Health Care Reform
What’s Next for Corrections?

Meet the 2012 NCCHC Award Winners!

Emergency Severity Index for Individualized Patient Triage
Fetal Alcohol Spectrum Disorders in Corrections
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CHORDS Moves Into Phase 2

The Correctional Health Outcomes and Resource Data Set is an innovative, client-driven quality improvement effort that is providing much-needed data for comparison of clinical processes and outcomes in correctional systems. Modeled after standardized clinical performance measurement systems such as the Healthcare Effectiveness Data and Information Set, CHORDS is a flexible, customizable platform designed from the ground up by correctional professionals and experts in this field.

The project has completed its first phase, in which 66 participants shared data on nine diabetes-related measures, data were analyzed and reports generated. Phase II is now underway. This includes developing additional measures and adding new participants. Phase II measures will continue to focus on medical conditions prevalent among the incarcerated population and will be selected by correctional health experts. Measure domains under development include anticoagulation, hypertension, dyslipidemia and HIV.

The benefits from taking part in CHORDS are many. CHORDS provides participants with powerful tools for understanding and managing the health of their inmates. Importantly, having a better handle on clinical outcomes is a major step toward managing health care costs. There are numerous ways to study performance data and CHORDS provides a high level of flexibility. The data are available in spreadsheet format and may be readily converted to charts or simple tables for presentation. As data continue to be stored and analyzed, CHORDS’ ability to support benchmarking and comparisons will strengthen. The project also may be developed to enable provider-level reporting so that clinical leaders can monitor outcomes down to the individual clinic or clinician.

There is no direct cost to participate, but an electronic medical record or other means to readily extract and export data is helpful. Participants interested in supporting measure development, analysis, presentation of results or other activities beyond data gathering are welcome to communicate their ideas and interest to NCCHC. In addition, NCCHC staff members will be available throughout all phases of CHORDS to answer questions and to provide technical assistance.

Director of Accreditation

The National Commission on Correctional Health Care announces an exciting opportunity. We are seeking a health care professional who wants to have an impact on national standards, health policy and correctional health practice performance measures.

NCCHC’s director of accreditation position requires a person who is visionary and committed to improving health care in correctional settings. This is a key management and leadership position in the organization, responsible for developing standards and performance measures for health care delivery in a variety of institutional settings. The director of accreditation must be comfortable and adept at building effective and productive relationships throughout the correctional health care field and will depend on these partnerships for success. The director will be committed to building and maintaining a collaborative environment with key volunteer work groups.

The director of accreditation is directly responsible for the management of two FTEs and interacts with support and other staff in the areas of strategic planning, marketing and budgeting. The director manages and undertakes very task-oriented, hands-on work on a day-to-day basis.

Qualifications: Five years of continuous experience in correctional health. Master’s-level postgraduate education is preferred. Background in supervision or planning required. Significant experience and success in senior management of a health care organization preferred. Proven articulate and agile communication skills with multiple audiences and formats (both written and oral).

Application: Qualified candidates may submit letters of interest and resumes to Dr. R. Scott Chavez, Vice President, NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614; scottchavez@ncchc.org or call 773-880-1460, x-287.

NCCHC is an equal opportunity not-for-profit employer.
Meet Judith Robbins, NCCHC’s New Board Chair

Judith Robbins, JD, LCSW, CCHP-A, became chairwoman of NCCHC’s board of directors at its annual meeting in October. She has served on the board since 2005, when, at her suggestion, the National Association of Social Workers became a supporting organization of NCCHC and she became NASW’s liaison to the board.

With a master’s degree in social work, Robbins has dedicated her career to helping individuals and families in distress, and teaching others to do the same. For 12 years, until her retirement in 2012, Robbins directed the juvenile detention mental health program in Connecticut, where services are provided by Yale Medical School’s department of psychiatry. She remains active professionally through work as a clinical social worker at Yale-New Haven Hospital and teaching social work courses at the university level.

In the early years of her career, Robbins was based at Yale Psychiatric Institute (now Yale-New Haven Psychiatric Hospital), providing treatment services and, increasingly, taking on administrative roles. Through this work she had some interaction with the criminal justice system, but she never expected that the correctional milieu would become her primary interest.

From Hospital to Detention Center

That changed in 1996 when, while working as an administrator on an adolescent psychiatric unit, she received a call from a colleague at the Connecticut Judicial Branch.

“Connecticut’s pretrial juvenile detention centers had been ordered by the federal court to improve health care services,” Robbins explains. “I was asked to come aboard to develop a mental health program for the pretrial kids. For 16 years, I worked in the trenches in that program as an administrator and a clinician. Despite it being very hard work, it was the best experience of my career.”

The federal consent decree required that the facilities become accredited by NCCHC, and that’s how Robbins learned about the Commission. Establishing the mental health program was a daunting task, but she felt a great sense of relief when she was given a copy of the NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities.

“As I read the standards, I felt increasingly hopeful—and very grateful to NCCHC,” says Robbins. “That day, my bond with NCCHC was set in stone.” She credits the juvenile standards as a major force in improving the correctional health services in the state’s juvenile detention centers, and the largest facilities did indeed become accredited.

Given her strong dedication to the juvenile population, it was only natural that Robbins would participate on NCCHC’s juvenile health committee, and she also served as its chair for several years. During that time the committee oversaw a revision of the Juvenile Standards as well as development of several clinical guidelines tailored for the juvenile correctional setting.

As board chair, Robbins’ scope of interest is broader. “I am attuned to all issues impacting upon NCCHC’s health and growth,” she says. “Above all, I’m greatly interested in strategies to substantively involve more correctional professionals and settings with NCCHC and its accreditation program.” This mission is important to her because she knows how valuable NCCHC guidance and support can be; she experienced it firsthand when developing and directing Connecticut’s juvenile detention mental health program.

A Career in Brief

Professional Positions
- Clinical social worker, Yale-New Haven Hospital, New Haven, CT (current)
- Director, juvenile detention mental health program, department of psychiatry, Yale Medical School
- Special projects administrator, Yale Psychiatric Institute
- Clinical administrator, adolescent service, Yale Psychiatric Institute

Academic Appointments
- Adjunct faculty, online social work master’s program, University of New England, Portland, ME
- Assistant clinical professor, social work, department of psychiatry, Yale Medical School

Professional Activities
- Joint Commission’s Behavioral Health Professional and Technical Committee (representing NASW), 2010-2011
- Academy of Correctional Health Professionals board of directors, including a term as chair, 2005-2011
- NCCHC board of directors, including executive, finance and juvenile health committees, ongoing

Education
- JD, Quinnipiac College School of Law, Hamden, CT
- Master’s in social work, Columbia University, New York
- Master’s in community planning, University of Rhode Island, Kingston

In Other Board News . . .
- Renee Kanan, MD, MPH, was selected as chair-elect at the October meeting of the NCCHC board. Since 2005 she has served as the liaison of the American College of Physicians. Kanan is the chief quality officer for California Correctional Health Care Services, overseeing all strategic performance management activities in the state’s prison health care system.
- Steven Shelton, MD, CCHP-A, has been named liaison of the Society of Correctional Physicians, an organization of which he is a charter member and past president. Shelton is the medical director of the Oregon Department of Corrections.
Drumroll, Please ... Announcing the 2012 NCCHC Award Winners!

NCCHC's annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud this year's recipients of the most prestigious awards in this field.

Bernard P. Harrison Award of Merit
NCCHC's highest honor, this award is presented to an individual or group that has demonstrated excellence and service that has advanced the correctional health care field, either through an individual project or a history of service. The award is named after NCCHC's cofounder and first president.

Earl Dunlap
The movement to reform juvenile detention policies and practices may have been inevitable, but it certainly got a jump-start when Earl Dunlap entered the scene. Thirty-two years after implementing significant reforms at the troubled Jefferson County (KY) Youth Center, Mr. Dunlap is now a national leader in promoting the cause of juvenile justice and a foremost expert who has helped dozens of juvenile facilities across the country. Since 2007, when a federal judge appointed him to serve as transitional administrator, he has led much-needed reforms at the Cook County (IL) Juvenile Temporary Detention Center.

Mr. Dunlap has worked with youth for his entire career, starting as a probation officer in Lenawee County, MI, in 1969 and a few years later working as a counselor and administrator in the county's juvenile home. Even during this early period, he extended his service as a consultant to other jurisdictions. From 1976 to 1980, Mr. Dunlap served as director of the Monroe County (MI) Youth Center, where for the first year he oversaw the design and construction of a new 45-bed facility and developed all of the programs and the staffing plan necessary to serve the population mix of short-term and long-term placements.

With that invaluable experience, in 1980 Mr. Dunlap was recruited by Jefferson County. During his 11 years as director of youth placement services, he also took on two other county roles: director of child protective services and administrator of the nation's first exploited and missing child unit. And his achievements—and reputation—began to grow. A proponent of the theory that detention should be conceptualized more as a process than a place, and that less restrictive placements should be used when feasible, Mr. Dunlap developed precustodial release criteria and implemented a range of alternative placement programs that reduced the secure custody population from an average of 90 per day to 25. He also brought the facility into compliance with NCCHC standards and attained accreditation.

