeti, ACA health care services specialist, at DoreenE@aca.org, or call (703) 224-0120.
Editor’s Commentary continued

safe, humane and constitutionally sound restrictive housing program;
• What are the checks and balances your institution has in place to assure that the “four S’s” are successfully implemented 24 hours a day, seven days a week? These include: safety for the public, safety for the staff, safety for the inmate and safety for the institution;
• Are we constantly reviewing and evaluating our restrictive housing programs?; and
• Are we reviewing and revisiting essential components?

When President Epps was asked to testify on Capitol Hill in the summer of 2012, he stated:

“I often say, ‘You have to decide who you are afraid of and who you are mad at,’ when making decisions on the use of [restrictive housing] in prison. Almost 95 percent of all offenders will return to society. There are a very small number of offenders who have to be in [restrictive housing] because of their continued threat to staff and offenders. These are the offenders we are ‘afraid of’ because of their demonstrated violence or threats to the public. Corrections professionals and the criminal justice system must be careful not to use [restrictive housing] in prison to manage those who we are mad at because this is an expensive option that takes away resources from important government areas such as education, human services, health care, etc., which are the services most needed to make a better society. Corrections is no different than anything else in our nation; it continues to change and improve. Corrections leaders must realize that to be successful, you must always be willing to change and listen to all stakeholders involved in the criminal justice system. You cannot take a one-sided approach. I have been most successful when I have made decisions that were in the best interest of all. We must continue to climb the corrections mountain.”

As a corrections professional, I believe that corrections professionals know better than critics, advocates or anyone else the pressure of administering safe, humane and constitutionally-sound facilities. We are challenging ourselves on the uses of restrictive housing by re-examining its uses, benefits, drawbacks and effects upon the incarcerated. If corrections professionals do not continue to address this important issue, we risk, once again, others making decisions for us. Using the adage “we need to be pro-active, not reactive,” we must examine, and continue to examine, various aspects of the use of restrictive housing.

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

All Health Authority Training

The 2013 CCHA All Health Authority Training: The Afterglow

The 2013 CCHA All Health Authority training was held Sept. 27-30, 2013, in Aurora, Colo. The feedback from the evaluations indicated it was a huge success, with 41 people in attendance. There were presentations and discussions on “Caring for Ill, Aging and Impaired Inmates;” “Contracting for Health Care Services;” “Patient Protection and Affordable Care Act;” “Clinical Updates;” “Recruitment and Retention Strategies for Health Care Staff;” “Critical Issues in Mental Health with a Focus on Segregation;” “Exemplary Practices;” and “Electronic Health Records.”

During the training we had the opportunity to meet in our assigned working groups on several areas of importance that have been outlined by the co-chairs. We also were able to network and have regional meetings. On Friday evening at the Welcome Reception, Robert Brown, acting director of the National Institutes of Corrections (NIC), brought warm greetings to the group. On Sunday morning, Charles Smith, Ph.D., regional administrator for the Substance Abuse and Mental Health Services Administration (and representing the U.S. Department of Health and Human Services), led an open discussion on the Patient Protection and Affordable Care Act and its impact on correctional health care delivery. On Sunday evening, a leadership award banquet was held where Rick Raemisch, the executive director for the Colorado Department of Corrections, delivered
the keynote address. That same evening, we also honored one of health care's finest, and presented the 2013 CCHA Correctional Healthcare Leadership Award to Viola Riggin, health authority for the Kansas Department of Corrections. Monday started off with a session, followed by CCHA business meeting, and closed with a special session on “Taking Care of Ourselves.”

Our special thanks to NIC for their continued support of this valuable program. Additionally, we would like to thank Correctional Care Solutions and Corizon for their contribution of unrestricted educational grants.
CCHA Leadership Awardee

The CCHA 2013 Correctional Healthcare Leadership Award was presented at CCHA’s 2013 All Health Authority Training. The award was presented to Viola Riggin, health authority, Kansas Department of Corrections — a veteran correctional health care professional with three decades of service in the corrections profession. This year, the recipient was the unanimous choice of the awards committee.

Riggin was nominated by her boss, Ray Roberts, secretary of corrections. In his letter, he states, “With such an in-depth understanding of correctional health care, this person’s expertise has been sought out in many other health care systems throughout the nation.” Riggin has served on many state and national boards.

The award was given to Riggin because of her devoted service to the citizens of her state, co-workers in the department of corrections, the offenders within her system, the corrections profession at large, CCHA and the American Correctional Association. She has written about correctional health care in national journals and has won several national awards for her work in the field. She served as the 2010-2012 co-chair of CCHA. ACA President Christopher B. Epps recently appointed her to the Standards Committee and Health Care Committee, and she is a current member of CCHA.
Federal Bureau of Prisons Update

Rear Adm. Newton Kendig, M.D.
Federal Bureau of Prisons

HIV Testing Program

The Federal Bureau of Prisons (BOP) issued updated policy on human immunodeficiency virus (HIV) testing for sentenced inmates at the end of 2013. Current BOP policy, based on federal regulations, mandates HIV testing for sentenced inmates who self-identify risk factors for HIV infection. BOP clinical practice guidelines also recommend “opt-out” testing for all sentenced inmates upon intake. In the updated BOP policy, “opt-out” HIV testing without the need for written informed consent, as per current Centers for Disease Control and Prevention recommendations, will be the required screening strategy for those inmates who do not have HIV risk factors.

HIV Post-Exposure Prophylaxis

In August 2013, the U.S. Public Health Service updated its guidance on the management of occupational exposures to HIV and post-exposure prophylaxis (PEP). The guidelines can be accessed on the National Clinician’s Post-Exposure Hotline’s website at www.nccc.ucsf.edu. Major changes compared to previous guidelines include the following:

- The status of the source patient should be determined, if possible, including the use of rapid HIV testing;
- A three-drug anti-retroviral regimen is recommended for all exposures for four weeks;
- Raltegravir (400 mg orally (PO), twice daily) plus truvada (one PO daily) is the preferred treatment regimen for HIV PEP;
- Certain situations warrant the use of expert consultation, such as suspected resistance of the source virus to certain anti-retroviral medications; and
- Guidelines for the follow-up of exposed personnel on treatment includes an assessment at 72 hours following the exposure.

The BOP is recommending that health care personnel call the National Clinician’s Post-Exposure Hotline at (888) 448-4911, with the exposed correctional worker so that expert consultation can be urgently obtained and a determination made as to whether an exposure occurred; and whether PEP for HIV is recommended. BOP clinical practice guidelines on the management of percutaneous exposures to bloodborne pathogens were updated at the end of 2013. All correctional systems should implement the new U.S. Public Health Service guidelines immediately.

Management of Bariatric Surgery Patients

The major epidemic of obesity in the U.S., along with the emergence of bariatric surgery as an increasingly safe and effective means of treating obesity, has resulted in increasing numbers of inmates entering jails and prisons with a history of bariatric surgery. The various types of bariatric surgery result in different reconstructions of the gastrointestinal tract with the potential for a broad range of nutritional deficits. Most practicing clinicians have had little training on the post-surgical management of bariatric patients, including the monitoring and replacement of nutrients. The BOP recently issued clinical practice guidelines on the management of patients who have had bariatric surgery, with concise recommendations for monitoring and treatment. The BOP has also established a standing workgroup to assess its management of morbidly obese inmates, including evaluating evidence-based medicine on the indications for bariatric surgery. Consideration is being given for approving bariatric surgery for certain inmates with long sentences who are morbidly obese and who meet specific clinical criteria.

Telehealth Expansion

The BOP recently expanded its telehealth program to include teledietetics and teledermatology. After a very successful pilot, the BOP has launched regional teledietician services. Registered dietitians provide individual and group counseling for inmates who have diabetes that is poorly controlled and/or who are overweight. Counseling includes recommendations for healthy selections of foods at the mainline dining hall, as well as from the commissary. Initial results indicate that inmates are highly engaged in these sessions and that blood glucose control has improved for participants. The BOP has hired a full-time, board-certified dermatologist to provide national consultations to 118 institutions. Dermatology teleconsults include in-person evaluations, diagnosis of rashes with treatment recommendations and review of dermatopathology. The vast majority of cases can be evaluated with a written clinical history and emailed digital pictures of the rashes alone. The dermatologist also provides residential training on performing skin biopsies. Although smaller correctional systems may not need the services of a full-time dermatologist, consideration might be given to a part-time contractual dermatologist to provide telehealth services as an efficient means of providing this subspecialty service.
Jurisdictional News

Northeast Report
Fred Vohr, M.D.
Rhode Island Department of Corrections

Many of us Northeast health authorities are relatively new to the job and are still learning about the ever-changing world of correctional medicine. Access to more experienced ACA members has been invaluable to all of us, and is our “anchor to weather.” We have established a rather informal communication network along with the listserv for help. We are all hopeful that those who control the budgets will begin to realize that prisons are not isolated entities, but part of the social fabric of the whole community, and that most of those folks who are incarcerated are indeed released. Hopefully, if afforded good programs, they are better citizens and will not recidivate.

