Accreditation Designation Proposal

Sponsoring Institution-Based Fellowship in Correctional Medicine (Carceral Medicine)*

* Carceral medicine should be considered as a potential alternative name for the proposed Sponsoring Institution-based fellowship. This alternative name refers to the carceral settings (i.e., prisons and jails) serving as participating sites for the fellowship, and avoids implying that the care provided by physicians in these settings is correctional.

I. Executive Summary

This proposal requests that the Accreditation Council for Graduate Medical Education (ACGME) begin to provide accreditation for Sponsoring Institution-based fellowship programs for physicians in correctional medicine. The accreditation of such fellowships will improve health care and population health by providing a formal graduate medical education (GME) pathway for physicians to acquire knowledge, skills, attitudes, and exposures associated with competent physicians providing care in prisons, jails, and other carceral settings.

ACGME accreditation designation for correctional medicine fellowships will address the demand for a competent workforce of physicians able to improve the health of incarcerated patients and populations. The fellowship will prepare physicians to provide direct patient care while addressing complex, systems-based challenges associated with health services delivery in corrections.

By combining clinical rotation experiences with longitudinal mentorship and an underlying curricular framework, fellowship programs will educate physicians to ensure their attainment of the ACGME Core Competencies. Fellows will develop an essential set of skills to address incarcerated or detained individuals' health and health care needs in collaboration with correctional facilities, and in compliance with policies, procedures, and regulations. Accredited fellowship programs will provide education regarding the social, historical, and legal contexts for health care in carceral settings, and will emphasize physicians' roles in transitions of care, including transition services and planning for community re-entry, to optimize patients' health outcomes.

Programs will have a duration of one or two years, and will include core and elective experiences in a format that allows for customization based on individualized learning goals. Fellowships will offer multidisciplinary learning opportunities inside and outside of correctional facilities. Sponsoring Institutions will have opportunities to design didactic education and scholarly activities that develop fellows' practical skills, including research, advocacy, and management. Fellows who complete the two-year program format may have opportunities to obtain a Master's-level degree (MPH, MHA, MPA) or a certificate while satisfying requirements for completing the fellowship. Fellows will have the option to engage in unsupervised clinical practice in their primary specialty or subspecialty to ensure their continued professional development outside the scope of the fellowship.

In addition to describing how the fellowship will meet criteria for accreditation designation, this proposal includes recommendations for the ACGME to engage in organized outreach and collaboration efforts that would support the development of Sponsoring Institution-based correctional medicine fellowships.

Over time, it is anticipated that the fellowships will become part of a more consistent and standard pathway that encourages the promotion and retention of a defined workforce of physicians who care for incarcerated or detained patients. The fellowship will be designed to

facilitate organizations' development of partnerships that promote the education of physicians committed to eliminating health and health care inequities by ensuring appropriate, systems-based patient care.

II. Introduction

The ACGME envisions a health care system in which the Quadruple Aim—improving patient experience and population and workforce health while lowering health care costs—has been realized, and understands that this vision will remain unfulfilled without the systematic elimination of inequities in health outcomes, achievement of health equity, and improvement in health across groups of people with social, economic, or environmental differences.[1,2,3,4] Consistent with the organization's strategic commitment to prepare physicians for public needs,[5] this proposal explores the potential for the ACGME's accreditation process to acknowledge the development of GME programs in which physicians attain competence in the care of incarcerated or detained patients.

The United States has the highest rate of incarceration in the world. In 2020, more than 5.5 million people were under the supervision of adult correctional systems, with approximately 1.7 million incarcerated in prisons and jails, and approximately 3.9 million on probation or parole.[6] There were 8.7 million admissions to jails in 2020.[7] Correctional health systems rely on numerous and complex approaches to delivering services in prisons, jails, and communities, and numerous jurisdictions are facing challenges in maintaining incarcerated individuals' constitutionally protected health care access.[8] Additionally, there is growing recognition of racial inequities and the need for systematic reforms to address the inequities of incarceration, including the establishment of new standards specific to health care in carceral settings.[9]

The ACGME monitors trends in physician education to better understand how organizations prepare residents and fellows for practice in a variety of health care environments. The physician workforce that provides care to incarcerated populations must possess a distinct body of knowledge and a unique skill set to function as effective health care practitioners and advocates in environments that can present challenges to meet standards for adequate patient care.[10] The competence of physicians who care for incarcerated patients requires the development of knowledge of patient populations, correctional systems, ethics, medico-legal guidance, public health, and setting-specific clinical issues.[11] The need for physician education in this area has been recognized by the American Osteopathic Association (AOA), which approved fellowship programs in correctional medicine prior to the transition to a single GME accreditation system under the ACGME.

Based on these observations, ACGME staff members completed a preliminary assessment of opportunities for accreditation of GME that prepares physicians for roles in correctional settings. A purposive sample of 32 individuals provided their insights in a series of 30-minute interviews with staff members of the ACGME's Department of Sponsoring Institutions and Clinical Learning Environment Programs between January 2, 2020 and March 8, 2021. Most interviewees were selected for their experience and knowledge of health care of incarcerated patients, or the education of physicians who work in prisons and jails. The Chair of the ACGME Institutional Review Committee and key ACGME staff members were also interviewed.

Building on insights from this preliminary assessment, ACGME staff members recommended the appointment of an advisory work group to develop a proposal for ACGME designation of accreditation of fellowships in correctional medicine. ACGME staff members also recommended the proposal include specifications for an internal development grant of up to four years to develop this new type of fellowship through enhanced outreach and collaboration. The ACGME staff recommendations were approved by the Executive Committee of the ACGME Board of Directors at its September 25-27, 2021 meeting.

Based on the recommendations, the Board asked ACGME staff members to convene an advisory group composed of correctional medicine experts and GME leaders within ACGME-accredited Sponsoring Institutions to develop this accreditation designation proposal based on the preliminary assessment and other available information. The advisory group was co-chaired by Donald M. Berwick, MD, MPP, FCRP, president emeritus and senior fellow at the Institute for Health Care Improvement and former Administrator of the Centers for Medicare & Medicaid Services; and Yolanda Hill Wimberly, MD, MSC, FAAP, FSAHM, chief health equity officer of Grady Memorial Hospital and former designated institutional official (DIO) of Morehouse School of Medicine. A complete list of members of the advisory group, and of ACGME staff members who supported the advisory group, is provided in Attachment 1.

To support the advisory group's preparation of the proposal, the ACGME's Department of Sponsoring Institutions and Clinical Learning Environment Programs conducted additional stakeholder interviews, gathered relevant reference materials, and obtained feedback from DIOs of ACGME-accredited Sponsoring Institutions.

The advisory group ensured the accreditation designation proposal was structured to demonstrate that the Sponsoring Institution-based fellowship in correctional medicine meets all criteria for accreditation designation under ACGME policy.[12] After addressing the criteria for accreditation designation, the proposal provides additional recommendations, including recommendations for enhanced outreach and collaboration activities that would support the development of Sponsoring Institution-based correctional medicine fellowships.

The advisory group respectfully submits this accreditation designation proposal, which has been reviewed by ACGME President and Chief Executive Officer Thomas J. Nasca, MD, to the ACGME Board for its consideration.