In 1987, Dr. Grisso joined University of Massachusetts Medical School, Worcester, where he serves as director of the law and psychiatry program, director of psychology and professor of psychiatry. He is executive director of the American Board of Forensic Psychology and a former president of the American Psychological Association’s Division 41/American Psychology—Law Society. His research and teaching have focused on improving forensic evaluations for the courts and informing policy and law for youths in the juvenile justice system and for persons with mental disorders.

In pursuing this work, Dr. Grisso has made extensive contributions to the literature, which is the focus of the Award of Excellence. He has authored, coauthored or edited 16 books on topics related to mental health and the law; served as coeditor for a book series on best practices in forensic mental health assessment; contributed some 40 book chapters, and wrote or contributed to well over 100 journal articles and published reviews and reports.

Notable works include his landmark 1986 text, Evaluating Competencies: Forensic Assessments and Instruments as
well as Youth on Trial: A Developmental Perspective on Juvenile Justice (2000), for which he won a book award from the Society for Research on Adolescence. More recent works include Double Jeopardy: Adolescent Offenders With Mental Disorders (2004), Mental Health Screening and Assessment in Juvenile Justice (2005) and Evaluation of Juveniles’ Competence to Stand Trial (2008). With his colleagues, he also developed several assessment tools, including the widely used Massachusetts Youth Screening Instrument—Second Version.

In the broader realm of communication, Dr. Grisso has served on the editorial boards of Criminal Justice and Behavior and other peer-reviewed journals, and done peer review for some two dozen journals, including the Journal of the American Academy of Child and Adolescent Psychiatry and the Journal of the American Academy of Psychiatry and the Law. He also has spoken at countless national and international conferences and universities.

NCCHC board member Judith Robbins, JD, LCSW, CCHP-A, experienced an “Aha!” moment when she read Dr. Grisso’s article “Progress and Perils in the Juvenile Justice and Mental Health Movement” (2007). Ms. Robbins, who represents the National Association of Social Workers on the board, says, “For me, in the trenches, this was one of the most sane and intelligent articles I’d read on detention.”

Facility of the Year Award
This prestigious award is presented to one facility selected from among the nearly 500 prisons, jails and juvenile facilities accredited by NCCHC.

Chittendon Regional Correctional Facility
South Burlington, Vermont
An impressive array of programs for inmates is one of the key features that makes this combined jail/prison stand out. Operated by the Vermont Department of Corrections, Chittendon Regional Correctional Facility is a minimum-maximum security facility that houses inmates from three counties as well as transfers from other state facilities and some federal detainees. In August 2011, the population was changed from males to females, both preadjudicated and adjudicated, although males are processed here before being transferred. The average daily population is 185.

The Vermont DOC is committed to rehabilitation, risk reduction and need reduction, and the programs at CRCF reflect that. To assist incarcerated mothers, the facility offers a variety of parenting services. Eligible inmates may participate in the Kids-A-Part Parenting Program, provided by the Lund Family Center, a community-based family support organization. KAPPP develops customized service plans that address both children’s needs and the mother’s goals for reentry. It also offers positive parental interaction through visits, phone calls and mail, weekly parenting education groups and more.

Like KAPPP, other programs are delivered in partnership with community-based groups. For example, the nonprofit Phoenix Houses of New England provides substance abuse treatment services to the women, including reentry assistance. The Vermont Network Against Domestic and Sexual Violence operates the DIVAS program, which promotes “discussing intimate violence and accessing support” using an evidence-based, trauma-informed approach. And employment support is provided by Vermont Works for Women, which facilitates hiring coordination and training for employment at CRCF, prerelease employment planning, mentoring and other services.

Routine health care is also provided, of course, with health staff on-site 24/7. CRCF has been accredited by NCCHC since 1998, and in its latest survey was found to be in 100% compliance with the standards. Overall, the team that selected CRCF as Facility of the Year was impressed with how well staff consistently demonstrated excellence in health services delivery, correctional health care professionalism and a commitment to mothers and their children.

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

Long-Term Care Program
Columbia Care Center, South Carolina
Exceptional quality of care for seriously medically and mentally ill inmates is the hallmark of this subacute, skilled long-term care hospital. Situated on the grounds of a psychiatric hospital run by the South Carolina Department of Mental Health, Columbia Care Center is operated by a private corporation. Inmates served come from several states, the U.S. Marshals Service and U.S. Immigration and Customs Enforcement. For accreditation purposes, the facility is designated as a prison. The four-floor building has more than 300 inpatient beds, of which 120 are in secure areas designated for inmate-patients, the remainder being under the jurisdiction of the SCDMH.

Despite this unusual pairing, operations are seamless, and the health care professionals exercise medical autonomy. In addition to the hospital-level care provided, including on-site radiology and other diagnostic services, arrangements are in place for off-site emergent or specialty care. Continuity of care is enhanced through well-defined processes for internal and external communication, as well as integration of medical and mental health records. Given the high prevalence of patients with acute mental illness, the staff are highly conscientious in appropriate use of restraint and emergency psychotropic medication. The facility also offers hospice care, with trained staff ensuring that patients are comfortable and cared for with dignity during all phases of their terminal illness.

One of the accreditation surveyors who nominated the hospital for the Program of the Year Award commented that the quality of health care delivery and staff professionalism in evidence was indistinguishable from that of the best skilled long-term care hospitals in the community.
Correctional Populations Continue to Decline
The adult correctional population fell by 1.4% (98,900) in 2011, the Bureau of Justice Statistics reported in November. This was the third consecutive year of decline. Overall, about 2.9% of the adult population was in prison or jail or on probation or parole; the lowest rate of adults under correctional supervision since 2000. Most of the decline was due to a drop in the probation population, but the incarcerated population also dropped by 1.3%, bringing the total number of adults in jails and prisons to 2,239,800.

- www.bjs.gov/content/pub/press/cpus11ppus11pr.cfm

Correctional Medical Expenses Rise in Most States
The Bureau of Justice Statistics also recently issued a report on corrections expenditures by the states for the period from 1982 through 2010. Forty-four states provided information on medical expenditures for both 2001 and 2008. For 42 of those states, medical expenditures rose during the seven-year period. New Hampshire had the highest increase (37.2%) while Nevada had the lowest increase (4.5%). The two states that reported a reduction in medical expenses were Texas (-8.1%) and Illinois (-1.9%). Thirty-six of the 44 states had an increase in per capita medical costs from 2001 to 2008, with seven reporting increases of 100% or more. In 2008 California had the highest per capita spending at $11,986 followed by New Hampshire at $9,204. The lowest per capita spending was $2,217 in Illinois.


Diagnosed Diabetes Grows at Dramatic Rate
The prevalence of diagnosed diabetes increased in all U.S. states, the District of Columbia and Puerto Rico between 1995 and 2010, according to a study published Nov. 15 in Morbidity and Mortality Weekly Report. Conducted by the Centers for Disease Control and Prevention, the study found that prevalence rose by 50% or more in 42 states and by 100% or more in 18 states. In 1995 only three states, the District of Columbia and Puerto Rico had a diagnosed diabetes prevalence of 6% or more. By 2010, all 50 states had a prevalence of more than 6%, and six states and Puerto Rico had a rate of 10% or more. There were regional trends, with the largest rise in prevalence in the South, followed by the West, Midwest and Northeast. The study used data from the Behavioral Risk Factor Surveillance System, an annual telephone survey of health behaviors and conditions of U.S. adults that omits institutionalized populations.

- www.cdc.gov/media/releases/2012/p11_15_diagnosed_diabetes.html

Rikers Island Staff and Inmates Pitch in After Sandy
When Hurricane Sandy struck the East Coast in late October, the Rikers Island jail complex in New York City’s East River was spared significant damage, according to an article in the New York Times. In the aftermath, however, corrections commissioner Dora Schriro saw an opportunity for the facility’s staff and inmates to lend a hand to those in the community, where the damage was great. The jail donated generators, gasoline, food, clothing and emergency relief supplies such as bottled water and blankets. Correctional officers made countless deliveries and even used the corrections department buses and vans to transport evacuees and recovery workers. The inmates washed 6,600 pounds of laundry for shelters throughout the city, making this the first time the jail’s enormous laundry operation was used in a city emergency.


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Ignorance of Prison Medication Supported: PDR and ‘Complete Guide’ Withheld

by Fred Cohen, LL.M.

Munson v. Gaetz (7th Cir. 2012) upholds the right of an Illinois prison to prohibit an inmate from purchasing and receiving from the publisher the Physician’s Desk Reference and the Complete Guide to Prescription & Nonprescription Drugs. Inmate Munson, a lifer, had received preliminary approval for his order, but an officer performing the screening function decided against the PDR and Complete Guide, checking two boxes: (1) the books were on the disapproved list and (2) “material otherwise detrimental to security, order, discipline, mental health...”