The new course at the Brown University School of Public Health, “Prisoner Health Inside and Out,” is a great success, and has given those who teach an opportunity to learn the views of our students who are very inquisitive, well-read and not shy about expressing their disappointment with our current system. When asked why they took the course, one student simply said that most of the males in her family had been incarcerated, and she wanted to learn more. We all want to learn more.

Delaware

This is an exciting time for the Delaware Department of Correction. Robert Coupe was appointed as the new commissioner earlier in 2013. He is the former superintendent of the state police. He hit the ground running, and the department is taking on new and challenging opportunities for improving its service delivery. The DOC went out on the required RFP process for medical and pharmacy services (this was required under its contract). By the time this newsletter is published, a decision on the winning bidder will be determined. Vincent Carr, D.O., is the new DOC medical director. He comes to the DOC with federal experience working for the Air Force, U.S. Department of State and U.S. Immigration and Customs Enforcement prior to joining the DOC. He was previously stationed at Dover Air Force Base. Delaware is working with CNT Infotech, our information technology (IT) contractor on implementing the EHR. The DOC is phasing-in the process, as it is an adjunct to its offender management system. There is a lot of great work being done in Delaware to reduce populations and to continue to provide opportunities for its offenders and staff.

District of Columbia

The District of Columbia Department of Corrections recently performed two successful and long-awaited, health-related software upgrades. Centricity EMR was upgraded from v5.6 to v9.5 and Correctional Institution Pharmacy System (CIPS) was upgraded from v7.2.16 to v9.0.164. The DOC adopted the EMR early and continues to enhance its use of technology to improve patient care. The agency recently purchased electronic signature pads and is currently researching a stand-alone EMR and medication dispensing system.

Maine

This has been an exciting year in Healthcare Services for the state of Maine. Beginning in March 2013, the department began the implementation of an electronic medical record system known as the Electronic Records Management System (ERMA). This system is a comprehensive tool to manage all aspects of health care relative to the incarcerated population. The system is fully operational statewide at all eight of Maine’s correctional facilities.

Also recently introduced was an electronic medication administration record (E-MAR). This allows for direct interface with the pharmacy and provides staff with electronic recordings of all medication passes. E-MAR is currently being utilized at all of the state’s correctional facilities.

The Maine Department of Corrections has active plans in the works to develop a forensic mental health unit to be housed within its maximum-security facility. This unit would be the first of its kind in this state. The unit is intended to be therapeutic, with 32 beds for aggressive patients who are in need of expanded mental health services. Work is in progress to open this unit on Feb. 15, 2014. For 2014, Maine will be revamping its sex offender and substance abuse programming.

New Jersey

The Automated Medical Observation System (AMOS) is the New Jersey Department of Corrections’ (NJDOC) software application that extends the reporting mechanisms of its EMR system (GE Centricity™). It is capable of reviewing medical records and sending individual HTML email messages to clinicians requesting that they take action. It has been operating daily since May 18, 2010, as a pilot study to determine if au-
Northeast Report continued

tonomous or semi-autonomous clinical messaging systems can alter physician practice habits, reduce clinical errors or reduce clinical waste.

Recently, AMOS was extended to assist in meeting the requirements of the Prison Rape Elimination Act (PREA). During the medical intake screening, health care staff complete an EHR-based, three-screen questionnaire to determine if an inmate is a PREA “person of interest.” If an inmate falls into one of the four PREA categories — past victim, current victim, past abuser or current abuser — the inmate is followed electronically through the EHR and generates targeted HTML emails to the person who must take action. AMOS determines when the “PREA inmate” needs to be scheduled for a mental health appointment and sends an email to the mental health program director. When a PREA inmate moves from one facility to another, AMOS detects the movement and sends a targeted email to the receiving facility PREA coordinator to take appropriate action. Each Tuesday, AMOS constructs a list of each facility’s PREA inmates and emails that list to the facility PREA coordinator. On a daily basis, AMOS also does a “collision check” to verify that an inmate abuser and inmate victim have not been inadvertently housed together. At no time does anyone need to remember to run a report or poll a master list, which may or may not be relevant to their facility. Given the complexity of PREA, it seems unlikely that a statewide correctional system would be able to monitor the location of all PREA inmates in the absence of AMOS.

Pennsylvania

The delivery of mental health services in the Pennsylvania Department of Corrections is changing. After a period of internal and organizational reflection, the DOC has promulgated many systemic changes to the ways psychological and psychiatric services are provided to state inmates. To lead the way, the Bureau of Health Care Services and Central Office Psychology departments have augmented their organizational structure with the addition of four regional licensed psychologist managers (LPMs) and a new mental health program manager. The regional LPMs serve as Central Office liaisons with the state correctional institutions (SCIs) and oversee the delivery of mental health services in their respective regions, while the mental health program manager is responsible for the tracking and identification of trends of mental health-related critical incidents throughout the system. With regard to mental health services, the DOC recognized the need for systemwide training initiatives. Consequently, the department has commenced the delivery of the Crisis Intervention Team (CIT) training and Mental Health First Aid training for all corrections employees. By the end of 2013, the DOC trained more than 300 employees in the CIT model. The department is scheduled to have all DOC staff trained in mental health first aid by the end of 2014. Additionally, more than a dozen SCIs have trained and introduced certified peer specialists (CPS). The department’s goal is to have CPSs at every SCI by August 2014. The unveiling of the mental health training initiatives to all department employees is only the beginning of Pennsylvania's strategy to change the culture of its system.

The Pennsylvania DOC has committed to many additional culture-change initiatives that involve relationships with community mental health and criminal justice experts. The department has received assistance from the National Alliance of Mental Illness (NAMI) with regard to reviewing and improving mental health-related policies. Similarly, the department has partnered with the Vera Institute of Justice to assess its segregation policies and practices. The DOC’s goal is to facilitate the efficacious use of these correctional tools, emphasizing their use only under exigent circumstances. The collaboration with Vera will also facilitate the ongoing systemic reduction of inmates confined to segregation. The DOC also recently consulted with Pennsylvania Mental Health and Justice Center of Excellence to complete a sequential intercept mapping of its correctional mental health system, from reception to reentry. This systemwide mapping assisted the DOC with the identification of gaps in its mental health procedures and ultimately enhanced the placement, identification, treatment planning and reentry of inmates with mental illness to the community. To this end, the department has refined the definition of serious mental illness with the intent of enabling improved tracking and identification of inmates involved with the departmental disciplinary process. The departmental disciplinary process, as it relates to inmates with mental illnesses and serious mental illnesses, has also been greatly augmented. The DOC’s hearing examiners received a specialized training on the amendments and new provisions to the disciplinary process by the licensed psychologist director, the department’s Office of Chief Counsel, and the supervising hearing examiner at the Central Office. These provisions include enhanced out-of-cell services for inmates in segregation, as well as informed sanctioning practices for inmates with mental illnesses and serious mental illnesses.

The Pennsylvania DOC has also concentrated significant efforts on improving, developing and implementing additional clinical operations. For example, suicide prevention committees consisting of multidisciplinary professionals have been established at every SCI. The committees meet monthly, review critical incidents, recommend policy changes, and evaluate facility processes and procedures as they relate to suicide prevention. Additionally, the department has drastically enhanced the requirements and procedures for clinical reviews of self-injurious behaviors, suicide attempts and completed suicides. One highlight of these changes is the requirement of the clinical review team to be chaired by the licensed psychologist manager. Two
other monumental changes that the department has executed include the implementation of recovery-based individual treatment plans and the development of several new specialized housing units, specifically designed for various levels of care and security.