III. Sponsoring Institution-Based Fellowship in Correctional Medicine

A. Improving Clinical Care and Patient Safety, and Addressing Population Health

> *"The clinical care and safety of patients and populations will be improved through the designation of the proposed fellowship." (ACGME Policies and Procedures, Section 12.30.a)*

To provide clinical services of adequate quality to address the needs of incarcerated patients and populations, and to advance health equity by improving care for the most vulnerable to poor health outcomes, it will be necessary to make a societal investment in preparing a workforce of physicians who are competent to provide health care in prisons, jails, and other carceral settings. The accreditation of Sponsoring Institution-based fellowships in correctional medicine is an opportunity for the ACGME to join this effort. Correctional medicine improves the clinical care and safety of incarcerated populations through the provision of health care and promotion of health inside prisons, jails, and other detention facilities, and extends outside of these facilities to the health systems that provide services to individuals while incarcerated and after release. The proposed fellowship will provide a formal pathway for physicians to learn to provide safe and high-quality care addressing a broad scope of health care needs of incarcerated patients and populations across a variety of settings.

Mass incarceration in the US involves the disproportionate imprisonment of people with lower socioeconomic status and from non-White communities.[13,14] Lower socioeconomic status and racism are associated with population-level inequities in health and health care. These differences, along with behavioral and societal factors, contribute to a far higher prevalence of physical and mental illness in incarcerated people than in the general population.[15] Before incarceration, patients receiving care in prisons and jails may have received little or no previous medical, mental health, or dental care. Many serious health conditions, including chronic illnesses; certain infectious diseases, such as human immunodeficiency virus (HIV) and hepatitis B and C; and substance use disorders (SUDs), are common among patients in carceral settings.[16,17,18] To provide appropriate care for incarcerated individuals, physicians must be competent in the prevention and treatment of various health conditions that are common in correctional settings, including emergent and complex health issues and advanced disease. Physicians providing care in the context of corrections must be prepared to address the unique situational and organizational demands of health care delivery in a variety of carceral settings, including jails, prisons, juvenile detention centers, and immigration detention centers. Correctional medicine also requires a commitment to safety, structural competency[19], and the practice of cultural humility in meeting the needs of imprisoned or detained patients, especially those who are from racial or ethnic minority groups, who have disabilities, who are poor, who face health literacy challenges, or who are gender non-conforming.

While incarcerated people have elevated health risks at the point of intake in correctional facilities, the experience of incarceration is itself hazardous, catalyzing health-harming processes and producing even higher risks of poor health outcomes.[20,21] There are a number of potential causes that may contribute to the worsening health of people under the care of correctional systems. Although access to basic medical care in correctional facilities has been established by US Supreme Court precedent as a constitutionally protected right, there is limited accountability for the obligation to provide these health care services, with few mechanisms for the enforcement of care standards outside of litigation and voluntary accreditation processes.[22] Social exclusion, a lack of autonomy, and exposures to unhealthy conditions, stress, and violence may negatively affect a person's health status during incarceration. A lack of social support and benefits during transitions from carceral settings to communities may also increase

vulnerability to adverse health effects.[23] Physician learners have reported that incarcerated patients receive health care that is inferior to that provided to non-incarcerated patients, as manifested in delays in care and limits on clinical decision-making, suggesting that their participation in care in prisons and jails risks reinforcing structural discrimination that is present in carceral systems.[24] Because of this risk, there have been calls for specialized education and training to ensure that physicians do not further contribute to the harms produced by incarceration.[25] Resident and fellow experiences in prisons and jails have been identified as a gap in ACGME-accredited education, and it has been argued that more robust and organized exposure to care in these environments would increase the likelihood of physicians choosing to work in correctional settings.[26]

Correctional medicine physicians improve care through their ability to support the health of patients as they move through carceral systems. Accreditation of correctional medicine fellowships will provide new opportunities to define standards for learning environments that may provide an appropriate context for physicians' clinical education in prisons, jails, and other carceral facilities. A fellowship-educated physician will attain the knowledge that is needed to mitigate adverse health effects and to protect the health of patients transitioning into, between, and out of correctional facilities. Exposure to carceral environments also presents occupational health and safety risks for health care practitioners; fellowship education will provide structured education regarding these risks and practices for reducing them. In these environments, fellows may experience unique stresses and emotional challenges that could be addressed with focused support systems and processes.

Correctional health systems have adopted service delivery models that differ in policy and practice from those serving the general population, and are often governed by rules that are specific to a facility or network of facilities and may not be transparent to the public. Public agencies and private, for-profit firms that operate correctional facilities are responsible for financing and arranging health care services, as public insurance does not cover health care provided inside prisons and jails.[27] For physicians working in these settings, ethical dilemmas of *dual loyalty* emerge when conflicts arise between the responsibility to provide appropriate patient care and the demands of a third party (e.g., correctional corporations, government departments) to meet correctional, criminal justice, or budgetary goals.[28] Formal education in correctional medicine will ensure that fellows develop an understanding of ethical and practical considerations that enables them to optimize patients' health and well-being when confronting challenges and obstacles to providing care.

In the ACGME's preliminary assessment, nearly all of interview participants indicated that physicians and carceral and health systems would benefit from formalized educational programs in correctional medicine, and that ACGME accreditation of a correctional medicine fellowship would provide an appropriate structure. Some participants indicated that ACGME accreditation would be useful in organizational efforts to enlarge the community of correctional medicine physicians. Some participants indicated that accreditation would standardize and, in their words, "legitimize" the pathways that prepare physicians to serve incarcerated patients.

Correctional medicine fellowship programs will include experiential and didactic education that ensures the attainment of ACGME Core Competencies with respect to the provision of health care in prisons, jails, and other correctional facilities. Consistent with the Quadruple Aim,[29,30] Sponsoring Institution-based fellowships in correctional medicine will be expected to follow an approach to health care quality and safety that optimizes the improvement of population health, the experience of people who are incarcerated and detained, and provider well-being while maximizing value in health care spending.

At a minimum, all correctional medicine fellows will be expected to attain competence in essential aspects of providing patient care in prisons and jails, while working with patients, staff members, and others to improve health outcomes. Under faculty member supervision, fellows will obtain practical experience in collaboration with corrections officers and other staff members who are responsible for the custody and safety of incarcerated individuals. Programs may provide fellows with opportunities to develop skills in a range of participating sites that may include, but are not limited to, prisons, jails, detention centers, specialized correctional facilities, hospitals, and community-based centers that serve incarcerated people. Fellows will be provided with educational experiences in locations outside of correctional facilities, such as courts of law, government agencies, and community organizations, that will build their knowledge of social, policy, and legal contexts for the care they provide. Fellows should study evidence and conclusions regarding the connections between structural racism and incarceration in America.