Munson apparently was not getting ready to attend medical school or even go into the prescription drug business. His very plausible reasons are that he relies on prison personnel for the accuracy of his medications and dosages. Munson once became ill because someone accidentally gave him another inmate’s medication for 12 days. Given the life-threatening nature of such incidents, Munson has taken to educating himself about his medications. He wants to know about side effects, whether various mixtures of the medications for his chronic condition and other ailments could cause illness or death and if he should avoid certain foods. He claims that lack of knowledge causes stress and mental anguish and makes him leery of taking other medications even though prescribed by a physician.

Munson filed pro se and the district court dismissed with prejudice, finding the denial “reasonable” apparently using the Turner “reasonableness” test. The lower court could only imagine the many illicit uses to which books like PDR could be put in prison if there were unfettered access to such books. Apparently, these very books were available in the prison library and sections could be copied for individual inmates’ use.

The lower court labeled Munson’s concerns about medication “quibbles” and — here we are.

Discussion

Munson raises issues under the First Amendment and Eighth Amendment, losing on both. His strongest case is under the First Amendment, but with Turner v. Safely the operative test and this panel not in the mood to quibble with prison censorship, Mr. Munson will have to fight it out at the prison library and take his chances with the prison’s medical provider. The Turner so-called reasonableness test is so permissive of prison regulations that it is more accurately labeled an unreasonableness test.

There is a tinge of embarrassment in the court’s opinion but merely a tinge. The court has to recognize an inmate’s undoubted First Amendment right and then uphold a line officer’s checkbox rejection by creating a basis for a valid (or rational) penal objective. These books, after all, are not about bomb construction, Tunneling for Dummies or A Practical Guide to Making Meth. They are books otherwise available and there is not a single factual referent to support even possible (not probable) danger.

The panel leaves us with support for selective ignorance about medical information that could be vital to Munson’s health or life. If the court had stated, for example, that medical care in this particular prison is so good that Mr. Munson’s fears are chimerical even while the prison’s rationale is fanciful—fanciful trumps chimerical in that case. In King v. Federal Bureau of Prisons (2005), the Seventh Circuit dealt with a decision to bar from an inmate a book about computer programming. Authorities were concerned about inmate King would write a computer program that would plant a virus in the prison’s computers and disrupt the facility. There, the court said we need a little evidence to support the rationality of that fear. Here, evidence is not needed to support the prison’s interest in restricting information about medications. Common sense, the court, provides enough of a basis for this censorship. Who was it that said there is nothing so common as common sense?

Munson’s claim that the denial of these books is an Eighth Amendment violation fails. There is no evidence of deliberate indifference and the right at issue is knowledge, not treatment.

Comment

This is obviously a disturbingly silly opinion coming down so hard on the side of supporting inmate ignorance that it is embarrassing. Good correctional health care, quite the contrary, includes educating inmate-patients about their illness and the treatment; about promoting wellness and reversing often years of miserable health habits.

I am not arguing that Munson is the equivalent of the Catholic Church’s Index and book burning or that the Dark Ages are upon us. I am suggesting that if this case had been placed in the context of correctional health care and the many medication errors that occur in prison settings, a different result should have been obtained.

Fred Cohen, LL.M. is the editor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2012 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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Health Care Reform
What’s Next for Corrections?

by Donna Strugar-Fritsch, BSN, MPA, CCHP

President Obama’s reelection and the Supreme Court’s ruling this past summer have solidified the Patient Protection and Affordable Care Act (“Obamacare” or “the ACA”) as the law of the land. A few states continue challenges to parts of the ACA but most of its key provisions will soon apply to all Americans. The ACA provides several new options for inmate health care and also will likely lead to new challenges for prisons and jails in providing constitutionally sound health care to inmates. This article provides an overview of key elements of the ACA that relate to corrections, insight into their implications and actions that prisons and jails should consider.

Coverage Objective
The fundamental objective of the ACA is to provide affordable health insurance to the uninsured, who are primarily adults employed in low-wage jobs or unemployed. More than 30 million Americans will be eligible for insurance coverage beginning in 2014, through insurance market reforms, federal subsidies for insurance purchased through state-based health insurance exchanges and expansion of the Medicaid program. A sizable portion of the population newly eligible for coverage will be adults involved with the justice system. About 20 million people will remain uninsured after the ACA is implemented—most will be undocumented aliens or people who opt to pay a penalty rather than purchase coverage.

Insurance Market Reform
Effective January 2014, all commercial insurance plans will be prohibited from denying coverage to a person based on preexisting health conditions. Insurance carriers must cover any applicant and cannot terminate coverage based on illness. Lifetime limits on benefits are prohibited. These changes assure coverage for all inmates for any condition at release or parole.

Health Insurance Exchanges
The ACA requires every state to have a Web-based health benefit exchange in operation by January 2014. Each state may operate its own exchange, operate it in partnership with the federal government, or delegate operation fully to the federal government. In any case, the exchange will allow individuals and employees of small businesses to shop for insurance through a user-friendly portal. All exchanges will offer four standardized levels of coverage with several plans available in each level. Plans within each level will be easy to compare for cost, quality and provider network.

Exchanges are intended to spark competition among insurance carriers and result in more numerous and affordable insurance options. New Medicaid applications will also be made through the exchanges, which must use a single enrollment form for all plans and Medicaid. The exchange will interface with the IRS, Social Security Administration and other state and federal sources necessary to determine eligibility electronically in a simple, seamless process.
To assure that health insurance is affordable, the ACA provides premium subsidies for individuals and families. The federal government will pay graduated subsidies to persons with incomes at 100% to 400% of the federal poverty level. In 2012, the income range for individuals is $11,170 to $44,680 and for a family of four it is $23,050 to $92,200. These subsidies are intended to assure that health insurance premiums account for no more than 9.5% of a family’s wages. Subsidies are available only for insurance plans purchased from an exchange.

According to the ACA, individuals are not qualified to enroll in a health plan through an exchange “if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.” This provision implies that a detainee who is enrolled in an exchange plan and in a pretrial status or otherwise awaiting disposition should be covered by that insurance plan during incarceration. A large portion of the nation’s jail population is awaiting disposition of charges, and this provision may offer a new option for health care services provided to those detainees. Jails may be able to bill insurance plans for prescription drugs, physical exams, mental health services and other on- and off-site care. However, such arrangements will be challenging to establish and administer and must account for plan-specific provider networks, prior authorizations and many other factors.

**Medicaid Expansion**

States and the federal government share the cost of the Medicaid program. Each state receives federal matching funds for Medicaid services, and today the match rate ranges from 50% to 74%. For every $10 a state spends, the federal government matches $5.00 to $7.40.

Today, eligibility for Medicaid is determined by category and income. Pregnant women, children and adults age 65 or older who meet their state’s income and asset tests are eligible. In most states, childless adults are eligible only if they have a disabling condition that will prevent them from working for a year or more. Other low-income adults are not eligible, except in a few states that have implemented federally approved waivers. Today, about 3% to 5% of state prison inmates are Medicaid eligible.

Effective January 2014, Medicaid eligibility for persons not covered by current categories will be based exclusively on income. All U.S. citizens with incomes at or below 133% of the federal poverty level can be eligible for Medicaid. Application and eligibility determination will be simplified and expedited: Applicants will use a simple form created by the exchange, and income and citizenship will be verified by the exchange. In 2014, nearly all prison inmates and many jail inmates will be Medicaid eligible.

In addition, the federal matching rate for new Medicaid expansion population will be 100%—the federal government will bear the full cost of the Medicaid expansion population for the first few years and 90% thereafter.

The Supreme Court has given states the option of deciding whether or not to participate in the Medicaid expansion, without penalty to their current Medicaid programs. Several states are deeply committed to the expansion; a few are highly opposed. Most states are expected to participate since nearly the entire cost is borne by the federal government and there are other significant financial implications in opting out of the Medicaid expansion.

In states that expand Medicaid per the ACA, nearly all persons who are incarcerated will be eligible for Medicaid or subsidized coverage at release or parole, creating a seamless continuum of coverage for this population for the first time. The Medicaid expansion has two major implications for corrections: matching funds for inpatient hospitalizations, and opportunities for continuity of care at release or parole.

**Medicaid and Inpatient Hospitalizations**

Medicare and many commercial insurance plans do not provide health care benefits to incarcerated persons. Federal Medicaid rules, however, currently allow federal matching funds for inpatient hospitalizations and skilled nursing home admissions when an inmate is enrolled in Medicaid; the hospital stay is longer than 24 hours and the hospital is one that serves the general public (even if the inmate is in a locked unit guarded by the jail or prison). No other services are eligible for Medicaid matching funds. This provision is confusing and widely misunderstood, but prisons, jails and Medicaid agencies that work through its complexities can significantly bolster their budgets. In addition, the correctional organization or county, rather than Medicaid, can pay the nonfederal share of the hospitalization so that the state Medicaid budget does not grow but the state or county cost for inpatient care is offset by federal matching funds.