Without reservation, the Pennsylvania DOC has established a commitment to enhance its mental health system. Considering the systemic changes to mental health policies, procedures and training initiatives, this evolution represents a time of change for Pennsylvania. With the support and direction of Secretary John E. Wetzel, the Pennsylvania DOC is dedicated to executing this transformation as one team. The Pennsylvania DOC will continue to embody positive change, especially with the delivery of its mental health services.

**EMR implementation initiative.** The Pennsylvania DOC is actively planning for the implementation of an EMR for its 26 SCIs. In the summer/fall of 2012, key stakeholders were presented with a multitude of off-the-shelf commercial EMR product demonstrations for consideration. This process exposed the lack of viable correctional application options available to the industry, as most emphasized billing and coding processes, which are not applicable in the DOC. Ultimately, one application was chosen for further evaluation.

Calendar year 2013 was consumed by a plethora of strategizing and planning activities. A project planning team conducted site visits at predetermined facilities to document routine medical, mental health and dental processes in order to prepare for a comprehensive gap analysis between the DOC’s clinical operations and policies and the selected application. After the in-depth, hands-on analysis, it was determined that the chosen application would not meet the DOC’s operational requirements. Fortunately, another application, currently in use and readily accepted by all DOC medical and mental health staff, is in a position to offer expansion of its functionality in accordance with the department’s needs.

In parallel to the site visits and workflow documentation, resource analysis was conducted to determine hardware and infrastructure needs as well as the availability of subject matter expert resources to participate in the project. This exercise has yielded a preliminary project governance structure which includes individuals with strong, vast knowledge of specific clinical processes, from medication ordering and administration, to processing mental health commitments. The vendors were informed of their selection for participation and are eager to continue to contribute to the success of this large-scale initiative.

Next steps include further defining the project plan, to include concrete milestones related to standard system development lifecycle process (i.e., development, quality assurance, user acceptance testing, beta testing and phased implementation); establishing a communication plan; change control and risk management tasks; as well as other pertinent project-related information. The goal is to implement full EMR functionality to all Pennsylvania DOC correctional institutions, thereby significantly reducing manual and paper processes, by the conclusion of 2014.

**Rhode Island**

The Rhode Island Department of Corrections is busy trying to keep up with the ever-changing world of IT. The DOC now has about four years of experience with EMRs and has discovered that many of the medical IT systems in Rhode Island do not “talk to each other.” The DOC is currently working on fixing this issue. Additionally, the DOC is reviewing its pharmacy/medline systems and inmate identifiers so that it can install a much more efficient E-MAR system.

The DOC has a very energetic statewide drug overdose prevention program from the Rhode Island Department of Health and it is actively teaching inmates about avoiding overdoses when released. The DOC is training substance abuse inmates in the use of Naloxone and rescue breathing before they are released. Inmates are given a small kit with Naloxone, a needle, a syringe and a nasal dispenser when they are released from the facility. The DOC connects all substance abuse inmates with an outside community facility for continuation of care.

The new course at the Brown University’s new School of Public Health, “Prisoner Health Inside and Out,” is halfway through its initial 10 weeks of intensive 2.5-hour classes. Each class has a tag team approach with faculty from the DOC medical and correctional staff faculty at Brown. The course was not announced until late summer 2013, but was immediately overbooked. It has been both a great success and great fun. More information will be presented about this at ACA’s 2014 Winter Conference.
The region has been very productive in several of the areas listed below. In general, the Patient Protection and Affordable Care Act (PPACA) and its implementation in the correctional environment is an area with which we are all involved. How these new regulations and benefits will impact each state is a known fact in some areas, such as Medicaid coverage for inpatient stays. However, the full impact of the PPACA in other operational areas such as “getting inmates signed up and approved” has implementation issues, as well as the various differences in state implementation and administrations. Additionally, some states are not participating. Each state is working with several levels of “unknowns.” Accordingly, special thanks to ACA and the committee members who have shared so much valuable information with all of us. The use of, or limiting the use of, special housing and the associated extended time in single cells for some inmates with severe custody issues and associated acting out behavior, as well as those who require protective custody, are issues under review in several states in this jurisdiction. In general, the Southern region has several new RFPs, which are issues, or in process. Several states are expanding or deploying EHRs, and a few states have or are developing services delivery systems within the State University Health System. Some of the other highlights include the following:

Arkansas

In Arkansas, a new health authority was appointed Jan. 1, 2014. Rory Griffin, currently the administrator for Medical and Dental Services, will be promoted to deputy director for Health and Correction Programs. Wendy Kelley will be taking the chief deputy director position and will miss being a member of CCHA. The Arkansas Department of Correction and Community Correction are changing health care providers as of Jan. 1, 2014 as well. Correct Care Solutions (CCS) will be providing medical, dental, psychiatric and pharmacy services (subcontracting with Maxor). The transition is going well.

Louisiana

As reported in the Times of Greater New Orleans, the Louisiana Department of Corrections has drastically expanded an online medical program in which doctors treat inmates through video conferencing. The department plans to take the number of offenders treated by telemedicine from 3,500 to 20,000 in the coming year. The shift is part of Gov. Bobby Jindal’s push to privatize state-run hospitals and medical clinics. Inmates traditionally received their more advanced or specialized treatment at those facilities.

The DOC provides primary physician care to offenders on-site at state prisons. However, officials now use video conferencing and other online services when inmates need to see medical specialists, such as cardiologists and neurologists. For example, an inmate who has recovered from a heart attack or cancer, and only needs routine check-ups to monitor their health, could seek treatment through telemedicine. Raman Singh, M.D., medical director for the Department of Corrections, said telemedicine is supposed to supplement the traditional patient-doctor encounter. Offenders can go off-site for doctor visits if needed, but a larger telemedicine program should cut back on the need for many outside medical trips.

Maryland

Maryland has completed the deployment of its 18 telemedicine units. Through cost savings with trip reductions, it has almost recovered the $1 million that was invested within the first six months.
Many of the states in the Midwest are working on a number of projects with similar themes. They include: bidding-out and starting the implementation of an electronic medical record (EMR); bidding-out all, or a portion of, their health care services; working to implement Medicaid payments for hospitalized patients and programs focused on reentry; and helping offenders receive their Medicaid card before release. These projects take resources, leadership and support from many different departments to be successful.

Illinois

The Illinois Department of Corrections (DOC) is getting ready to pilot its EMR at its female sites. The department is involved in two class action lawsuits — one in mental health services and one in medical services. There is a pending hepatitis C major lawsuit (not a class as yet). The DOC is expanding its telemedicine with the University of Illinois (psychology and nephrology) and exploring designating three or four facilities as regional care centers for the offenders with more serious medical problems.

Iowa

The Iowa Department of Correction started a collaborative project to provide mental health services to community-based corrections via telemedicine sessions to all of its patients. At this time, Iowa has four sites that take advantage of its services. Telemedicine sessions are every other week with the intention to expand to 23 sites during the next year.

Kansas

The Kansas Department of Corrections will be increasing its EHR capabilities in 2014. It will also be increasing on-site treatment through improved telemedicine.

Kentucky

The Kentucky Department of Corrections has recently awarded dental and pharmaceutical contracts to Mid America Dental and Diamond, respectively. The health care contract was awarded, but implementation has been delayed due to a protest. The DOC expects a request for proposal (RFP) for a new EHR to be out soon. In Kentucky, all such projects must now go through the Commonwealth Office of Technology. Its current EHR was deployed in 2005 and does not meet the department’s current needs regarding robust reporting. The DOC’s current hepatitis protocol does not include treatment with protease inhibitors given that new all-oral treatment regimens with fewer side effects will be out soon. However, in monitoring, if significant deterioration occurs such that waiting is not a safe option, the DOC will treat with a protease inhibitor regimen. It has treated three inmates thus far.