Mentorship of fellows by the program director and other faculty members will provide a structure for clinical, communication, and systems-based skills development and assessment over the duration of the fellowship. Fellows will gain experience functioning within systems that are critical to the promotion of patient safety and occupational safety. Substantial education concerning administration, correctional procedures, health policy, and criminal justice policy will prepare fellows for their health system roles. Clinical rotations, which may be customized based on fellows' expertise and past clinical experience, will build fellows' skills in managing quality improvement, including the improvement of population health in prisons and jails. The rotation settings will educate and train fellows to provide leadership of quality improvement activities through interprofessional team collaboration. Fellowship requirements will allow for flexibility to customize the learning experience to facilitate fellows' achievement of individualized career goals as well as identified workforce needs for specialized care within the field of correctional medicine.

Didactic education will anchor fellows' experiences in theoretical and practical knowledge that will be relevant to their subsequent corrections and health system roles. Local, regional, and/or national educational programming will introduce fellows to foundational concepts of correctional medicine and other relevant disciplines. Fellowship programs may also include Master's degree-level coursework, research, project-based learning, certificates, or other components that emphasize the improvement of health and health care in prisons, jails, and other carceral facilities.

B. Body of Knowledge

> *"[There is] a body of knowledge underlying the proposed fellowship that is (i) distinct from other areas in which accreditation is already offered, and (ii) sufficient for providing educational experiences that promote the integration of clinical, administrative, and leadership competencies that address the broad system-based needs of health care environments." (ACGME Policies and Procedures, Section 12.30.b)*

The multidisciplinary field of correctional medicine is based on a distinct body of knowledge that integrates clinical, administrative, and leadership competencies that address the systems-based health and health care needs of incarcerated people. While physicians in this field engage in the provision of primary, emergency, and preventive care, correctional medicine requires the ability to ensure that the full scope of patients' health needs are addressed in complex environments and situations that are unlike those commonly encountered in another accredited GME program.

Few opportunities exist for residents and fellows to participate in correctional medicine rotations. Some elements of experiential learning in correctional medicine are currently included as minor curricular components of a small number of ACGME-accredited specialties. Specialized elective rotations in ACGME-accredited family medicine, internal medicine, obstetrics and gynecology, and psychiatry residency programs are examples of GME that may incorporate some of the relevant knowledge areas. However, correctional medicine is not a principal focus of any ACGME-accredited specialty or subspecialty, and it has been recognized that this is a distinct area of opportunity for formal GME.[31,32] The underlying focus areas of correctional medicine will include:

- Situational and organizational demands of patient care practice and referrals inside prisons, jails, and detention facilities, related to:
    - primary care
    - chronic illness management
    - emergent health issues, including those resulting from violence or self-injury
    - mental illness
    - SUDs
    - care of people with intellectual or developmental disabilities
    - psychosocial and behavioral issues
    - infectious disease
    - wound care
    - preventive care
    - women's health
    - transgender health
    - child and adolescent health
    - environmental health
    - suicide prevention
- Skills in care management for incarcerated people

    - mental health and addiction treatment services
    - transition support for community re-entry
    - transfers for inpatient care
    - transfers to other correctional facilities
    - dental care
    - trauma-informed care
    - hospice and end-of-life care
    - patient functional assessment
    - patient engagement
    - health care proxies and advance directives
    - treatment in enhanced or specialized restraint situations (e.g., isolation, physical restraints, pregnancy)
- Health resource management within correctional facilities
    - budget management
    - health care finance
    - health care workforce and staffing
    - medical supplies procurement
    - evaluations and accommodations for disabilities
    - assurance of appropriate nutrition resources
    - assurance of appropriate hygiene resources
    - assurance of appropriate exercise resources
    - occupational health clearances
- Administration of health services in correctional settings
    - compliance with policies, procedures, laws, regulations, and consent decrees
    - human resources in corrections
    - medical records documentation and management
- Medication management specific to correctional settings
    - medication administration
    - formulary
    - drug diversion
- Interpersonal and communication skills in correctional settings
    - patients and families
    - interprofessional care teams, including correctional facility staff members
    - outside health care facilities and services (e.g., hospital and laboratory staff)
    - law enforcement, legal, and judicial processes
- Ensuring and improving patient safety
- Occupational safety in correctional settings, including safety protocols
- Health care ethics in carceral settings
    - dual loyalty of health care professionals
    - custody issues and patient autonomy
    - patients' rights
    - care of people sentenced to death
    - research ethics
    - use of restraints and administrative segregation

- Selected focus areas in population health and social drivers of health for incarcerated populations
    - structural and social health and health care inequities, including but not limited to:
        - race and ethnicity
        - socioeconomic status
        - LGBTQ
        - aging in correctional facilities
        - social isolation and separation from community and family
    - epidemiology and disease outbreaks relevant to carceral settings
    - public health data collection and management relevant to carceral settings
- Structural competence and cultural humility
- Historical, legal, political, social, and economic contexts of correctional systems and mass incarceration
- Advocacy in correctional and health policy

Representing essential knowledge in correctional medicine, these focus areas will help to define fellows' attainment of competence as they prepare for unsupervised clinical practice in prisons, jails, and other correctional facilities. The focus areas incorporate and build on medical knowledge areas identified in past accreditation requirements of the AOA for correctional medicine fellowships.[33] The fellowship's foundation in systems-based education distinguishes it from specialty-based education, in that it requires setting-specific experience incorporating clinical, administrative, and operational knowledge.

A selected bibliography of works relevant to physician education in correctional medicine is included as Attachment 2.

C. Physician Workforce

> *"[There is a] need for a sufficiently large group of physicians to apply the knowledge and skills of the proposed fellowship in their health care environments." (ACGME Policies and Procedures, Section 12.30.c)*

It is estimated that there are 1,668 prisons; 2,932 jails; 1,510 juvenile correctional facilities; and 186 immigration detention centers in the US.[34] It is estimated that more than 1,000 physicians practice primarily in these settings, and available workforce information points to a need for additional physicians to provide health care services for millions of incarcerated people. For the US general population, there are 2.6 physicians per 1,000 people;[35] state prison systems, for example, may employ 1.0 physicians or fewer per 1,000 incarcerated people.[36,37] Physicians who practice in carceral settings vary in their qualifications and professional experience. Many jurisdictional authorities actively engage in workforce planning to recruit physicians who are interested in practicing correctional medicine, and educational opportunities such as GME programs have been identified as an essential pathway into the field that should be further developed.[38] Sponsoring Institutions may seek to form relationships with agencies responsible

for the health of people who are incarcerated to develop workforce pathways through the development of accredited correctional medicine fellowships.

While the Sponsoring Institution-based fellowship in correctional medicine will provide preparation to work in a range of facilities and with different incarcerated or detained populations, there exists a common set of knowledge and skills that all correctional medicine physicians must possess to provide safe and effective care. The fellowship will provide the educational foundation for competent practice in the various environments that provide care for people who are incarcerated or detained, and may offer opportunities for learning to care for patients in specialized facilities. Fellows will be prepared to function as leaders in these health care environments as they manage and collaborate with health care teams that may include nurses, mental health providers, technicians, and others.