As noted, today about 3% to 5% of a prison population is eligible for Medicaid; these inmates may account for 10% to 50% of inpatient hospital care. In 2014, when nearly all inmates will be Medicaid eligible, nearly all inpatient hospitalizations will be eligible for federal matching funds at 100%.

About a dozen state departments of correction and a few large jails are collecting Medicaid federal matching funds for some or all eligible inmate hospitalizations. Other corrections organizations have not pursued Medicaid matching funds because the volume of eligible admissions has been relatively small and establishing a process is complex. Beginning in 2014, the volume of hospitalizations eligible for federal match at 100% becomes very large and Medicaid enrollment becomes simpler. All prisons and jails, whether currently collecting federal match or not, should work with the state exchange and Medicaid to establish a standard process to enroll inmates in Medicaid, keep them enrolled and collect available federal funds for hospitalizations.

**Medicaid and Continuity of Care**

The ACA offers important new opportunities for improving continuity of care for inmates being released or paroled. Enrolling inmates in Medicaid will be a simple process using the state’s health benefit exchange and a simple application.

continued on page 12
Many eligibility determinations will occur in real time and will no longer depend on lengthy, labor-intensive disability determinations.

Inmates with mental illness, HIV/AIDS, hepatitis and other chronic or serious conditions will have a continuous source of primary and specialty care and prescription drugs at release. This provision will afford an opportunity for correctional institutions and community-based providers to ensure continuity of care. Access to health care following incarceration is a known deterrent to reoffending, so this new opportunity can enhance health and public safety and also reduce incarceration costs for recidivism.

Prisons and jails should be aware that eligibility for Medicaid does not necessarily equate to a source of care in the community. Seamless access to free-world health care is contingent on several factors:

- The inmate must be enrolled in Medicaid or an exchange plan effective on the date of release. Someone must assist the inmate to enroll via the Web-based exchange prior to release or parole.
- The inmate must be established with a community provider. For inmates with active health conditions, a “warm handoff” in which the inmate has an appointment with a community primary care provider is ideal. Someone must establish contact with the insurance carrier or Medicaid system and coordinate postrelease care with the corrections plan of care.

These are new functions for prisons and jails. They will require new resources and planning, and developing processes will take time.

Medicaid managed care organizations, federally qualified health centers and local primary care practices are potential partners in developing these processes. Depending on the state Medicaid plan, all may have significant financial risk for new Medicaid beneficiaries who are ex-offenders and therefore have a strong interest in preventing unnecessary emergency room visits and hospitalizations. “Warm handoffs” and aligning parole officers with an ex-offender’s primary care provider can prevent these unnecessary expenses.

**Impending Health Care Workforce Shortages**

The ACA’s health insurance coverage expansions will create new demand for primary care, mental health services, substance abuse treatment and prescription drugs for 30 million people, far exceeding today’s health care workforce capacity. Corrections organizations should expect increased challenges in recruiting and retaining nurses, primary care providers, pharmacists, psychiatrists and mental health providers. Challenges will likely emerge by mid-2014 and worsen thereafter. Unfilled positions can significantly reduce inmate access to necessary care and create significant risk for inmates and correctional facilities. Staffing requirements in vendor contracts do not protect prisons and jails—widespread workforce shortages will hinder vendor recruitment but the consequences of poor care will fall on corrections.

Prisons and jails should immediately begin to redesign health care practices to assure that medical providers are fully occupied, clinicians do not spend unnecessary time on paperwork or nonclinical interactions and custody is fully engaged in assuring that inmate “no-shows” are minimized. Examples of such redesign efforts include the following:

- Expand clinic hours to 10- or 12-hour shifts
- Eliminate physician approval for shoes, low bunks and other accommodations
- Upgrade scheduling systems to integrate mental health, dental and medical appointments, “compress” multiple inmate appointments and manage prescription drug renewal
- Require primary care providers to manage psychotropic medications for stable inmates, with psychiatrists in a consultative role
- Expand telemedicine so that in-house psychiatrists and primary care providers see inmates in rural locations
- Eliminate provider appointments and pharmacy fills for over-the-counter medications

Changes of this scope require support from all sectors of corrections and from the highest leadership in custody and health care. They will take time and effort, and should begin immediately in order to be operational when workforce shortages emerge.

**Preparing for the Affordable Care Act**

The ACA creates several new opportunities and challenges for correctional health care and addressing them will be complicated and involve many stakeholders. January 2014 is just around the corner, so prisons and jails should begin to prepare immediately. All prisons and jails should take the following steps, at a minimum:

- Educate custody and health care leaders at the highest level of the organization about the ACA and the decisions prisons and jails must make
- Engage with the state’s exchange effort to build seamless and ongoing enrollment of inmates into Medicaid or exchange plans as inmates move between jails, prisons and the community
- Decide whether to directly assist inmates in enrolling in coverage on the exchange and, based on that decision, build appropriate processes
- Develop or expand processes to collect federal matching funds for inpatient hospitalizations of inmates enrolled in Medicaid
- Build relationships and discharge planning processes with community providers, especially Medicaid managed care organizations
- Ensure that vendor contracts can be modified to address changes that arise as a result of the ACA. This could include revisiting payments if hospital costs are covered by Medicaid, new duties in discharge planning, etc.
- Begin to revise on-site clinical practices so that all providers are operating at “the top of their licenses,” productivity is increased and scheduling is optimized.

Donna Strugar-Fritsch, BSN, MPA, CCHP, is a principal with Health Management Associates, Lansing, MI. She presented on this topic at the National Conference on Correctional Health Care in October.
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Emergency Severity Index: An Individualized Patient Triage System

by Susan Laffan, RN, CCHP-RN, CCHP-A

When we hear the word triage, we think of an incident that deals with multiple patients. The word triage is derived from the French verb trier, which means to sort or to choose. Originally the process was used by the military to sort soldiers wounded in battle for the purpose of establishing treatment priorities.

Until the past decade or so, triage acuity rating systems in U.S. emergency departments were not standardized and often had only three levels. However, in 2003 both the Emergency Nurses Association and the American College of Emergency Physicians came out in support of a standardized five-level triage system.

The Emergency Severity Index is a five-level triage scale developed by emergency department physicians Richard Wuerz and David Eitel more than 10 years ago. The ESI is an individualized patient triage system, so it would be applicable for one patient or multiple patients. The levels go from 1 to 5, with level 1 being most critical. Therefore, the lowest acuity level would be level 5. But the model goes beyond evaluating acuity level. The ESI triage algorithm is based on four key decision points (see figure at right). Triage nurses also use the ESI to consider what resources, such as diagnostic tests and procedures, they expect will be required in conjunction with the patient’s presentation, complaints and vital signs. This enables them to determine the appropriate treatment plan for each patient.

This systematic approach can also be applied to all types of correctional facility patients. It is important for those working in correctional facilities to understand the resources available on-site and the appropriate staff to provide higher levels of care keeping within specific scopes of practice. Resources may include an EKG machine, ability to draw and receive “stat” laboratory results, specific treatments such as hand-held respiratory treatments and the use of a specialty unit that has the capability to monitor and/or observe patients closely.

How ESI Works

ESI is a rapid sorting of patients into five groups with clinically meaningful differences in projected resource needs. This enables the rapid identification of patients that require immediate attention as well as those who do not need to be seen on an emergent basis.

Each step of the algorithm guides the user toward the appropriate questions to ask or the type of information to gather. The four decision points depicted in the algorithm are critical to apply the ESI accurately and reliably. The answers to the following questions will guide the nurse to the correct triage level.

A. Does the patient require immediate lifesaving intervention?

B. Is this a patient who should not wait for treatment/intervention?

C. How many resources will this patient require?

D. What are the patient’s vital signs?

An easy way to keep the order of the levels in perspective is to always start with level 1 and work your way through the algorithm with additional information and evaluation of the patient. If the patient does not require immediate, lifesaving measures, then move to the level 2 criteria. If the patient does not meet the level 2 criteria, then continue to move through the remaining levels to determine the appropriate ESI level.

Decision Point A: Does the patient require immediate lifesaving intervention?

If the answer is “yes,” the patient is triaged at ESI level 1 and the triage process is complete. Examples of ESI level 1 include cardiac and or respiratory arrest, acute stroke symptoms with life-threatening conditions, severe respiratory distress, any state of shock or hypoperfusion, symptomatic chest pain, a critically injured trauma patient who is unresponsive and a patient who may die or lose a limb or organ if not treated immediately. Level-1 patients require immediate physician involvement.

Among the interventions that are lifesaving are those meant to secure an airway, maintain breathing, support...
circulation or address a major change in level of consciousness. Interventions that are not considered lifesaving include some that are diagnostic or therapeutic but would not save a life.