Michigan

The Michigan Department of Corrections is heavily focused on preparing for the Patient Protection and Affordable Care Act implementation — its Medicaid expansion takes effect around April 1, 2014. The DOC is setting up mechanisms at intake, during incarceration and at discharge to sign inmates up for Medicaid and to do proper discharge planning for outgoing inmates so they can navigate the exchange and the human service delivery system when they leave. The DOC is working with the community mental health, public health, long-term care and other systems to make sure it builds those connections to be ready for implementation. It is also actively negotiating with its hospital network to make sure those networks stay connected with the DOC through all the changes associated with Medicaid expansion. The DOC currently has separate vendor contracts for mental health and physical health care. In keeping with its strategic plan and focus on integrated care, it is issuing an RFP (most likely in early 2014) for a vendor who can help the DOC achieve its integrated care model and also help it move toward a more preventive health management approach. The DOC is building a utilization management (UM) structure — not to duplicate the UM its vendors are using, but to provide a more systematic overall approach to UM from the DOC perspective. It has conducted a comprehensive study of its older adult/medically fragile population and is seeking state funding to develop designated housing unit space for this population. At the same time, the DOC is working with legislative leadership on the possibility of contracting with an outside nursing home, similar to Connecticut’s approach.

The DOC is reducing the number of seriously mentally ill inmates in restrictive housing through the opening of new transitional units. The governor of Michigan has appointed a Mental
Health Diversion Council, which is charged with developing strategies to prevent unnecessary incarceration of the mentally ill. The DOC is helping lead this, and the governor is making this a priority area for funding.

**Minnesota**

The Minnesota Department of Corrections has selected a new vendor, Centurion, and the contract began Jan. 1, 2014. The DOC is working with its Medicaid agency to develop processes to enroll its offenders into Medicaid when they are inpatients. The DOC is also working with its health exchange to enroll offenders when they leave prison. It also has a request for information published for an EHR, and is hoping to get a better handle on how much an EHR will cost.

**Missouri**

Missouri’s EMR plans to go live in early 2014. The Missouri Department of Corrections (MODOC) is a member of the National Consortium of Offender Management Systems (NCOMS), a group of states based on the concept of developing a “comprehensive, web-based offender management system.” As a member of NCOMS, MODOC will be sharing screens and functions from and with other states. Those states include: Alaska, Colorado, Idaho, Indiana, Maryland, Montana, New Mexico, Oregon, South Carolina and Utah. MODOC’s Missouri Corrections Integrated System (MOCIS) health care module will include: orders, charting guides, inmate care requests, diagnosis codes, nursing protocol, appointments, treatment plans, mental health, and substance abuse and sex offender treatment.

Missouri’s current Medical and mental health contract will expire June 30, 2014. Its contract went out for bid in early November 2013, and the closing date was Nov. 27, 2013. A decision should be made by March 2014.

**Nebraska**

Nebraska is working on establishing an electronic medication administration record. It is also involved in a master plan that includes a possible proposal for a health care unit to consolidate and increase its infirmary beds and to care for dementia patients and inmates with ongoing activities of daily living (ADL) needs. Also, the department is in the process of finding a replacement for its retiring health services chief operating officer.

**South Dakota**

The South Dakota Department of Corrections has several projects on which it is currently working. The DOC has a RFP out for an EMR system. The goal is to have a system chosen to start the process by March 2014. The DOC is looking to make a hepatitis C policy change to treat patients with protease inhibitors (Boceprevir or Telaprevir in combination with the current Peginterferon and Ribavirin). The DOC is currently using telehealth for both 24 hours a day, seven days a week emergency room access, as well as use for many specialist visits (such as dermatology, cardiology, gastro, infectious disease, etc.). For 2014, the DOC is working to bring more services inside the walls to avoid outside transports — the current focus is on physical therapy and orthopedics.

**Wisconsin**

The Wisconsin Department of Corrections has been very active with many projects during the last six months with many projects, starting with the new two-year budget on July 1, 2013. The Bureau of Health Services bid out its third party administrator contract and awarded it to a Wisconsin company called Vestica. It has a RFP out for its EMR, and bids were due Dec. 16, 2013. The bureau is conducting an audit review of all offenders 50 years of age or older, as well as any offenders who meet Americans with Disabilities Act requirements. The objective is to project bed needs for assisted living and nursing home offenders. Medicaid payments for all hospitalized offenders are being implemented as of Jan. 1, 2014. The bureau is working with reentry staff to develop a program that will provide information about applications for Medicaid coverage 30 days before release.
The West region members met in September 2013 in Denver. A great showing and even better dialogue was presented. The group engaged in a miniature strategic planning session to better define the intent and goals of the region, as well as the support for the entire coalition. The topics focused on communication and sustainability. The group decided to conduct agenda-driven conference calls every other month facilitated and supported by the region chair. The first conference call was held Dec. 1, 2013.

The region members then transitioned their conversation to the goals of the region, with support being at the core and the continued refinement of best practices. The goals are as follows:

- Continue to foster peer-to-peer support;
- Enhance networking and resource sharing;
- Ensure sustainability;
- Continue to access standards of care in support of ACA and best practices;
- Foster the expansion of ACA standards and accreditation; and
- Support all forms of communication, both internally and externally, of the coalition.

These goals will drive the agenda elements and better prepare the region in supporting the mission of the coalition, while continuing to refine its practice and relations. The West region is made up of the following members:

- Alaska: Laura Brooks;
- Arizona: Arthur Gross;
- California: Diane Toche;
- California/Los Angeles Sheriff’s Department: Kevin Kuykendall;
- Colorado: Renae Jordan;
- Hawaii: Wesley Mun;
- Idaho: Shane Evans;
- Montana: Laura Janes;
- Nevada: Romeo Aramas;
- New Mexico: Elke Jackson;
- Oregon: William Hoefel;
- Texas: Lannette Linthicum;
- Utah: Richard Garden;
- Washington: Kevin Bovenkamp; and
- Wyoming: Anne Cybulski-Sandlian.

Alaska

Working with the Mat-Su Animal Shelter, Hiland Mountain Correctional Center (HMCC) began the Special Pet Obedience Training (SPOT) program in May 2006. The program is governed by a letter of agreement between the institution and the Mat-Su Borough Animal Care and Regulation Division. The program has been successful since its inception. HMCC inmates have trained more than 250 dogs, and the public has adopted just about every dog that successfully completed the program. Selected inmates partner with shelter dogs for an intensive eight- to 10-week obedience training program, resulting in dogs that are more desirable for adoption by the public. Dogs live in kennels that are kept in the rooms of inmates who train them. The dogs learn basic obedience skills including how to sit, stay, heel, shake and roll over. Staff at the Mat-Su Animal Shelter assess each dog for suitability of temperament and the potential to be trained.

In 2007, SPOT staff and inmates developed the skills necessary to begin the process of specialized training for specific types of service. HMCC particularly trained the dogs for those with post-traumatic stress disorder and mobility for wounded warriors. The program was based on a very successful service dog training program at Camp Lejeune in Jacksonville, N.C. It is estimated that without volunteer time and labor from inmates, it can cost up to $38,000 to train a service dog of this type. The program has demonstrated its ability to succeed, as its first graduate — a Labrador mix named Wyatt — completed training and is now a service companion for a wounded warrior. The Military Order of the Purple Heart, Alaska Department helped facilitate the match between Wyatt and Sgt. William Ondell of Ft. Richardson.

Hawaii

Hawaii is planning to “go live” with its eClinicworks EMR in mid-January 2014. A facility phase-in approach will be used to get the whole system online. Hawaii is also implementing a telemedicine program in early March 2014. This will enable its providers to see patients between all facilities, as well as provide for out-of-facility specialty consultations.
**West Report continued**

**Idaho**

Idaho has received much national press attention lately with one of its private prisons and the issuance and award of a new total-risk correctional health care contract. After a very competitive process and a few challenges, Corizon was awarded the contract. The contract comes with many enhancements and expectations. The Idaho Department of Correction (IDOC) is most excited about the current award that will bring an EHR to corrections in Idaho for the first time. Coupled with the enhancements of its primary case management system and the community system (WITS), the state is looking forward to robust data collection and analysis.

The most impressive development is the court accepting the department's final monitoring agreement to start the clock of a 32-year old *Balla vs. Idaho* case. The monitoring has been in development for the last 12 months and has been finalized. At the end of a 24-month monitoring period, the case will close out a four-part federal case surrounding access to mental health, medical, special diets and conditions of confinement of old housing units.

**Utah**

In Utah, the legislature and a governor's appointed committee — the Prison Relocation and Development Authority — continues to evaluate moving its 4,000-bed prison away from the Salt Lake City area. Utah has had great success with Medicaid billings for those eligible and off-site for more than 24 hours. It is working with state and county agencies to prepare for the ACA audits. Otherwise, all things are going well.