D. Professional Societies

> *"[There are] national medical or medical-related societies with substantial physician membership, and with a principal interest in the proposed fellowship." (ACGME Policies and Procedures, Section 12.30.d)*

The American College of Correctional Physicians (ACCP) and the Academic Consortium on Criminal Justice Health (ACCJH) have been identified as two professional societies with substantial physician membership and with a principal interest in the proposed fellowship. In addition to professional societies, there are other organizations that collaborate with physicians in the field of correctional medicine. The National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA) provide accreditation for correctional facilities and maintain standards for correctional health care. The NCCHC and the AOA also provide professional certification for physicians in correctional settings.

The ACCP, formerly known as the Society of Correctional Physicians, is a membership organization that was founded in 1992 to provide representation, advocacy, and a communication forum for correctional medicine physicians.[39] In addition to hosting an annual educational conference and other educational events, the ACCP coordinates publications, awards, and other resources.

Also a membership organization, the ACCJH organizes regular conferences and educational activities. Its membership includes physicians, other health care professionals, and researchers, and its activities focus on the advancement of health care in corrections through collaboration, education, and research. Organizational sponsors include UMass Chan Medical School, Jacob & Valeria Langeloth Foundation, and the National Institute on Drug Abuse of the National Institutes of Health.[40]

The AOA offers subspecialty certification in correctional medicine for physicians according to requirements and an examination administered by the American Osteopathic Conjoint Correctional Medicine Examination Committee.[41]

The NCCHC administers voluntary accreditation processes for jails, prisons, juvenile confinement facilities, and correctional facilities that provide mental health services or opioid treatment programs, based on minimum standards for providing appropriate health care for incarcerated people. NCCHC offers multiple types of professional certification in correctional health. There is a credential available exclusively to physicians (CCHP-P) that is granted on the basis of an examination, along with credentials available to nurses, mental health professionals, and others.[42]

The ACA provides accreditation of facilities based on operational standards for adult, juvenile, and community corrections, with the goal of enhancing the quality of correctional practices for incarcerated people, staff members, and the public. Standards have been developed for more than 25 operational focus areas, including health care in prisons, jails, and juvenile facilities. The ACA provides professional certification for corrections staff, including some specialized certifications for non-physician health care professionals.[43]

Correctional medicine physicians work within interprofessional teams that may include roles for a variety of health professionals. There may be opportunities to collaborate with accrediting organizations for other health professions education that are interested in addressing workforce needs within prisons, jails, and other carceral settings.

E. Educational Programs and Research Activities

> *"[There are] academic units or health care organizations of educational programs and research activities such that there is national interest in establishing fellowship programs." (ACGME Policies and Procedures, Section 12.30.e)*

There are existing educational and research activities that demonstrate academic interest in establishing fellowship accreditation at a national level. At present, there are examples of short-term clinical experiences in prisons and jails for residents. These experiences have various clinical foci and do not include long-term clinical exposure to correctional systems. The accreditation designation of a Sponsoring Institution-based fellowship in correctional medicine would provide an important advancement in supporting a standardized approach to GME in corrections, and in creating the structure needed to optimize available learning resources that support the development of physicians who can effectively address the health needs of incarcerated individuals.

Prior to the transition to a single GME accreditation system under the ACGME, the AOA established basic standards of education and training for physicians and approved fellowship programs in correctional medicine.[44] In total, 14 physicians have achieved AOA board certification in correctional medicine. One formerly AOA-approved fellowship program in correctional medicine at Nova Southeastern University was notable for having achieved sustainability in educating multiple fellows under the leadership of the late Dr. Dianne Rechtine.

An online, interdisciplinary Master's degree program in correctional health administration at the George Washington University was identified.[45] Other Master's degree programs (e.g., programs in public health and public administration) provide opportunities for education and research related to correctional health systems. Participants interviewed in the preliminary assessment described informal correctional medicine curricula used by health care organizations, as well as national conferences, seminars, and other educational activities. Membership organizations, such as NCCHC and ACCJH, provide educational offerings including annual conferences, brief intensive courses, and informal educational programs that vary in scope and content. ACCJH provides educational programming that focuses on health research in corrections.

Participants interviewed in the preliminary assessment described limited existing educational opportunities addressing a broad range of knowledge and practice in correctional medicine. Several participants indicated that their institutions offered some limited exposure to residents and/or medical students through elective rotations in a local correctional setting, or in an inpatient setting that on occasion provides care for incarcerated patients. However, exposure was limited to isolated (block) experiences and longitudinal educational experiences were non-existent, with the exception of fellowships formerly approved by the AOA. Some participants identified current opportunities for experiential learning in correctional medicine that are organized within clinical departments by way of specialty-specific rotations in their organization. For example, the University of Texas Medical Branch provides health care for the state's adult and juvenile correctional facilities and is a notable system that educates and trains residents and fellows in the care of incarcerated persons. Such experiences were uncommon. Most participants reported that specialty-specific education was limited to diagnostic and treatment decisions in community-based health care settings and did not provide sufficient exposure for the attainment of competence in providing care within correctional systems.

The absence of a commonly defined structure for GME in correctional medicine has limited organizations' ability to recruit, educate, train, and retain physicians in an efficient or consistent manner. Accreditation of the correctional medicine fellowship will be designed to facilitate long-term, structured clinical education in multiple carceral settings, which will provide opportunities for physicians to develop the knowledge, skills, and attitudes needed for practice. Sponsoring Institutions with correctional medicine fellowships will be expected to provide opportunities for interprofessional collaboration, learning, and leadership. If a Sponsoring Institution offers related programs that are available for multiple professions, coordination of the correctional medicine fellowship with other programs will be encouraged.

In April 2022, ACGME staff members surveyed DIOs (n=106) in a poll after presenting an overview of the proposed Sponsoring Institution-based fellowship in correctional medicine during a scheduled video conference meeting (Attachment 3). Forty-nine of the DIO survey respondents (46%) reported that their Sponsoring Institutions have one or more clinical learning environments serving incarcerated patients. Eighteen respondents (17%) reported that their Sponsoring Institutions had an academic unit or health care organizational partner that currently offers some type of education and training for physicians in correctional medicine.

F. Projected Number of Programs

> *"[The] projected number of programs [is] sufficient to ensure that ACGME accreditation is an effective method for quality evaluation, including current and projected numbers of fellowship programs." (ACGME Policies and Procedures, Section 12.30.f)*

As there has been no previous survey of the GME community regarding correctional medicine, ACGME staff members conducted a survey of DIOs in April 2022 (n=106; see Attachment 3). In that survey, most respondents (53%) indicated that their Sponsoring Institutions would benefit from having education and training opportunities for physicians in caring for incarcerated patients. When asked to estimate their Sponsoring Institution's level of interest in the fellowship, 8% of DIOs replied "very interested," 26% "moderately interested," and 34% "a little interested."

There are 874 ACGME-accredited Sponsoring Institutions, and the DIO survey suggested that some Sponsoring Institutions perceive there is potential for educating and training physicians in correctional medicine. Considering early interest in the fellowship and the availability of institutional resources, it is estimated that at least 10 fellowship programs will achieve accreditation within five years.