**Decision Point B: Should the patient wait?**
Here, the triage nurse obtains subjective and objective information to evaluate whether the situation is high risk, the patient is confused or the patient is in severe pain or distress. Examples of high-risk situations include active chest pain but hemodynamically stable, stroke symptoms without life-threatening conditions, an immunosuppressed patient with a fever and a suicidal or homicidal patient.

Patients with a baseline mental status of confusion do not meet level-2 criteria. Rather, the concern is whether the patient is demonstrating an acute change in level of consciousness. As to pain or distress, the triage nurse needs to assess the level through clinical observation as well as a self-reported pain rating of 7 or higher.

Level-2 patients are a high priority and treatment should be initiated rapidly. Unlike with level-1 patients, the nurse can initiate care through protocols without the immediate presence of a physician.

**Decision Point C: How many different resources are needed?**
If the patient does not meet the criteria for levels 1 or 2, the triage nurse then determines how many different resources the physician is likely to use to reach a disposition decision using the concept of what is “prudent and customary” in the given situation. The estimate of resources must be based on the standards of care, not on whatever resources happen to be available at that site or on provider preferences. Resources can be hospital services, tests, procedures, consults and interventions that will be required to provide adequate care for that patient. The number of resources determines the patient’s ESI level: If the prediction is for two or more resources, the patient is triaged at level 3; if one resource will be needed, triage is at level 4; and if no resources are needed, level 5.

**Decision Point D: What are the patient’s vital signs?**
Before triaging a patient at level 3, the nurse looks at the vital signs. Vital signs represent a set of objective data for use in determining the general parameters of patients’ health and viability and include pulse, respiratory rate and oxygen saturation; body temperature is used only for children under age 3. The acuity level is determined by the stability of vital functions and the potential threat to life, limb or organ. A determination of the type of treatment and speed at which they should be provided is established. If the vital signs are outside the accepted parameters and the triage nurse believes them to be meaningful, the nurse should consider upgrading the ESI triage level to 2.

**Time to Treatment**
The ESI does not specify time periods in which a patient must be seen by a physician. However, an estimate of how long a patient can wait can be an important factor to assess in triage. Certain medical events and conditions are time sensitive. Examples of important time parameters include door to cardiac catheterization, 90 minutes; acute stroke symptoms, three hours to medication intervention; traumatic injuries, one hour to medical/surgical intervention. A triage level may be upgraded to accommodate any of these types of patients due to the urgency of treatment needed. In the case of trauma, a separate response level categorization may be needed. Triage and trauma response level should be recorded as two different scores.

**Correctional Considerations**
When an inmate-patient must be sent from a correctional facility for care, there are various ways that the patient can be transported, including correctional vehicle, ambulance with basic first-aid responders and ambulance with advanced life support staff such as paramedics or nurses. Choosing the most appropriate transport method and route could very well save that patient’s life.

For a health services department considering implementing the ESI, it is important to remember that making such a change will take time, careful planning and a group of professionals dedicated to a successful change process. Although the ESI algorithm looks simple, there are several key concepts that need to be well understood in order to maintain the reliability and validity of the tool. Professionals are urged to read the entire ESI Implementation Handbook (see note below) and understand it thoroughly. The book also provides case scenarios to aid in application of the principles, as well as frequently asked questions and test assessment questions. Finally, all institutional policies and procedures must be reviewed and updated or changed to reflect the use of the ESI system.

Strategies that may contribute to the successful implementation of the ESI system include placing wall posters with the algorithm in clinical areas, providing nurses with pocket-sized laminated cards of the algorithm and conducting informal chart reviews with a focus on the appropriateness of the ESI level.

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The information in this article is adapted from Emergency Severity Index, A Triage Tool for Emergency Department Care, Version 4, Implementation Handbook, 2012 Edition, Agency for Healthcare Research and Quality Publication No. 12-0014. The handbook is derived from the Emergency Severity Index Version 4 Triage Algorithm, which is the intellectual property of The ESI Triage Research Team, LLC. The authors grant permission to use the algorithm in its original form in clinical practice and to incorporate it into training materials. Use of the ESI algorithm and the derivative materials must not replace, wholly or in part, critical thinking and the need for sound clinical judgment. Find the handbook online at www.ahrq.gov/research/esi.
Confronting Fetal Alcohol Spectrum Disorders in Correctional Populations

by Carolyn Szetela, PhD

Fetal alcohol spectrum disorders is a recently adopted umbrella term referring to any negative effects a person experiences resulting from prenatal alcohol exposure. As they are often unrecognized, FASDs are sometimes referred to as “an invisible disability.” Like many other health conditions that affect behaviors, the prevalence of FASDs is higher in correctional populations.

As a trainer with the Southeastern FASD Regional Training Center, Nashville, TN, I have had opportunities to talk with correctional health care providers about FASDs. While providers' knowledge about FASDs varies, they see a strong connection between characteristic FASD behaviors and the behavioral struggles they observe in inmates on a regular basis. Providers have also shared their desire for information and strategies to better intervene when an inmate is suspected of having an FASD.

Summarizing the Problem

Alcohol is a teratogen that can cause lifelong brain deficits. The developing brain is vulnerable to the effects of alcohol throughout pregnancy, and the timing and amount of exposure influence whether and how the fetus will be affected. Effects can range anywhere on a continuum from no discernible effects to severe damage. Research to identify the prevalence of such damage is challenging, partly because the effects are often maladaptive behaviors that can overlap with other causes, and accurate maternal drinking histories are often unknown. However, study designs have improved in recent years and evidence supports a U.S. prevalence of one per 100 persons or possibly higher.

The most marked of the FASDs is fetal alcohol syndrome, a diagnosis that includes specific significant anomalies of the central nervous system or its functions, specific atypical facial features and a one-time demonstration of growth deficit. People with FAS are more likely than others to be identified, in part, because of the severity of their disability and because the FAS facial features can serve as a visible signal of a need for evaluation.

People with other types of FASDs far outnumber those who have FAS but are less likely to be diagnosed. This can lead to a lifetime without recognition of their brain damage or why they lack expected controls over personal cognition, emotions and behaviors. Affected individuals may also try to hide or mask their problems to avoid being marginalized as stupid, lazy or defiant. Additionally, health providers and others are often uncomfortable confronting the taboo issue of women who, albeit unintentionally, harm a child by alcohol misuse or dependence. If these mothers face stigma and misunderstanding instead of compassion and assistance, this may reinforce any reluctance they may have to acknowledge their children’s problems.

FASDs involve brain deficits that affect behavior, including difficulties with organized thinking, appreciation of consequences, regulation of emotions and impulse control. Many affected persons encounter law enforcement or the criminal justice system. For example, someone with an FASD may repeat a rule of behavior and affirm agreement with that rule without understanding when it applies or how to realize the behaviors it asks of them. This can present challenges to lawful behavior as well as in correctional settings, where rules are abundant and violations are punished.

As in the general population, FASDs are routinely underdiagnosed among inmates. A 2003 report on correctional facilities representing a population of more than 3 million inmates found an impossibly low incidence rate: one person known to the study respondents to have FAS. Today, awareness of FASDs in correctional systems is improving. But we are only beginning to climb the awareness curve, and we sorely lack evidence-based recommendations to respond to the needs of inmates with FASDs.

Correctional Providers’ Recommendations

In the absence of adequate evidence for effective strategies for inmates with FASDs, correctional providers have offered some of their own experience and common sense. Inmates suspected for FASD should have:

• Access to a formal evaluation
• Reasonable accommodations to minimize overstimulation
• Extra time to process information and respond to questions
• Modified mental health treatments (shorter, simpler benchmarks and less emphasis on conceptual processing)
• Access to alcohol and drug abuse treatments, especially for pregnant women and women of childbearing age

Indeed, correctional health providers can often successfully adapt their experience treating inmates with other identified cognitive and mental health conditions to help those who may have overlapping challenges related to FASDs. Some intervention strategies are unique to FASDs, but there is no need to reinvent the entire wheel.

I have been struck with a sense that correctional health providers have a strong desire to do what is best for patients they suspect of having an FASD. Awareness about FASDs and associated behaviors can pave the road for providers to address the justice, incarceration, health and reentry needs of people with FASDs. As a start, awareness of FASDs can bring the immediate reward of understanding for inmates whose lives may be full of misunderstanding. In cases where suspicion of an FASD is high, health providers may pursue an FASD evaluation as well as counseling to help the inmate gain insight. Furthermore, increased recognition and research on FASDs among correctional populations will help speed us toward better responses and treatment.

Carolyn Szetela, PhD, is an associate professor in the department of professional and medical education, Meharry Medical College, Nashville, TN. She is the primary author of the Ethical, Legal and Policy Issues chapter in the CDC’s Fetal Alcohol Spectrum Disorders Competency-Based Curriculum Development Guide for Medical and Allied Health Education and Practice. Contact her at cszetela@mmmc.edu.
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INDICATION

ATRIPLA® (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate [DF] 300 mg) is indicated for use alone as a complete regimen or in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients at least 12 years of age and weighing ≥40 kg (88 lbs).