**Washington**

**Missioned housing for offenders with cognitive disabilities.** The Washington Department of Corrections is creating a missioned housing offender living unit at Cedar Hall-Washington Correction Center (WCC). This special housing will ensure that offenders with intellectual disabilities (IQ below 69); many with borderline intellectual functioning (IQ 70-79); and some offenders with traumatic brain injuries at the moderate and severe levels are appropriately treated, protected from abuse and provided specialized habilitation programming in a safe, secure environment. Offenders will develop skills that will allow them to function more independently, both while in prison and when released.

These offenders are more vulnerable than the average offender to being harassed, extorted, robbed and assaulted. Moreover, these offenders also tend to present with inadequate coping skills, inadequate social skills, lack of judgment, lack of insight and significant impulsivity. Correctional officers will receive specialized training in the provision of services to offenders with cognitive disabilities. Training will provide staff the tools necessary for them to be able to provide supports such as coaching, assisting, monitoring and prompting. Offenders may need help with specific tasks until they have acquired the skills to complete the tasks independently. Some will need staff assistance completing forms, and with issues such as classification, program assignments and disciplinary hearings. Others will need additional monitoring of their self-care, personal safety, behavior and property. Prompting will help those offenders needing reminders to begin or complete an activity such as accessing medical care or complying with basic expectations.

Habilitative programming will be offered that will help offenders:

- Learn how thinking affects their actions and how actions affect what happens to them and those around them;
- Understand their feelings of anger, why their anger causes problems and what they can do about it;
- Understand more about themselves, decide if change is needed and gain skills to make a plan for self-change;
- Learn about many illnesses and diseases and the things they can do and choices they can make to help keep healthy (the focus would be on health, mental health and addictions); and
- Understand the habits of a criminal lifestyle and new ways to put an end to criminal thinking and make better choices.

A variety of work assignments will be available that give offenders an opportunity to learn job skills, and develop good work habits that can apply to jobs after they are released. Efforts will be made to coordinate services with the Developmental Disabilities Administration staff in the county to which the offender will be returning.
The PPACA continues to be controversial at this time. The controversy surrounds three specific issues:

**Insurance cancellations:** First, the issue of citizens not being able to keep their current health care plans. Hundreds of thousands of Americans received cancellation notices because their insurance policies do not meet the requirements of PPACA. However, the president has now said insurers can keep consumers on health care plans that do not meet the minimum standards of Obamacare. Under the administrative fix, insurers that do continue offering plans that do not meet the minimum standards will have to tell consumers of the deficiencies and detail other options for coverage.

Insurance companies may extend through the end of 2014 offering health care policies that would not meet the minimum standards of the act. The change is an attempt to address the president’s pledge that “if you like your health care plan, you can keep your health care plan” under the sweeping changes enacted by PPACA. Therefore, in December, 2013, the president extended the individual mandate until Jan. 1, 2015, for any individual that had a plan and lost his or her plan due to the PPACA rule changes.

**Website functionality and security:** Second, while people are able to enroll via telephone, there are significant problems with the website for enrollment. The website does not function properly to allow citizens to enroll in new health care insurance plans covered by the federal exchange system.

The HealthCare.gov website was functioning optimally by the end of December and reports more than 90 percent of users can now successfully complete their applications. Still, the site will continue to be a work in progress. There were significant glitches up front, but functionality is greatly improved as of Jan. 1, 2014. The Department of Health and Human Services (HHS) reports it has fixed the security hole that would have allowed the potential for anyone with ill intent to highjack user accounts.

**Enrollment:** Third, the marketplace was not seeing enough enrollments to pay for the program as of November. While the national number is 106,185 (“who have selected a marketplace plan”), the number for the federally run marketplace was only one-quarter that size – 26,794. Unlike insurance companies (that don’t count subscribers until first payment), these numbers are simply those who have successfully navigated the entire shopping process and selected a Bronze, Silver, Gold or Platinum plan.

States such as California and other states that have state-run marketplaces are showing much more success in enrolling their population. It is reported by those monitoring usual patterns of insurance enrollment sites that as it drew closer to December 31, 2013, the rate of enrollment in the federal exchange greatly increased. It is unclear if the numbers will be sufficient to ever meet the expectations reported at the onset of the PPACA. All of this will have a significant impact on how we enroll the inmate population both during incarceration for those pre-sentenced inmates, and for those being discharged.

**Follow up changes in law includes:** Dec. 2, 2013, HHS proposed several modifications to the transitional reinsurance program. It proposed changes to the March 2013 final regulations that: further defined “major medical” for the purpose of transitional reinsurance program payments; modified the contribution requirement for certain self-insured, self-administered major medical plans beginning in 2015; changed the timing for payment of the fee; and provided the annual contribution amount for the 2015 benefit year.

The purpose of the EHR Working Group is to share information, trends, and procurement and implementation strategies with health authorities. Following the September 2013 meeting in Denver, the summary of the group’s activities were gathered and future deliverables were developed. The group identified several key issues that are important for any correctional system during the development, procurement and implementation process. The key considerations include, but are not limited to:

- Consider State Health Information Exchange requirements;
- Develop a customized EHR versus an “out-of-the-box” product;
Working Groups continued

- Have realistic expectations (balancing wants versus needs);
- Evaluate need for Health Insurance Portability and Accountability Act compliance;
- Consider ongoing tech support needs;
- Evaluate pharmacy and U.S. Drug Enforcement Agency requirements;
- Identify all stakeholders and applicable interfaces;
- Access infrastructure (including wireless capabilities);
- Develop a comprehensive training program;
- Develop a “roll-out” strategy;
- Develop succession planning for continuity of knowledge sharing/transfer;
- Include agency staff/contractors; and
- Demand to see RFP respondents training materials and plan.

The working group will be forming a survey to distribute to all CCHA members via SurveyMonkey. The group will also be collecting examples of EHR RFPs and training materials. The group anticipates that the survey will be sent out prior to March 1, 2014. Upon completion of the data collection and materials, the working group will develop a manual it has nicknamed “EHRs for Correctional Dummies.” The group hopes to have this prepared prior to ACA’s 144th Congress of Correction in August 2014.

Exemplary Practice Working Group
Chair: Shane Evans, Idaho

The Exemplary Practice Working Group met as part of the CCHA training in Denver. As this was the first meeting of this group, the main focus was to garner consensus regarding the goals and mission of the working group in support of the greater goals of CCHA. The group wanted to broaden the scope of correctional health care excellence. The following is the basic agenda that guided the group's focus for the initial conversation:

- Working group mission and focus;
- Review of national approaches — ACA, National Commission on Correctional Health Care Correctional Health Outcomes and Resource Data Set, Healthcare Effectiveness Data and Information Set, Public Health Model for Correctional Health Care and Dashboard from the California Department of Corrections and Rehabilitation;
- Benchmark development; and
- Reporting development.

Clinical Care Working Group
Chair: Rear Adm. Newton Kendig, M.D., Federal Bureau of Prisons

The initial meeting of the Clinical Care Working Group convened in Aurora, Colo., on Sept. 28, 2013. The working group spent the majority of its first meeting with an open dialogue about the many clinical areas that are challenging for the field of correctional medicine. The group decided to form the following three sub-working groups to focus on the most compelling issues:

- Hepatitis C — this group will explore strategies for prioritizing care for inmates with hepatitis C, with the assumption that future treatment options will include an expensive, all-oral regimen with few adverse side effects. Overview will be considered for presentation at a future CCHA meeting;
- Disabled Inmates and Accommodations/PREA — this group will utilize the CCHA listserv and evaluate existing policies, guidelines and best practices on this topic for future presentations to CCHA; and
- Pain Management — this group will utilize the CCHA listerv and evaluate existing policies, guidelines, best practices and training modules on this topic for future presentations to CCHA.

The working group also recommended that managing geriatric inmates and identifying best practices/useful performance measures for ambulatory care be considered by the CCHA co-chairs as topics for future meetings. Finally, the working group discussed topics warranting ongoing review, organ transplantation, bariatric surgery, medication-assisted treatment for addiction and indications for genetic testing.
The initial conversation involved the primary goals and intent of the group. The group is not seeking to reconstruct the standards and guidelines that had been created prior to the inception of the working group. The elements of ACA health care standards would continue to be the basis for all further conversations. With that in mind, the group recognized the goals of having broad-based, quality guidelines to include recommendations for quality control, quality assurance and key performance indicators. Additionally, the group saw the need to explore national standards and develop benchmarked elements that achieve outstanding patient and system outcomes.