G. Fellowship Duration

> *"The duration of the Sponsoring Institution-based fellowship programs is at least one year." (ACGME Policies and Procedures, Section 12.30.g)*

Sponsoring Institution-based fellowships in correctional medicine should be configured in either a one- or two-year format. The duration of the program should be one year to provide an opportunity to achieve general competence to practice medicine in prisons and jails. A two-year program format will allow for the attainment of general competence, as well as opportunities for in-depth learning through elective experiences, which may include learning to care for special populations or developing competence in leadership and administration, research, and/or completion of a Master's degree (e.g., MPH, MPA, MHSA).

H. Fellowship Eligibility

> *"Physicians who have completed a residency program in a core specialty designated for accreditation by ACGME are eligible to enter Sponsoring Institution-based fellowships." (ACGME Policies and Procedures, Section 12.30.h)*

Completion of a residency program in any core specialty designated for ACGME accreditation should be required for a physician to enter a Sponsoring Institution-based fellowship program in correctional medicine. A fellowship program should ensure that physician leaders across medical specialties are eligible for appointment, provided that ongoing clinical practice opportunities in the core specialty are available to fellows while they are appointed to the

program. A fellowship program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of fellows, faculty members, senior administrative staff members, and other relevant members of its academic community.

I. Experiential Education

> *"The educational program of the fellowship is primarily experiential." (ACGME Policies and Procedures, Section 12.30.i)*

The curriculum for a fellowship in correctional medicine should consist primarily of experiential learning. Fellows should participate in clinical and administrative rotations in at least two correctional settings, including a minimum of one prison and one jail. These settings should provide experience in addressing the full scope of acute and chronic medical and mental health issues of patients. Fellows should learn to administratively manage care through exposure to systems components that are critically important for care and health outcomes in corrections, including intake, transfers to and from correctional and health care facilities, community supervision, and transition services for community re-entry.

Educational experiences in correctional medicine are distinct from those in other graduate medical education programs because of differences in patient populations, service delivery models, and environments for practice. Physicians in carceral settings care for patients who are poorer and sicker than the general population, who are generally prohibited from receiving assistance through Medicaid and other public programs while incarcerated, and for whom private insurance plays a limited role.[46,47] Many patients have not received prior care and may be likely to require medical interventions for acute or chronic medical issues. There is a routine need for physicians to recognize and address SUDs and mental illnesses, which are highly prevalent among incarcerated patients.

The competent practice of medicine in prisons, jails, and other detention facilities requires physicians to participate in and lead efforts to diminish inequities in health and health care. Fellows should develop an understanding of relevant social, criminal justice, and health policy issues, and consciousness of the structural conditions for incarceration and its effects on the health of people who are incarcerated or detained.

Health service delivery systems in prisons, jails, and detention centers have different decision-making and oversight structures and processes from care provided outside these settings; few of the oversight and regulatory processes that govern health care services pertain in carceral settings. In many care activities, physicians draw upon skills that are needed to provide an appropriate standard of care while meeting the demands of their profession and working within correctional system requirements, governance structures, and decision-making processes. Physicians adapt to highly variable and setting-specific medical records systems and function within different formularies and medication administration protocols. To provide appropriate care, physicians must navigate consent and custody issues, which often have ethical implications. Physicians play a vital role in maintaining patients' health while incarcerated, and

in preparing patients for release, and should be able to facilitate the provision of transitional services that enhance social support and continuity of care, and ensure the receipt of health-promoting benefits.

During the fellowship, fellows should have rotation experience in the administration of health care in corrections, to include resource management, budgeting, leadership, regulatory processes, and quality improvement. In these rotations, fellows will participate in the activities of leadership teams under the mentorship and supervision of physicians within correctional health systems. Fellows will also have progressive responsibility for day-to-day management responsibilities through focused experiences within correctional systems, and responsibility for collaboration with individuals with administrative leadership responsibility in prisons and jails.

The ACGME should set standards that determine appropriate learning environments for experiences in correctional medicine. Clinical learning environments for the fellowship can provide experience in federal, state, county, municipal, tribal, or other jurisdictions. Experience in immigration detention centers, health care for women, health care for transgender individuals, and juvenile detention centers may provide opportunities for fellows to develop competence in providing care in specialized settings. Fellowship experiences may occur in hospitals, clinics, and community-based care sites where care is provided to currently or previously incarcerated people. Observational and/or administrative experience may be obtained in courts, agencies, or organizations responsible for community supervision or transition services, and other educational sites.

The program director, through mentorship and supervision, should ensure that fellow experiences contribute to the attainment of competence in correctional medicine. The program director and core physician faculty members should possess specialty or subspecialty certification by a member board of the American Board of Medical Specialties (ABMS) or the AOA. In the aggregate, physician faculty members should have expertise in primary and emergency care, as well as behavioral health, addiction treatment, women's health, and pediatric and adolescent health. Programs must prepare fellows to function within interprofessional teams, and may engage interprofessional team members that could include nurses, nurse practitioners, physician assistants, pharmacists, case managers, social workers, physical therapists, dentists, hygienists, psychologists and other mental health professionals, nutritionists, and others.

Occupational safety in prisons and jails should be emphasized in fellows' educational experiences. This should be accomplished through direct supervision and progressive autonomy of fellows, which may rely on program director and faculty mentorship, as well as peer support systems. Particular attention should be paid to orienting fellows to site-specific safety issues, and rotational safety when transitioning between educational experiences at participating sites.

Protected time to attend a regularly scheduled, moderated, peer supervision group with skilled facilitation for fellows across all fellowships should be incorporated into each fellow's

experience. The purpose of such a group would be tri-fold: to develop a network of colleagues; to learn alternate approaches to complex care from different systems; and to provide a safe space in which to process the challenges – emotional, physical, ethical, and others – that may arise during this work.

At the beginning of rotation experiences in prisons, jails, and other carceral settings, fellows should be provided with a thorough introduction to workforce safety-related policies and protocols, including rules for interacting with patients, security and safety systems, incident reporting, communications protocols, work attire regulations, and restrictions on materials to avoid unintended use by patients. Fellows should receive training in situational and environmental awareness, including assessing and mitigating risks, responding to and de-escalating situations, requesting help, and using basic self-defense tactics. Faculty members should guide fellows regarding limits to disclosure of personal information to patients and access to information about the care they are receiving. Programs must have systems and education in place addressing physical and mental workplace injury, including assault, harassment, and psychological trauma. Fellows should be trained in infection control and exposure to controlled substances in correctional settings.

Lectures, workshops, and journal clubs utilizing remote communities of learning (e.g., ECHO model[48]) may provide important support for the scholarly environment in fellowship programs. Scholarly activity and research projects may be linked to the goals and objectives of rotation experiences and should be aligned with individual fellows' interests. For fellowship programs following the two-year format, there should be flexibility to meet some ACGME requirements for experiential and didactic education through fellows' participation in degree- or certificate-granting activities. In determining the potential role for degree-granting programs (e.g., MPH, MHA, MPA) in fellowships, Sponsoring Institutions should consider the time needed to pursue a degree; the rigidity/flexibility of curriculum; the opportunity cost to experiential learning; the difficulty of completing a Master's degree in a one-year fellowship format; and the variability of focus on physician learning in Master's degree programs. With respect to certificate-granting programs, Sponsoring Institutions should consider the potential for standardization of program structure; consistency with core knowledge, skills, attitudes, and exposures of the fellowship; and the enhancement of scholarly activity. The integration of degree- or certificate-granting activities with the fellowship program may be facilitated by institutional partnerships with other organizations (e.g., schools or medicine or public health).