SELECTED IMPORTANT SAFETY INFORMATION

WARNING: LACTIC ACIDOSIS/SEVERE HEPATOMEGALY WITH STEATOSIS and POST TREATMENT EXACERBATION OF HEPATITIS B

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including tenofovir DF, a component of ATRIPLA, in combination with other antiretrovirals.

ATRIPLA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of ATRIPLA have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who have discontinued EMTRIVA® (emtricitabine) or VIREAD® (tenofovir DF), which are components of ATRIPLA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue ATRIPLA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

- Rash was reported in 46% (2657) of pediatric patients receiving efavirenz. Grade 3 or 4 rash was reported in 5% of pediatric patients compared to 0.9% of adults receiving efavirenz.
- In addition to common adverse events reported in adults, anemia (7%) and hyperpigmentation (32%) were observed in pediatric patients treated with emtricitabine.

1. Baseline viral load > 100,000 copies/mL
2. Baseline viral load ≤ 100,000 copies/mL
3. Study RN5: A randomized, open-label, active-controlled, multicenter study comparing tenofovir disoproxil fumarate (TDF) 300 mg + emtricitabine (FTC) 200 mg vs. abacavir (ABC) + lamivudine (3TC) 150 mg, in combination with efavirenz (EFV). 511 antiretroviral-naive patients. From weeks 0 to 48, patients received TDF/FTC fixed-dose combination in place of TDF + FTC. Mean baseline CD4 cell count was 175 cells/mm² and median baseline HIV-1 RNA was 5.01 log₁₀ copies/mL. TUDVR analysis (N=467) excluded 22 patients with baseline
   NNRTI resistance and 2 patients who were treatment experienced.
4. Other reasons for discontinuation include loss to follow-up, patient withdrawal, noncompliance, protocol violation, and other reasons.
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In a 3-Year Clinical Trial in Treatment-Naïve Adult Patients4,5...

- Powerful and reliable virologic control through 3 years in patients with high* and low† baseline viral loads1,4

  - In Study 934, 84% of treatment-naïve adult patients taking ATRIPLA as its components (n=244) achieved viral load <400 copies/mL vs 73% with Combivir® (zidovudine/lamivudine) + EFV (n=243) through 48 weeks (primary endpoint). The difference in the proportion of patients who achieved and maintained HIV-1 RNA <400 copies/mL through 48 weeks largely resulted from the higher number of discontinuations due to adverse events and other reasons4 in the Combivir group in this open-label study. Through 144 weeks, 71% of patients taking ATRIPLA (n=227) maintained viral load <400 copies/mL vs 58% with Combivir + EFV (n=229). 73% (88/120) of patients taking ATRIPLA with high baseline viral load† achieved and maintained viral load <400 copies/mL vs 59% (66/112) with Combivir + EFV, and 66% (73/107) of patients taking ATRIPLA with low baseline viral load* achieved and maintained viral load <400 copies/mL vs 57% (67/117) with Combivir + EFV.

- Low rate (3%) of virologic failure4,6

  - In Study 934, 3% of treatment-naïve adult patients taking ATRIPLA (n=227) experienced virologic failure vs 6% with Combivir + EFV (n=229) through 144 weeks4,6

- Low percentage of patients developed NNRTI (5%) and NRTI (1%) resistance-associated mutations4

  - In Study 934, through 144 weeks, resistance to EFV occurred in 5% (n=13) of patients in the ATRIPLA arm and 9% (n=21) in the Combivir + EFV arm, primarily caused by the K103N mutation. The M184V/I mutation, associated with resistance to FTC, was observed in 1% (n=2) of patients in the ATRIPLA arm and 4% (n=10) of patients in the Combivir + EFV arm. No patients developed the K65R mutation, which is associated with reduced susceptibility to tenofovir.

- Demonstrated long-term safety and tolerability profile, with a low rate (5%) of discontinuation due to AEs4,6

  - In Study 934, through 144 weeks, the most frequently reported Grade 2-4 adverse reactions reported in >5% of subjects receiving ATRIPLA were diarrhea (8%), nausea (8%), fatigue (8%), depression (5%), dizziness (5%), anemia (6%), upper respiratory tract infection (6%), rash event (5%), headache (6%), insomnia (5%), arthralgia (5%), and nasopharyngitis (5%)

  - Through 144 weeks, 5% of patients in the ATRIPLA group discontinued due to adverse events vs 12% in the Combivir + EFV group; discontinuation for other reasons was 20% in the ATRIPLA group and 22% in the Combivir + EFV group.

  - The most common adverse reactions that led to discontinuations were: investigator-defined insomnia (n=2; <1%) and rash (n=2; <1%) in the ATRIPLA arm; investigator-defined anemia (n=14; 6%) in the Combivir + EFV arm.

Please see Important Safety Information, including Boxed WARNINGS, and Brief Summary of Full Prescribing Information on the following pages.

AE = adverse event; EFV = efavirenz; FTC = emtricitabine; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; TDF/3TC = tenofovir disoproxil fumarate 300 mg Tablets

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IMPORTANT SAFETY INFORMATION

WARNING: LACTIC ACIDOSIS/SEVERE HEPATOMEGALY WITH STEATOSIS AND POST-TREATMENT EXACERBATION OF HEPATITIS B

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported in patients taking ATRIALA, including rare cases of liver cell death, including fatal outcomes. ATRIALA, a component of ATRIALA (enalaprilat/entecrinatine/torvaphin disoproxil fumarate), in combination with other antiretrovirals.

ATRIALA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of ATRIALA have not been established in patients coinfected with HBV and HAV. Severe acute exacerbations of hepatitis B have been reported in patients who have discontinued ENTRILONA (entecrinatine) or VIREACO (tenofovir DF), which are components of ATRIALA. Hepatocellular carcinoma has occurred with both clinical and laboratory follow-up for at least 7 months in patients who are coinfected with HAV and HBV and continue ATRIALA. If appropriate, initiation of anti-HBV therapy may be warranted.

Contraindications

- ATRIALA is contraindicated in patients with previously demonstrated clinically significant hyporeninemic hyperkalemia (e.g., Severe, Severe, or Severe, Severe) or diabetic patients on dialysis, or with serum creatinine levels greater than 2 mg/dL or less than 1.5 mg/dL or not transplantable, or with coadministration of ATRIALA with aminoglycosides, or with the use of enalaprilat, one of the components of ATRIALA.
- ATRIALA should not be administered concurrently with varenicline because it significantly decreases the concentrations of varenicline, resulting in increased efavirenz plasma concentrations and significantly increased efavirenz plasma concentrations.
- Concomitant use of ATRIALA with St. John’s-wort (Hypericum perforatum) at J. St. John’s-wort-containing products is not recommended because this may lead to loss of virologic response and increase the risk of virologic failure, as evidenced by virologic failure, or for non-nucleoside reverse transcriptase inhibitors (NNRTIs).

Warnings and Precautions

- Efavirenz plasma concentrations may be altered by substrates, inhibitors, or inducers of CYP3A4. Efavirenz may alter plasma concentrations of drugs metabolized by CYP3A or CYP2B6.
- Since ATRIALA contains entecrinatine and tenofovir DF, ATRIALA should not be coadministered with COMBIVIR (entecrinatine/tenofovir DF), ATRIALA (entecrinatine/tenofovir DF), or VIREACO (tenofovir DF). Since ATRIALA contains efavirenz, ATRIALA should not be coadministered with SUSTIVA (efavirenz) unless needed for dose adjustment when coadministered with ritonavir. Due to similarities between entecrinatine and lamivudine, ATRIALA should not be coadministered with drugs containing lamivudine, including Combivir (lamivudine/zidovudine), Epivir (epivir HEP, lamivudine), Emtriva (emtriva), Truvir (truvira sulfate/zidovudine), or Truvira (truvira, lamivudine/zidovudine), or Truvira (truvira, lamivudine/zidovudine).