To this aim, the group reviewed additional governing or quality bodies. The review resulted in the working group adopting — as its broad guide — the three priority aims of the National Quality Standard. The three aims are far-reaching and align correctional health care with broader national initiatives to improve the overall health of the nation. The aims are:

- Better care;
- Healthy people/healthy communities; and
- Affordable care.

These three aims encompass the goals of any effective health care delivery system, while ensuring correctional health care remains consistent with external efforts. Additionally, it provides a proper framework for continued exploration and refinement.

- Recruitment and Retention Working Group
  Chair: Jim Greer, Wisconsin

In its group meeting, the Recruitment and Retention Working Group discussed different strategies to help recruit and retain health care professionals. Many suggestions were shared by the group members. These ideas included:

- Recruitment bonuses;
- Paid moving expenses;
- Site-specific, add-on pay for hard-to-fill areas;
- Add-on for board eligibility and/or board certification for medical doctors;
- Broadband position classification to higher salary;
- 10- or 12-hour shifts;
- Loan forgiveness programs, such as Health Professional Shortage Area and other state loan programs;
- On-call pay for after hours;
- Quarterly meeting with continuing education units;
- Educational funds for conferences; and
- Pay for college courses for bachelor’s and master’s degrees in nursing.

The group also discussed recruitment activities, which included:

- Hiring recruitment firms for medical doctor positions;
- Discussing which websites were most effective for recruitment;
- Mailer programs;
- Recruitment videos;
- Job fairs;
- Student placement; and
- The American Psychological Association internship program for doctorate psychology students.

The group also discussed the challenges of salary compression and trying to stay competitive with the private sector.

Mental Health Working Group
Chair: Carolina Montoya, Florida

As presented at the September 2013 CCHA meeting, the Mental Health Working Group’s principle focus is the development of a protocol for restrictive housing as a housing alternative. The group’s goal is a draft protocol for the CCHA meeting at ACA’s 2014 Winter Conference Jan. 31-Feb. 5, 2014. The protocol will reflect the most current thinking on this controversial issue and offer information regarding its definition, use and recommended procedures. The group, which includes representatives from both jails and prisons, will address these diverse correctional environments. The group would like to benefit from existing protocols and appreciates assistance and guidance from all CCHA members. Please forward any appropriate documentation to Carolina Montoya at M7526@miamidade.gov.
My name is Doreen Efeti and I joined ACA’s Office of Correctional Health Care (OCHC) in October 2013 as a health care services specialist. I reside in Silver Spring, Md., where I have lived for more than 17 years. I am originally from Cameroon, which is in West Africa. Growing up in a community where people lack access to adequate health care made me want to do more to alleviate the suffering that illness can cause. I have always believed in the saying that “prevention is better than cure,” and this has led to my passion for public health. I first came across public health in my undergraduate studies, which sparked my desire to educate people and communities on making healthy choices.

I received my Bachelor of Science degree in public and community health with a minor in biological sciences from the University of Maryland at College Park. After joining the workforce for several years, I enrolled in a dual master’s program at Benedictine University, where I earned a master’s degree in public health (health education and promotion) and business administration (health care administration). In 2006, I received my professional certification from the National Commission for Health Education Credentialing as a certified health education specialist, and I am currently preparing to sit for the Master Certified Health Education Specialist exam in spring 2014.

I began my career as a health writer/editor for Lockheed Martin on a National Cancer Institute contract, creating cancer information fact sheets for the general public and health professionals on various cancer-related topics. Since then, I have held several positions coordinating, planning and implementing health programs. My experience encompasses education of chronic disease management and community health promotion on different health topics. I have utilized my training and curriculum-development skills to create train-the-trainer curriculum and health education materials to assist communities in addressing health disparities and health literacy. My most recent position at a national nonprofit health organization was educating renal health professionals on kidney disease management as a professional education manager at national conferences and through online continuing education courses.

Since joining ACA, I have been introduced to the field of corrections by gaining field experience in both jail and prison systems. In the past two months, I spent a week at Henrico County (Va.) Jail East and West, where I received an extensive shadowing experience on the intake and release process at a county jail. This experience offered insight into the coordination of care that is offered in a jail setting and the efficiency in addressing the health needs of individuals at the entry point in the correctional system. My week in Huntsville, Texas, with Lannette Linthicum, M.D., introduced me to the Texas Department of Criminal Justice (TDCJ) and the diverse health services TDCJ provides to the offender population. In Texas, I learned about the prison system while also learning about the historical perspective of correctional health care and the impact it has on the delivery of inmate health care. Taking part in several ACA audits at various jails and prisons during the past few months has offered a clear understanding of the impact that health performance standards play in ensuring that quality health care services are delivered to the offender population. Learning about correctional health care has awakened my interest in working in corrections, and how I can impact the lives of inmates and corrections professionals with my role at ACA.

Outside of work, I enjoy volunteering my time to assist the Christian Education Committee at my church and teaching Sunday school. I also enjoy spending time with my family, especially my niece and nephew. I am excited about the opportunity to work with the members of this coalition to help achieve its goal. I believe our time working together will not only yield tremendous professional benefits for all of us, but will also provide the opportunity to enhance the lives of inmates and further the goals of ACA. I can be contacted at DoreenE@aca.org; or (703) 224-0120.

Department Updates

OCHC worked on many initiatives during 2013. At the 143rd Congress of Correction in National Harbor, Md., more than 40 health care workshops were presented that focused on treatment issues and addressing the health care needs of the offender population. The CCHA All Health Authority Training was held Sept. 27-30, 2013, in Aurora, Colo.

During the year, OCHC collaborated with other ACA departments on various projects to benefit the correctional health care community. The office worked with the Standards and Accreditation Department on health care accreditation for all Kansas Department of Correction facilities. The office will continue to work in 2014 to engage other correctional systems in the stand-alone health care and full accreditation process. Throughout the year, OCHC also responded to inquiries and provided guidance about health care standards from the field.

OCHC is also working with the ACA’s Professional Development Department with regard to health care professionals’ certification. In October 2013, ACA launched the new health services administrator certification exam. The exam will be administered at the 2014 Winter Conference in Tampa, Fla., for
Correctional Health Care continued

qualified candidates. More than 45 health care and treatment workshops and several plenaries will be presented at the 2014 Winter Conference. OCHC is also in the process of developing marketing materials for ACA health care services. Another major initiative for the office was the publication of the November/December 2013 issue of Corrections Today, titled “Correctional Health Care – Rising to the Challenges.” This issue featured articles addressing the Patient Protection and Affordable Care Act (PPACA), healthy menu initiatives, clinical updates and other topics.

OCHC is hard at work with ACA’s various treatment committees and CCHA workgroups to address issues affecting correctional health care. During the 2014 Winter Conference, the treatment committees will hold a meeting to accomplish their specified tasks. One plenary session held during the conference will be on PPACA, to be presented by the CCHA workgroup. The invited speaker for the Health Care Special Session and Luncheon is Acting Surgeon General Rear Adm. Boris D. Lushniak, M.D., M.P.H.

In 2014, OCHC will be hosting a public health intern whose primary duties will be assisting the office in meeting the needs of the field. Other projects for 2014 include the development of a behavioral health certification for practitioners; several health care trainings; and submission of various grants. The office will continue its charge on addressing restrictive housing and how it affects correctional health care.

Legislative Update

Eric Schultz
Director, Government and Public Affairs
American Correctional Association

 Coverage of inmates by the Patient Protection and Affordable Care Act has recently come to the forefront, and Rep. Fred Upton (R-Mich.), chairman of the House Committee on Energy and Commerce, has expressed significant interest and concern about the expansion of Medicaid and its coverage of the offender population. He has submitted a formal request to the Government Accountability Office asking it to investigate and report on the matter. In response, ACA and many other organizations have joined to send a letter to the chairman clarifying the law’s impact on the incarcerated population.