Achievement of competence in the fellowship will be measured with reference to the goals and objectives of these experiences. Fellows should be evaluated no less frequently than every three months using objective, competency- and Milestone-based performance evaluations based on feedback from multiple sources.

IV. Guidance for Implementation of the Sponsoring Institution-Based Fellowship

A. Accessibility of Accreditation to Sponsoring Institutions

Any ACGME-accredited Sponsoring Institution should be eligible to sponsor a fellowship in correctional medicine. The ACGME accreditation model for fellowships in correctional medicine should:

- account for variability and adaptivity of types of settings, resource availability, and experiential learning opportunities;
- anticipate that faculty members and mentors representing multiple professions may be involved in the supervision and education of fellows;
- facilitate networking of programs and individuals in Sponsoring Institutions with shared interests;
- permit the appropriate and effective use of shared educational resources, and technology for distance education;
- enable the local definition of career paths in correctional medicine that prioritize the needs of underserved areas/populations; and,
- emphasize the importance of community engagement.

B. Ongoing Clinical Practice

Fellows in correctional medicine should have opportunities to pursue ongoing clinical practice in their primary specialty and/or subspecialty while completing the program. While responsibilities for direct care for patients who have not experienced incarceration are outside the scope of the fellowship, fellows' engagement in this practice may facilitate their continued professional development as clinicians.

Under current ACGME requirements for subspecialty fellowship programs, ACGME Review Committees may allow fellows to engage in unsupervised practice in their primary specialties.[49] This option should be studied for adaptation in the Program Requirements for the Sponsoring Institution-based fellowship in correctional medicine. In the accreditation of fellowship programs, the ACGME should ensure that fellows' ongoing clinical practice obligations are appropriately balanced with their fellowship education. This will require Sponsoring Institutions and their fellowship programs to provide some oversight of ongoing clinical practice and its effects on fellows' participation in their programs.

Correctional medicine programs will be expected to ensure that fellows have adequate time to complete their responsibilities in the fellowship. When determining appropriate specifications for ongoing clinical practice in the Sponsoring Institution-based fellowship, the ACGME should consider the Common Program Requirements (Fellowship), which restrict fellows' time in independent practice. The expectation would be that ongoing clinical practice would not exceed 50 percent of fellows' working time.

Because it is external to the correctional medicine fellowship, ongoing clinical practice in a fellow's primary specialty or subspecialty should be optional for the fellow. In developing its accreditation guidance for the fellowship, the ACGME should address the potential for physicians' part-time participation in Sponsoring Institution-based fellowships, which may extend

physicians' time in the program and may be compatible with certain options for ongoing clinical practice.

C. Internal Development Grant to Support Fellowship Accreditation

In September 2021, the ACGME Board of Directors approved staff recommendations to develop this accreditation designation proposal based on the preliminary assessment of accreditation opportunities in correctional medicine. At that time, the Board indicated that the proposal should include specifications for an internal development grant of up to four years to develop this new type of fellowship through enhanced outreach and collaboration.

Through this internal grant, the ACGME should study opportunities and challenges for fellowships in correctional medicine as the basis for further development of fellowship accreditation, collaboration with other organizations, and education and outreach activities for Sponsoring Institutions. GME programs in correctional medicine will differ from other ACGME-accredited programs in learning experiences that are specific to the care delivery models and clinical learning environments in carceral settings. These differences should be further explored in the ACGME's outreach and collaboration efforts, and foci may include, but not be limited to:

- systems supporting safety, quality, and risk management;
- institutional partnerships and affiliations with participating sites;
- institutional collaboration in curriculum development and delivery;
- program director and faculty development;
- fellow credentialing and onboarding processes;
- fellow transitions between rotation sites; and,
- policy and legislative contexts for health care/education financing.

In addition to these activities, the grant should support the exploration of opportunities for specialty and subspecialty GME to educate and train physicians in providing health care for currently and formerly incarcerated people outside of carceral settings. This exploration should consider ways in which residents and fellows may be involved in optimizing community health outcomes, such as participation in health interventions intended to prevent incarceration and to enhance social and family support for incarcerated people.

In planning and implementing the outreach and collaboration activities supported by the internal grant, the ACGME Department of Sponsoring Institutions and Clinical Learning Environment Programs should ensure they are separated from program review processes to avoid conflicts of interest in fellowship accreditation. The activities should focus on shared learning and engagement that includes Sponsoring Institutions, organizations interested in the improvement of health care and population health, and ACGME staff members.

D. Fellowship Accreditation Process

Responsibility for accreditation decisions will be assigned to the ACGME Institutional Review Committee, which will ensure the inclusion of expertise necessary to provide peer review evaluation of Sponsoring Institution-based fellowship programs in correctional medicine. The ACGME Board's delegation of accreditation authority for the fellowship may necessitate the addition of accreditation functions to the existing Institutional Review Committee, which may include augmentation of the Review Committee for functions related to the review of correctional medicine fellowship programs.

The Department of Sponsoring Institutions and Clinical Learning Environment Programs, in collaboration with other ACGME departments, will be responsible for the implementation of the Sponsoring Institution-based fellowship in correctional medicine, including the development of Program Requirements and accreditation processes, at the direction of the ACGME's Board of Directors and President and Chief Executive Officer, and in accordance with ACGME Policies and Procedures.

Attachment 1

Advisory Group Members	
Name	**Title**
Donald M. Berwick, MD (Advisory Group Co-Chair)	President Emeritus and Senior Fellow Institute for Health care Improvement
Yolanda Hill Wimberly, MD (Advisory Group Co-Chair)	Chief Health Equity Officer, Grady Memorial Hospital
Elisa Crouse, MD	DIO, Associate Dean of Graduate Medical Education University of Oklahoma College of Medicine
Elizabeth Ford, MD	Director of Mental Health and Criminal Justice Initiatives New York State Psychiatric Institute
Robert Juhasz, DO	Clinical Professor of Medicine Ohio University Heritage College of Osteopathic Medicine
Cynthia Kelley, DO	DIO, Vice President, Medical Education Summa Health
Eleni O'Donovan, MD	Director of Education, Medical Director District of Columbia Department of Corrections
Olubenga Ojo, MD	Chief Medical Officer, Chief Physician Executive Texas Department of Criminal Justice Hospital
Steven Rose, MD	DIO Mayo Clinic College of Medicine and Science
Michelle Staples-Horne, MD	Medical Director Georgia Juvenile Department of Justice
Carolyn Sufrin, MD, PhD	Assistant Professor of Gynecology and Obstetrics Johns Hopkins Medicine
Vikki Wachino	Principal, Viaduct Consulting, LLC, and Former Deputy Administrator and Director of the Center for Medicaid and CHIP Services
Emily Wang, MD	Professor of Medicine and Public Health Yale School of Medicine
Brie Williams, MD, MS	Professor of Medicine, Center for Vulnerable Populations University of California, San Francisco
Johnny Wu, MD	Chief of Clinical Operations Centurion, LLC
ACGME Staff Members	
Name	**Title**
Philip Jackson, MPA	Accreditation Administrator, Institutional Accreditation
Paul Foster Johnson, MFA	Executive Director, Institutional Accreditation
Olivia Orndorff, MSLIS	Associate Executive Director, Institutional Accreditation
Cassandra Pritchard, MPP	Senior Accreditation Administrator, Institutional Accreditation
Kevin Weiss, MD, MPH	Chief Sponsoring Institutions and Clinical Learning Environment Programs Officer