- ATRIALA should not be administered with HEFPRE (adefovir dipivoxil).
- Serious psychiatric adverse events, including depression (0.4%, 0.9%, suicidal ideation (0.7%, 0.3%), nonfatal suicide attempts (0.5%, 1%), aggressive behavior (0.4%, 0.3%), violent behavior (0.2%, 0.2%), and mania (0.2%, 0.4%) have been reported in patients receiving efavirenz and other antiretrovirals, respectively. In addition to efavirenz, factors identified in a clinical trial that were associated with an increase in psychiatric symptoms included a history of injection drug use, psychiatric history, and use of psychiatric medication. There have been occasional reports of suicide, delusions, and psychoses-like behavior; however, the relationship to efavirenz is not known. It should be evaluated immediately to determine whether the risks of continued therapy outweigh the benefits.
- Fifty percent of patients reported central nervous system (CNS) symptoms (including dizziness (25.1%), insomnia (16.6%), impaired coordination (5.3%), paresthesia (5.8%), abdominal pain (3.2%), and hallucinations (2.2%) when taking ATRIALA compared to 25% of patients receiving control regimens. These symptoms usually begin during Days 1-2 of therapy, generally persist for the first 2-4 weeks of therapy, were severe in 2.0% of patients, and in 2.0% of patients discontinued therapy. Upon the completion of these events, the prevalence of CNS symptoms of at least moderate severity ranged from 5% to 9% in patients treated with regimens containing efavirenz. ATRIALA is a component of the less frequently reported central nervous system (CNS) symptoms. Patients receiving ATRIALA should be alerted to the potential for additive CNS effects when ATRIALA is used concomitantly with alcohol or psychoactive drugs. Patients who experience CNS symptoms such as dizziness, impaired coordination, and/or drowsiness should avoid potentially hazardous tasks such as driving or operating machinery.
- It is recommended that creatine clearance (CrCl) be calculated in all patients prior to initiating therapy and as clinically appropriate during therapy with ATRIALA, and routine monitoring of C02 and serum phosphorus should be performed for patients at risk of renal impairment, including patients who have previously experienced renal events while taking adalimumab. ATRIALA should not be used in patients with CrCl < 60 mL/min. Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphatemia), has been reported with the use of tenofovir DF. ATRIALA should be avoided with concurrent or recent use of a nephrotoxic agent.
- ATRIALA (efavirenz/entecrinatine/torvaphin disoproxil fumarate) may cause fatal harm when administered during the first trimester to a pregnant woman. Women should not become pregnant or breastfeed while taking ATRIALA. Breastfeeding is not recommended in combination with other methods of contraception (e.g., oral or other hormonal contraceptives). Because of the long half-life of efavirenz, adequate contraceptive measures are recommended for 12 weeks after discontinuation of ATRIALA. If the patient becomes pregnant while taking ATRIALA, the patient should be advised of the potential harm to the fetus.
- Mild-to-severe rash is a common side effect of efavirenz. In controlled clinical trials in adults, 26% of patients treated with efavirenz experienced new-onset skin rash compared with 17% of patients treated in control groups. ATRIALA should be discontinued in patients developing severe rash associated with blistering, desquamation, mucosal involvement, or fever. Rash was reported in 4.0% (647) of patients receiving efavirenz. Grade 3 or 4 rash was reported in 0.9% of patients receiving efavirenz compared to 0.9% of adults receiving efavirenz.
- Liver enzymes should be monitored before and during therapy in patients with underlying hepatic disease, including hepatitis B or C infection, in patients with marked transaminase elevations, and in patients who may have a history of cirrhosis or other risk factors. Reports of hepatic failure, including cases in patients with no pre-existing hepatic disease or other identifiable risk factors, were characterized by fulminant course, progressing in some cases to hepatocellular injury (associated with proximal renal tubulopathy and which may contribute to mortality) and have been reported in association with the use of tenofovir DF.
- Use ATRIALA with caution in patients with a history of seizures. Convulsions have been observed in patients receiving efavirenz, generally in the presence of known medical history of seizures.
- Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including components of ATRIALA. Autoimmune disorders (e.g., Graves’ disease, polymyositis, and Guillain-Barré syndrome) have also been reported in patients treated with ATRIALA, and it is recommended that patients treated with ATRIALA receive an adequate dose of ritonavir for at least 24 weeks after initiating treatment.
- Redistribution/accumulation of body fat has been observed in patients receiving antiretroviral therapy.

Adverse Reactions

- In Study 304, through 14 weeks, the most frequently reported adverse events in ≥15% of subjects receiving efavirenz + entecrinatine + tenofovir DF were dizziness (9%), nausea (9%), fatigue (9%), diarrhea (8%), headache (6%), pruritus (4%), rash (3%), injection site reactions (3%), arthralgia (3%), and chills (2%).
- The most common adverse reactions (incidence ≥10%, any severity) occurring in Study 304 include diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, abnormal dream, and rash.
- Skin discoloration, associated with entecrinatine, may also occur.
- Pediatric patients: In addition to the adverse events reported in adults, anemia (7%) and hyperglycemia (12%) were observed in pediatric patients treated with entecrinatine.

Drug Interactions

- Coadministration of ATRIALA with didanosine should be undertaken with caution. Patients receiving this combination should be monitored closely for didanosine-associated adverse reactions.
- Pharmacokinetic have shown to increase tenofovir concentrations. Patients on lopinavir/ritonavir plus ATRIALA should be monitored for increased tenofovir-related adverse reactions. ATRIALA should be discontinued in patients who develop tenofovir-associated adverse reactions.
- Coadministration of ATRIALA and stavudine is not recommended. Efavirenz and tenofovir DF have been shown to decrease concentrations of stavudine. ATRIALA has also been shown to increase the concentration of stavudine. Renal contraindications.
- Sequestration should not be used as the only protease inhibitor in combination with ATRIALA.
- See Full prescribing information for complete list of drug-drug interactions.

Hepatic Impairment

ATRIALA is not recommended for patients with moderate or severe hepatic impairment because of insufficient data. Use caution in patients with mild hepatic impairment.

Dosage and Administration

The dose of ATRIALA for patients at least 12 years of age and weighing ≥40 kg (90 lb) is 1 tablet containing 2 mg of efavirenz, 1 tablet (containing 20 mg of entecrinatine, and 300 mg of tenofovir DF) once daily taken orally on an empty stomach. Dosing at bedtime may improve the tolerability of nervous system symptoms. ATRIALA is not recommended for use in patients <12 years of age or in patients with CrCl <50 mL/min. When ATRIALA is administered with rifampin to patients weighing ≥50 kg, an additional 200 mg/day of efavirenz is recommended.

Please see Brief Summary of Full Prescribing Information, including boxed WARNING, on the following pages.
INDICATIONS AND USAGE
ATRIPTA (rimeletrytenol hemihydrate) intranasal spray is indicated for the acute treatment of migraine headache in adults. It is not intended for the treatment of chronic migraine headache in adults.

CONTRAINDICATIONS
ATRIPTA is contraindicated in patients with a history of hypersensitivity to any of the components of ATRIPTA, or to ergots or ergot derivatives. ATRIPTA is also contraindicated in patients with symptoms of coronary artery disease, or with a history of MI, CHF, or severe chronic bronchitis.

ADVERSE REACTIONS
ATRIPTA is generally well-tolerated. The most common adverse reactions reported in clinical trials were headache, nausea, vomiting, dysgeusia, and flushing.

Intranasal ATRIPTA was associated with increased symptoms of upper respiratory tract infections compared to placebo.

The incidence of reported adverse events was similar in patients treated with ATRIPTA and those treated with placebo.

Intranasal ATRIPTA was not associated with any increases in heart rate or blood pressure.

There were no significant changes in laboratory parameters or vital signs.

In patients with a history of MI, CHF, or severe chronic bronchitis, the incidence of adverse events was similar to that observed in the general population.

In patients with symptoms of coronary artery disease, the incidence of adverse events was similar to that observed in the general population.

In patients treated with ATRIPTA, the incidence of adverse events was similar to that observed in the general population.

ADVERSE DRUG REACTIONS
ATRIPTA is generally well-tolerated. The most common adverse reactions reported in clinical trials were headache, nausea, vomiting, dysgeusia, and flushing. Intranasal ATRIPTA was associated with increased symptoms of upper respiratory tract infections compared to placebo. The incidence of reported adverse events was similar in patients treated with ATRIPTA and those treated with placebo. Intranasal ATRIPTA was not associated with any increases in heart rate or blood pressure. There were no significant changes in laboratory parameters or vital signs. In patients with a history of MI, CHF, or severe chronic bronchitis, the incidence of adverse events was similar to that observed in the general population. In patients with symptoms of coronary artery disease, the incidence of adverse events was similar to that observed in the general population. In patients treated with ATRIPTA, the incidence of adverse events was similar to that observed in the general population.
Effect on Adverse Reactions - In addition to the adverse reactions reported in adults, anemia and hyperglycemia were observed in 7% and 10%, respectively, of patients with type 2 diabetes. Anemia was reported in 13% of those with type 2 diabetes and in 17% of those with type 1 diabetes. Hyperglycemia was reported in 19% of patients with type 2 diabetes and in 30% of those with type 1 diabetes. Both conditions were more common in patients treated with insulin compared to patients treated with oral agents.

Steatorrhea - Diarrhea occurred in 41% of patients treated with insulin alone or in combination with oral agents, and in 12% of patients treated with insulin alone or in combination with oral agents. The frequency of diarrhea was similar among patients receiving either the short-acting or long-acting insulin analogs.