The Justice and Mental Health Collaboration Act of 2013 is still pending in the Senate due to holds by Sen. Mike Lee (R-Utah) and Sen. Tom Coburn (R-Okla.). Stakeholders are working with their staff to get them to release the bill and allow it to proceed to the floor for consideration. It has been pending floor action since June 2013 when it was reported out of committee. To help move the bill forward, supporters are seeking to add additional co-sponsors, particularly Sen. Lamar Alexander (R-Tenn.); Sen. John Boozman (R-Ark.); Sen. Saxby Chambliss (R-Ga.); Sen. Bob Corker (R-Tenn.); Sen. Deb Fischer (R-Neb.); Sen. Johnny Isakson (R-Ga.); Sen. Mark Kirk (R-Ill.); Sen. John McCain (R-Ariz.); Sen. Lisa Murkowski (R-Alaska); and Sen. Tim Scott (R-S.C.).

The Smarter Sentencing Act of 2013 was introduced by Sen. Richard Durbin (D-Ill.), along with Lee and Sen. Patrick Leahy (D-Vt.) in the Senate in July 2013, while its companion in the House was introduced just recently by Rep. Raul Labrador (R-Idaho), along with Rep. John Conyers (D-Mich.) and Rep. Robert Scott (D-Va.). A hearing was held on federal mandatory minimum sentences in September, which is the primary focus of the legislation. It essentially expands the judicial “safety valve,” thus giving federal judges greater discretion to sentence nonviolent drug offenders below the prescribed minimums. It does not abolish the established mandatory sentences. Rather, it broadens the criteria for those eligible for the safety valve. The bill would also allow offenders sentenced prior to the Fair Sentencing Act (which rectified the crack cocaine versus powder sentencing disparity) to apply for a sentence reduction.

The U.S. Parole Commission (USPC) Extension Act of 2013 was introduced in late September 2013, passed by the House, passed by the Senate and signed into law by the president in swift order. The legislation simply reauthorizes the USPC for another five years. The U.S. Sentencing Commission, which was established in 1984, gave the USPC jurisdiction over sentences covering crimes prior to that date. While there is no parole in the federal system, there are still offenders in the system serving sentences covered by the commission.

Recently, ACA joined with the National Sheriffs’ Association and the Major County Sheriffs’ Association in submitting comments and concerns to the Federal Communications Commission regarding its recent Report and Order and Further Notice of Proposed Rulemaking in the Matter of Rates for Interstate Inmate Calling Services. The order established rate caps for debit calls/prepaid calls and collect calls of 12 cents and 14 cents, respectively. The one-size-fits-all rate caps will apply to all correctional facilities, regardless of size and/or the nature of the facility. The commission emphasized in its order that the rates charged by Independent Care System providers need to be cost-based and that site commissions cannot be included in the calculation of costs.
The Centers for Disease Control and Prevention National Occupational Research Agenda has recently updated its National Public Safety Agenda. The revised agenda — dated Oct. 29, 2013 — includes a new section for Wildland Fire Fighting and the related strategic, intermediate and actively output goals. The revised agenda has been posted on the public safety website for review. For more information, visit http://www.cdc.gov/niosh/nora/sectors/pubsaf/agenda.html.

### Legislative Update continued

The Centers for Disease Control and Prevention National Occupational Research Agenda has recently updated its National Public Safety Agenda. The revised agenda — dated Oct. 29, 2013 — includes a new section for Wildland Fire Fighting and the related strategic, intermediate and actively output goals. The revised agenda has been posted on the public safety website for review. For more information, visit http://www.cdc.gov/niosh/nora/sectors/pubsaf/agenda.html.

### PREA Update

Bridget Bayliss-Curren  
Standards and Accreditation Specialist  
American Correctional Association

In the third month of the auditing cycle for the Prison Rape Elimination Act (PREA), ACA has conducted eight PREA audits, with three more scheduled before the end of the year. The largest facility audited to date, Federal Correctional Complex Victorville in Adalante, Calif., was audited the week of Oct. 21, 2013, and the results are expected within 180 days of the audit’s completion. The final PREA report will be posted on the Federal Bureau of Prison’s website at www.bop.gov. The first facility audited was Federal Correctional Institution Gilmer in Glenville, W.Va., and its audit report will be available by the end of February 2014 on the BOP website.

The PREA Resource Center is currently training auditors for the expected demand of various facilities. The second auditor training was conducted at the National Advocacy Center in Columbia, S.C., during the week of Nov. 18, 2013, with more than 50 potential auditors in attendance. The potential auditors included victim’s advocates as well as private contractors, ACA auditors and accreditation managers. The event involved five days of intense training on topics such as lesbian, gay, bisexual and transgender sensitivity; interviewing techniques; and ethics. Once participants have passed a background investigation and a test on the PREA material, their names and contact information will be included on the PREA Resource Center website.

Kathy Black-Dennis, ACA’s director of Standards and Accreditation, and Bridget Bayliss Curren, ACA accreditation specialist, were both on hand to assist in the training and to respond to any questions regarding the ACA-coordinated PREA audits. The next auditor training is scheduled for Jan. 13-17, 2014, at the National Advocacy Center. The application to attend future auditor trainings, as well as information on PREA standards interpretation, resources and technical assistance, can be found on the PREA Resource Center website at www.prearesourcecenter.org.

There will be seven PREA-related workshops at ACA’s 2014 Winter Conference in Tampa, Fla., Jan. 31-Feb. 5, 2014. Topics will include a “PREA Health Care Standards Review,” (continuing education contact hours will be available); “Developing a PREA Compliant LGBT Policy for Your Facility;” “PREA Audit for Juvenile Facilities: What to Expect and How to Prepare;” and “PREA Health Care” (continuing education contact hours will be available). David Haasenritter, ACA auditor, and Russ Perdue, warden of the Federal Correctional Institution Gilmer, will also be conducting a workshop on their experiences and lessons learned during the first PREA audit. For a complete listing of workshops scheduled for the 2014 Winter Conference, as well as registration information, please visit www.aca.org.
Conventions, Advertising and Corporate Relations
Caitlin Mann, Director

ACA’s 2013 Winter Conference took place in Houston, Jan. 25-30, 2013. The conference was a success, with about 3,000 people in attendance from all around the world. We were thrilled to have Gary Maynard, former secretary of the Maryland Department of Public Safety and Correctional Services, as the keynote speaker at the annual Health Care Special Session and Luncheon. We had a great discussion from the panelists and attendees at the first plenary session, “Re-Evaluating Administrative Segregation: The Human, Public Safety and Economic Impact.”

The 143rd Congress of Correction convened at the Gaylord National Resort and Convention Center in National Harbor, Md. (Washington, D.C., area), Aug. 9-14, 2013. The congress kicked off with the Health Care Welcome Reception, and continued with days filled with educational workshops and opportunities for attendees to meet and network with their peers. We were honored to have H. Wesley Clark, M.D., J.D., M.P.H., director of the Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment, as the keynote speaker for the Health Care Special Session and Luncheon. Secretary of the U.S. Department of Veteran Affairs Eric Shinseki provided the keynote speech at the General Session. On Tuesday evening of the congress, we honored Brig. Gen. Mark S. Inch and Barbara Corinne Inch (posthumous) and Patrick W. Keohane at the annual E.R. Cass Correctional Achievement Award Banquet.

Looking ahead to 2014. ACA’s 2014 Winter Conference will be held in sunny Tampa, Fla., Jan. 31-Feb. 5, 2014. All meetings and events will take place at the Tampa Marriott Water-side Hotel and the Tampa Convention Center. We are looking forward to many events, educational sessions and workshops. A plenary session on the Patient Protection and Affordable Care Act will be held Saturday, Feb. 1, 2014, and a plenary session on restrictive housing will be held Monday, Feb. 3, 2014, which is the third in a series discussing this critical, multifaceted topic. Get ready for a week of collaboration, education and networking with corrections’ finest. For information on registration and housing, please visit www.aca.org/conferences/winter2014. For additional information or questions, please contact Caitlin Mann, director of Conventions, Advertising and Corporate Relations at (800) 222-5646, ext. 0011; or WC2014@aca.org. We hope to see you in Tampa, Fla.

The 144th Congress of Correction will convene Aug. 15-20, 2014, in Salt Lake City at the Salt Palace Convention Center. Information on the congress will be available in early spring 2014 on ACA’s website at www.aca.org/conferences.