Attachment 2

Selected Bibliography

Abbott PA, Brooker R, Hu W, Hampton S, Reath J. “I just had no idea what it was like to be in prison and what might be helpful”: educator and learner views on clinical placements in correctional health. Teach Learn Med. 2020;32(3):259-270. doi:10.1080/10401334.2020.1715804

Alemagno SA, Wilkinson M, Levy L. Medical education goes to prison: why?. Acad Med. 2004;79(2):123-127. doi:10.1097/00001888-200402000-00005

American Osteopathic Association. Basic standards for fellowship training in correctional medicine. August 2012.

Fuehrlein BS, Jha MK, Brenner AM, North CS. Availability and attitudes toward correctional psychiatry training: results of a national survey of training directors. J Behav Health Serv Res. 2014;41(2):244-250. doi:10.1007/s11414-013-9336-0

Gips J, Spiegel A, Norton A, et al. Health care in the age of mass incarceration: a selective course for medical students in their preclinical years. MedEdPORTAL. 2020;16:11014. Published 2020 Nov 12. doi:10.15766/mep_2374-8265.11014

Glenn JE, Bennett AM, Hester RJ, Tajuddin NN, Hashmi A. “It's like heaven over there”: medicine as discipline and the production of the carceral body. Health Justice. 2020;8(1):5. Published 2020 Feb 8. doi:10.1186/s40352-020-00107-5

Hale JF, Haley HL, Jones JL, Brennan A, Brewer A. Academic-correctional health partnerships: preparing the correctional health workforce for the changing landscape—focus group research results. J Correct Health Care. 2015;21(1):70-81. doi:10.1177/1078345814558057

Haley HL, Ferguson W, Brewer A, Hale J. Correctional health curriculum enhancement through focus groups. Teach Learn Med. 2009 Oct;21(4):310-7. doi: 10.1080/10401330903228513.

Hart D. Health risks of practicing correctional medicine. AMA J Ethics. 2019;21(6):E540-E545. Published 2019 Jun 1. doi:10.1001/amajethics.2019.540

Hashmi AH, Bennett AM, Tajuddin NN, Hester RJ, Glenn JE. Qualitative exploration of the medical learner's journey into correctional health care at an academic medical center and its implications for medical education. Adv Health Sci Educ Theory Pract. 2021;26(2):489-511.

Holoyda BJ, Scott CL. Psychiatric education in the correctional setting: challenges and opportunities. Int Rev Psychiatry. 2017;29(1):11-20. doi:10.1080/09540261.2016.1222356

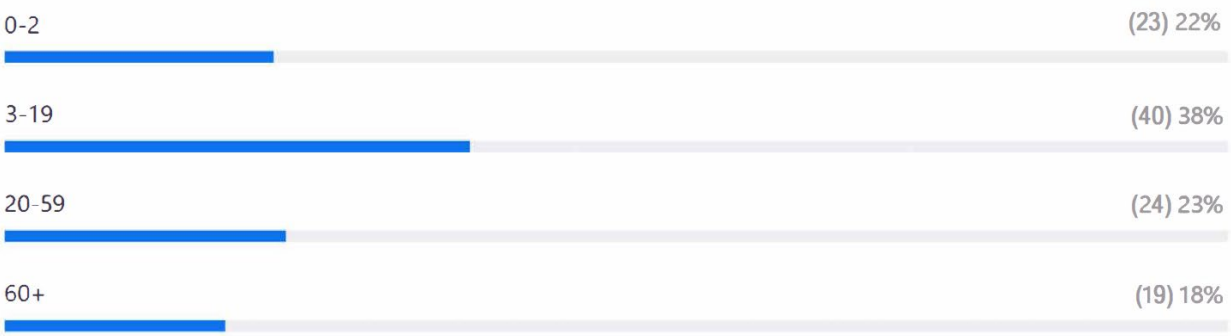
Wakeman SE, Rich JD. (2010). Fulfilling the mission of academic medicine: training residents in the health needs of prisoners. Journal of general internal medicine, 25 Suppl 2(Suppl 2), S186–S188. https://doi.org/10.1007/s11606-010-1258-4

White Hughto JM, Clark KA. Designing a transgender health training for correctional health care providers: a feasibility study. Prison J. 2019;99(3):329-342. doi:10.1177/0032885519837237

Attachment 3

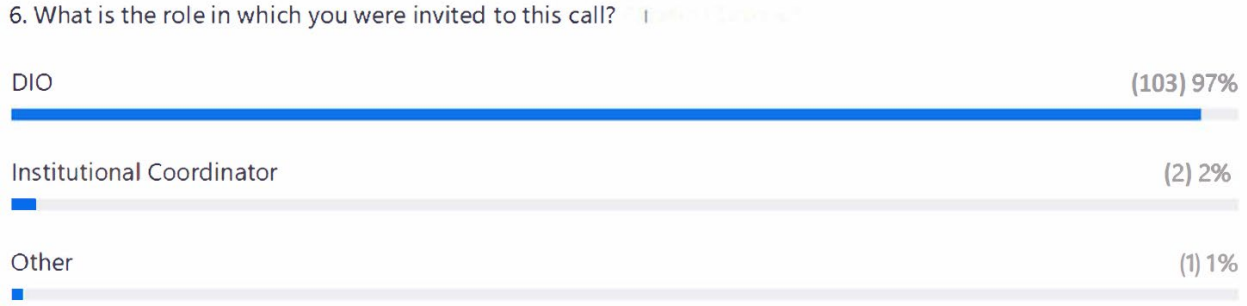
DIO Poll Results (n=106)

1. How many ACGME-accredited programs does your Sponsoring Institution have?



2. Do you have one or more clinical learning environments that serve incarcerated patients?

3. Does your sponsoring institution have an academic unit or healthcare organizational partner that currently offers some type of training for physicians in correctional medicine?



References

[1] Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Affairs. 2008;27(3):759–769.
[2] Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: care of the patient requires care of the provider. Ann Fam Med. 2014;12(6):573-576.