Communications and Publications
Susan L. Clayton, MS, Director

ACA has once again been recognized with Awards for Publications Excellence. This year, the April/May 2012 Reentry Programs issue of Corrections Today won in the magazines and journals category, and Pathways for Offender Reentry: An ACA Reader won in the Books and eBooks category.

The 2013 Directory of Adult and Juvenile Correctional Departments, Institutions, Agencies, and Probation and Parole Authorities is available for purchase. Surveys for the 2014 directory have been distributed. Staff are currently working on the next edition of the Jail Directory.

The department continues in its efforts to provide current and engaging information that impact the corrections field through its periodicals. Staff are currently working on the March/April 2014 issue of Corrections Today. We are also working on upcoming issues of Corrections Compendium and On the Line. The November/December 2013 issue of Corrections Today focused on various aspects of correctional health care.

This year, the following books were published: 2011 State of Corrections; What Works: Defeating Recidivism: Keys to Making It Happen; and Cage Your Rage, Second Edition. A book that focuses on riots and disturbances as well as a new edition of Conflict Management and Conflict Resolution in Corrections are currently in production.

Membership Services
Susanna Butler, Director

Exciting things are happening in the Membership Services Department at ACA. The department has a new director and membership specialist who are actively updating the membership applications, developing new brochures and also updating the gear store. Staff look forward to increasing ACA’s membership with innovative systems that focus on customer satisfaction. Along with new developments within the department, they hope to exceed members’ expectations and organizational goals.
ACA Department Updates continued

Professional Development
Kelli McAfee, Director

ACA’s Professional Development Department offered numerous training opportunities, both online and in person, in 2013. The new correctional health services administrator (CHSA) exam was rolled out at the 143rd Congress of Correction in National Harbor, Md. The department has observed a significant interest in the new certification, and is currently accepting application for the exam. The CHSA exam will be offered at the 2014 Winter Conference in Tampa, Fla.

We are in the process of revising all 14 of the core security courses and developing a strategic plan for course development during the next three years. On Nov. 1, 2013, the department hosted the first study tips webinar. We had great attendance and questions. Certification webinars will be held monthly.

In September 2013, ACA completed a one-week basic leadership training in Virginia. In November 2013, ACA completed phase two of the leadership development training in Virginia. In March 2014, ACA will host the first train-the-trainer, 40-hour course of the year. Trainers from across the country will come for a training refresher, and new trainers will gain valuable skills. The department plans to host additional monthly webinars on certifications and other trainings for 2014. For additional information, please contact Kelli McAfee at kellim@aca.org; or call (703) 224-0172.

We will offer more than 90 workshops at the 2014 Winter Conference in Tampa, Fla. Workshop proposals for the 144th Congress of Correction are also being accepted through Feb. 21, 2014. To submit a proposal, please contact Temitope Fagbemi at temitopef@aca.org or (703) 224-0074.

Standards and Accreditation
Kathy Black-Dennis, Director

ACA’s Standards and Accreditation Department has been engaging in many initiatives and offering excellent assistance and guidance to the corrections field. In 2013, 381 facilities and programs were accredited. At the 143rd Congress of Correction, the Golden Eagle Award was presented to Oriana House Inc, in Akron, Ohio. The Keohane Award, recognizing outstanding auditors, was given to David Haasenritter, U.S. Army; and the Dunbar Award, recognizing outstanding contributions to the accreditation process, was presented to Jeff Rogers, correctional consultant, Frankfort, Ky.

The Adult Local Detention Facilities (ALDF) Health Care Standards Committee and Standards and Accreditation Department staff are working together to pilot the new, stand-alone health care standards for jails. The 2014 Standards Supplement is in production and will be available in early 2014. The Standards and Accreditation Department was involved in many trainings throughout 2013. This includes participation in Vision 21, a U.S. Office of Victims of Crime strategy meeting. The final report, Vision 21: Transforming Victim Services Final Report, is available online at http://ovc.ncjrs.gov/vision21. A two-day intensive training was held for all members of ACA’s Commission on Accreditation for Corrections, April 19-20, 2013, in Oklahoma City.

In 2013, the department made a concerted effort to attract, train and utilize new auditors from all areas of corrections. Specifically, auditors with experience in correctional health care were needed to focus on the provision of medical, dental and wellness services in the majority of ACA audits. In addition, Standards and Accreditation Department staff have conducted audits in Mexico utilizing the international core standards; held monthly webinars to train auditors and accreditation managers; worked with the PREA Resource Center on auditor training and audit implementation; analyzed various proposals/approaches for developing electronic standards files; and attended National Institute of Corrections jail inspector training in July 2013. The following books on standards are in some type of revision: Correctional Training Academies; Correctional Industries; Juvenile Detention Facilities; and the ALDF Health Care Standards.
U.S. Department of Health and Human Services (HHS) Updates

**Linda Mellgren**

HS has a number of projects under way to increase access to health care for justice-involved populations. Two projects, funded in September 2013, focus on broader Patient Protection and Affordable Care Act (PPACA) implementation issues, but include a specific emphasis on the implications of providing coverage to individuals who have been involved in the criminal justice system. The first project focuses on the issues that counties in states with county-run Medicaid programs face in implementing the Medicaid expansion, including administration, outreach, and enrollment. The project will look at the interaction between Medicaid and other county systems, such as criminal justice and human service systems as part of its assessment and technical assistance efforts. The second project will help HHS identify promising outreach and marketing strategies for low-income men who have not been widely eligible for Medicaid and who often cannot afford or have been excluded from private health insurance. This project will focus on lessons learned from other successful marketing campaigns targeted to low-income men. Justice-involved, low-income men are a population of interest. Other projects funded in prior years include:

- Assessing the effects of prerelease prison or jail Medicaid enrollment on three reentry outcomes — post-release Medicaid enrollment and utilization, employment, and recidivism — in Oregon (prison) and Connecticut (at jail entry);
- Using ex-offenders trained as community health workers to link high-risk, medically needy individuals being released from prison to community primary care providers;
- Helping behavioral health providers improve their capacity to serve the expanding pool of Americans who have insurance coverage for mental health and addiction treatment services, including working with correctional and behavioral health partners; and
- Identifying and disseminating a core set of best practices for community-based organizations performing health insurance enrollment assistance for the reentry population.

In addition to these projects, HHS convenes the Access to Health Care subcommittee for the Federal Interagency Reentry Council that focuses on policy and operational issues that affect justice-involved individuals’ ability to access care under provisions of PPACA and through other federally funded programs. One special effort of the Access to Health Care subcommittee has been the formation of a Health Information Technology Workgroup (HITWG) chaired by the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator within HHS. The goal of this group is to improve public health and public safety by coordinating federal efforts to improve health care for individuals involved with the justice system through strategic use of health information technology. The HITWG will promote the adoption and meaningful use of electronic health records and other health information technologies by health care providers within the criminal justice system, and promote interoperability and effective health information exchange between health care providers in the criminal justice and health care systems.

National Institute of Corrections (NIC) Updates

**Anita Pollard**

*Executive manager program in correctional health care.* The goal of this new training is to develop a better-prepared, correctional senior-level workforce that is knowledgeable in health care administration. Training topics include: government regulatory standards; constitutional requirements and ethics; strategic planning; quality improvement; workforce development; finances; contracts; administration of health care; mental health, dental health, custody needs-to-know; and key-stone/capstone case.

This blended curriculum will require a commitment from registrants that they participate in online pre- and post-training meetings in addition to the 40-hour classroom training. The two-person team consists of the warden or associate warden and the health services administrator or the jail administrator and his or her health services administrator who has been in his or her position for fewer than 18 months. Registration can be completed through the NIC Learning Center at http://nic.learn.com. The following are the 2014 training dates:

- Event number: 14P3401
  Travel: March 9, 2014 and March 15, 2014
  Training: March 10-14, 2014
Federal Updates continued

- Event number: 14P3402
  Travel: May 4, 2014 and May 10, 2014
  Training: May 5-9, 2014

- Event number: 14P3403
  Travel: July 13, 2014 and July 19, 2014
  Training: July 14-18, 2014

Crisis Intervention Team (CIT) training. In fiscal year 2014, NIC will offer the CIT training through partnership programs. Interested jails or prisons should contact Anita Pollard, NIC corrections health manager, at APollard@bop.gov to inquire about the process to submit a technical assistance request for this training.

From the staff at the American Correctional Association!

HAPPY NEW YEAR!