[3] ACGME. 2020 Strategic Plan Summary. Accessed March 27, 2022.
[4] US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Accessed March 27, 2022.
[5] ACGME. 2020 Strategic Plan Summary.
[6] Kluckow R, Zeng Z. Correctional populations in the United States, 2020 – statistical tables. US Department of Justice, Bureau of Justice Statistics, Office of Justice Programs. March 2022. Accessed May 10, 2022.
[7] Minton TD, Zeng Z. Jail inmates in 2020 – statistical tables. US Department of Justice, Bureau of Justice Statistics, Office of Justice Programs. December 2021. Accessed May 10, 2022.
[8] Redemske D. Providing health care in the prison environment. Policy analysis. Accessed March 27, 2022.
[9] Rich JD, Allen SA, Williams BA. The need for higher standards in correctional health care to improve public health. Journal of General Internal Medicine. 2015;30(4): 503-507.
[10] Allen SA, Wakeman SE, Cohen RL, Rich JD. Physicians in US prisons in the era of mass incarceration. Int J Prison Health. 2010;6(3):100-106.
[11] Haley HL, Ferguson W, Brewer A, Hale J. Correctional health curriculum enhancement through focus groups. Teaching and Learning in Medicine. 2009;21(4):310-317.
[12] ACGME Policies and Procedures. (Section 12.30.) Effective February 25, 2022. https://acgme.org/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf. Accessed April 13, 2022.

[13] Gips J, Spiegel A, Norton A, et al. Health care in the age of mass incarceration: a selective course for medical students in their preclinical years. MedEdPORTAL. 2020;16:11014.
[14] Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. Annu Rev Public Health. 2012 Apr;33:325-39. doi: 10.1146/annurev-publhealth-031811-124614.
[15] Bui J, Wendt M, Bakos A. Understanding and addressing health disparities and health needs of justice-involved populations. Public Health Rep. 2019;134(1_suppl):3S-7S. doi:10.1177/0033354918813089
[16] Bai JR, Befus M, Mukherjee DV, Lowy FD, Larson EL. Prevalence and predictors of chronic health conditions of inmates newly admitted to maximum security prisons. J Correct Health Care. 2015 Jul;21(3):255-64. doi: 10.1177/1078345815587510
[17] Gough, E., Kempf, M.C., Graham, L. et al. HIV and Hepatitis B and C incidence rates in US correctional populations and high risk groups: a systematic review and meta-analysis. BMC Public Health 10, 777 (2010). https://doi.org/10.1186/1471-2458-10-777
[18] Fazel S, Yoon IA, Hayes AJ. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. Addiction. 2017 Oct;112(10):1725-1739. doi: 10.1111/add.13877.
[19] Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014 Feb;103:126-133. doi: 10.1016/j.socscimed.2013.06.032.
[20] Brinkley-Rubinstein, L. Incarceration as a catalyst for worsening health. Health Justice 1, 3 (2013). https://doi.org/10.1186/2194-7899-1-3
[21] Binswanger IA, Redmond N, Steiner JF, Hicks LS. Health disparities and the criminal justice system: an agenda for further research and action. J Urban Health. 2012 Feb;89(1):98-107. doi: 10.1007/s11524-011-9614-1.
[22] Minton, Zeng. Jail inmates in 2020 – statistical tables.
[23] Fazel, Yoon, Hayes. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women.
[24] Hashmi AH, Bennett AM, Tajuddin NN, Hester RJ, Glenn JE. Qualitative exploration of the medical learner's journey into correctional health care at an academic medical center and its implications for medical education. Adv Health Sci Educ Theory Pract. 2021;26(2):489-511.
[25] Glenn JE, Bennett AM, Hester RJ, Tajuddin NN, Hashmi A. "It's like heaven over there": medicine as discipline and the production of the carceral body. Health Justice. 2020;8(1):5. Published 2020 Feb 8. doi:10.1186/s40352-020-00107-5
[26] Holoyda BJ, Scott CL. Psychiatric education in the correctional setting: challenges and opportunities. International review of psychiatry. 2017;29(1):11-20. Accessed February 2, 2022. https://search.ebscohost.com/login.aspx?direct=true&db=edsbl&AN=vdc.100048542350.0x000001&site=eds-live

[27] Scotti S. Health care in and out of prison. State legislatures. 2017;43(8):22-23. Accessed February 1, 2022. https://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=28914521&site=eds-live
[28] Pont J, Stöver H, Wolff H. Dual loyalty in prison health care. Am J Public Health. 2012 Mar;102(3):475-80. doi: 10.2105/AJPH.2012.300374.
[29] Berwick, Nolan, Whittington. The Triple Aim: care, health, and cost. 759–769.
[30] Bodenheimer, Sinsky. From Triple to Quadruple Aim: care of the patient requires care of the provider. 573-576
[31] Wakeman, S. E., & Rich, J. D. (2010). Fulfilling the mission of academic medicine: training residents in the health needs of prisoners. Journal of general internal medicine, 25 Suppl 2(Suppl 2), S186–S188. https://doi.org/10.1007/s11606-010-1258-4
[32] Haley, Ferguson, Brewer, Hale. Correctional health curriculum enhancement through focus groups. 310-317.
[33] American Osteopathic Association. Basic standards for fellowship training in correctional medicine. August 2012.
[34] Sawyer W, Wagner P. Mass incarceration: the whole pie 2022. Prison Policy Initiative. March 14, 2022. https://www.prisonpolicy.org/reports/pie2022.html. Accessed April 2, 2022.
[35] World Health Organization. Global health workforce statistics. World Bank Open Data. https://data.worldbank.org/indicator/SH.MED.PHYS.ZS. Accessed April 2, 2022.
[36] Pew Charitable Trusts. Prison health care: costs and quality: how and why states strive for high-performing systems. April 2017. https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality. Accessed April 2, 2022.
[37] The Sentencing Project. State-by-state data. (US Bureau of Justice statistical data for 2019). https://www.sentencingproject.org/the-facts/#map. Accessed April 2, 2022.
[38] Rorvig L, Williams B, Ahalt C. Assessing medical systems for the CA prison health care receivership: maintaining a qualified provider workforce: recruitment. (Final Report). California Correctional Health Care Services. June 12, 2019. https://cchcs.ca.gov/. Accessed April 2, 2022.
[39] Paris J. ACCP/SCP history. https://accpmed.org/accp_scp_history.php. Accessed April 4, 2022.
[40] Academic Consortium on Criminal Justice Health. https://www.accjh.org/about-us. Accessed April 4, 2022.
[41] American Osteopathic Association. Subspecialty certification in correctional medicine. https://certification.osteopathic.org/correctional-medicine/certification-process/correctional-medicine/. Accessed April 8, 2022.
[42] National Commission on Correctional Health Care. https://www.ncchc.org/. Accessed April 4, 2022.
[43] American Correctional Association. https://www.aca.org/. Accessed April 4, 2022.
[44] Holoyda, Scott. Psychiatric education in the correctional setting: challenges and opportunities. 11-20.
[45] George Washington University School of Medicine & Health Sciences. GW launches correctional health administration online master's program. June 6, 2019. https://smhs.gwu.edu/news/gw-launches-correctional-health-administration-online-masters-program. Accessed April 8, 2022.
[46] Haley, Ferguson, Brewer, Hale. Correctional health curriculum enhancement through focus groups. 310-317.
[47] ACGME Policies and Procedures. (Section 12.30.).
[48] Project Echo - moving knowledge, not people. Accessed May 17, 2022. https://hsc.unm.edu/echo/.
[49] ACGME Common Program Requirements for fellowships. Effective July 1, 2020. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRFellowship2021.pdf. Accessed April 8, 2022.