Effective - Use of the effective dose will allow for a more rapid control of blood glucose levels and minimize the risk of hypoglycemia and hyperglycemia. The effective dose is usually achieved within 24 hours of initiating therapy. The optimal effective dose is determined by the patient's response to treatment, as determined by the frequency and severity of hypoglycemic and hyperglycemic episodes.

Established and Other Potential of Significant Drug Interactions - Avoid concurrent administration of insulin with other drugs that may affect carbohydrate metabolism. For information on the potential for drug interactions, refer to the manufacturer's package insert or consult a pharmacist.

Antidiabetic agents: Sulfonylureas - Sulfonylureas may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of sulfonylureas and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: GLP-1 receptor agonists - GLP-1 receptor agonists may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of GLP-1 receptor agonists and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Thiazolidinediones - Thiazolidinediones may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of thiazolidinediones and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Metformin - Metformin may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of metformin and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Dapagliflozin - Dapagliflozin may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of dapagliflozin and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Sodium-glucose cotransporter 2 (SGLT2) inhibitors - SGLT2 inhibitors may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of SGLT2 inhibitors and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Octreotide - Octreotide may decrease the effectiveness of insulin in treating type 2 diabetes. Concurrent use of octreotide and insulin may increase the risk of hypoglycemia.

Antidiabetic agents: Insulin - Concurrent use of insulin with other antidiabetic agents may increase the risk of hypoglycemia.

Adverse Reactions: Hypoglycemia - Hypoglycemia is the most common and serious adverse reaction associated with insulin therapy. The risk of hypoglycemia increases with the dose of insulin and can be life-threatening in severe cases.

Adverse Reactions: Hyperglycemia - Hyperglycemia is a common adverse reaction associated with insulin therapy. The risk of hyperglycemia increases with the dose of insulin and can be severe in some cases.

Adverse Reactions: Weight Gain - Weight gain is a common adverse reaction associated with insulin therapy. The risk of weight gain increases with the dose of insulin and can be significant in some cases.

Adverse Reactions: Injection Site Reactions - Injection site reactions are common adverse reactions associated with insulin therapy. The risk of injection site reactions increases with the dose of insulin and can be severe in some cases.

Adverse Reactions: Skin Reactions - Skin reactions are common adverse reactions associated with insulin therapy. The risk of skin reactions increases with the dose of insulin and can be severe in some cases.

Adverse Reactions: Other - Other adverse reactions associated with insulin therapy include nausea, vomiting, diarrhea, constipation, and headache.

Pharmacodynamic: Injection Site Reactions - Injection site reactions may occur at any location where insulin is administered. The risk of injection site reactions increases with the dose of insulin and can be severe in some cases.

Pharmacodynamic: Skin Reactions - Skin reactions may occur at any location where insulin is administered. The risk of skin reactions increases with the dose of insulin and can be severe in some cases.

Pharmacodynamic: Other - Other adverse reactions associated with insulin therapy include nausea, vomiting, diarrhea, constipation, and headache.
AOA Expands Opportunities for Osteopathic Physicians in Corrections

The American Osteopathic Association is making headway in its efforts to recognize correctional health care as a distinct practice area. First, the AOA’s Council on Postdoctoral Training approved basic standards for fellowship training in correctional medicine. Approved at the AOA’s annual meeting in October, the standards will enable institutions to provide comprehensive, structured education to prepare osteopathic physicians to become correctional medicine specialists. In addition, this fellowship training will prepare physicians to become eligible for a new correctional medicine certification to be offered by the AOA.

The standards were developed by the American College of Osteopathic Family Physicians, the American College of Osteopathic Internists and the American Osteopathic College of Occupational and Preventive Medicine. They address education program goals, institutional requirements, program requirements and content, qualifications of the program director, fellow requirements, and evaluation of the fellows. They also outline the curriculum components.

Fellowship programs are being developed in Oklahoma and Texas, according to the AOA. To establish a fellowship, typically a hospital or a medical center partners with a specialty college, whose role is largely one of oversight and project management to ensure proper application of the standards. Approval of the fellowship will be awarded after rigorous review by the Council on Postdoctoral Training. The only current fellowship for osteopathic physicians in this specialty is offered by Nova Southeastern University, which in 2009 launched the program in partnership with the Florida Department of Corrections.

Certification Program in the Works

The fellowship is also a path to earn a Certificate of Added Qualifications in Correctional Medicine from the AOA. “This joint project of the American Osteopathic Board of Family Physicians, the American Osteopathic Board of Internists and the American Osteopathic Board of Occupational and Preventive Medicine is the first of its kind in the profession,” says Ellen Woods, MSc, the AOA’s director of certifying board services.

The correctional medicine CAQ exam is now being developed, its content will be based on the findings from a job task analysis and the resulting table of specifications that detail the topics to be covered. The first examination will take place in October 2014 at the AOA’s annual meeting in Seattle, WA.

The AOA is seeking correctional medicine physicians with primary board certification to help develop the exam by serving as subject matter experts and writing test items in designated topic areas. If they meet the requirements, the subject matter experts will be awarded a five-year certificate in correctional medicine eligibility. For information on this certification program, contact the AOA or call (312) 202-8103.

Drug Interactions: A statement to patients and healthcare providers is included in the product’s 2019/2020 (AHA) Redbook. Refer to Chapter 29 for a detailed discussion of this topic. AHA recommends that patients be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.

General Information for Patients: Patients should be advised that:
- AHA recommends that patients be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.
- All interactions should be considered when prescribing medications. The AHA recommends that patients be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.
- Patients should be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.

Common Adverse Effects: Common adverse effects include:
- Nausea, vomiting, diarrhea, constipation, bloating, headache, and dizziness.
- Patients should be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.
- Patients should be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.

Reproductive Risks: Patients should be advised to consult their doctor before taking any new prescription or over-the-counter medication. For more information, visit www.aha.org.
The Ten Essential Public Health Services: A Framework for Correctional Health Care

Despite growing recognition that correctional health is a component of community health, systematic public health approaches remain uncommon in correctional institutions, say Nancy Winterbauer, PhD, and Ryan Marie Diduk, MPH, in an article in the January issue of the Journal of Correctional Health Care.

Noting that the public health model for correctional health care has evolved from a primary focus on infectious disease control to a model of comprehensive health care that also recognizes the importance of continuity of care upon reentry, the authors describe the application of a public health services framework to a large jail system.

In 2006, the Jacksonville, FL, sheriff’s office contracted with the Duval County Health Department’s division of institutional medicine to provide health care services in the county’s jails. This partnering of two local government agencies enabled administrators to pursue a more comprehensive public health model for inmate health services.

The Ten Essential Public Health Services

The effort was modeled after the Ten Essential Public Health Services framework, developed in the mid-1990s by the Centers for Disease Control and Prevention and its partners to delineate the core functions of public health in society. The framework is the basis of the National Public Health Performance Standards devised to monitor the performance of the public health system and includes the following elements:

1. Monitor health to identify and solve community health problems
2. Diagnose and investigate health problems and hazards in the community
3. Inform, educate and empower individuals and communities about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

The jail health services team used this model to frame current activities, identify gaps in service and structure objectives aimed at further integrating the essential public health services with correctional health care.

The authors describe efforts related to each of the 10 service areas. For example, to monitor inmate health (No. 1), the jail implemented an electronic medical record and used ICD-9 codes to enable comparisons with local, regional and national data. Overall, the authors found that the framework fit well with the unique correctional population and setting. The only essential service that had limited relevance was No. 6, on enforcing laws and regulations that protect health and ensure safety.

Unfortunately, due to liability issues the partnership was terminated at the end of the three-year contract, and the institutional medicine division became part of the sheriff’s office. The authors noted that the project was still in the early stage—moving from concept to implementation—and that rigorous evaluation would have been necessary.

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Replicating MISTERS: An Epidemiological Criminology Framework Analysis of a Program for Criminal Justice-Involved Minority Males in the Community — Roberto Hugh Potter, PhD, Timothy Akers, PhD, and Daniel Bowman, MS

Correlates of Condom Self-Efficacy in an Incarcerated Juvenile Population — Sharon Tsay, MD, Gwendolyn Childs, PhD, RN, Dayna Cook-Heard, and Marsha Sturdevant, MD

Continuity of Care in a Cohort of HIV-Infected Former Jail Detainees — Thana Khawcharoenporn, MD, Chad Zawitz, MD, Jeremy D. Young, MD, MPH, and Harold A. Kessler, MD

The Ten Essential Public Health Services Model as a Framework for Correctional Health Care — Nancy L. Winterbauer, PhD, and Ryan Marie Diduk, MPH, CHES


Field Report: Peer Health Education in Haiti’s National Penitentiary: The “Health through Walls” Experience — Barry Zack, MPH, Coretha Smith, MEd, Mark C. Andrews, MEd, and John P. May, MD, CCHP

Commentary: Treatment of Older and Elderly Inmates Within Prisons — Marina Stal, MA

A self-study exam in each issue offers continuing education credit. Academy of Correctional Health Professionals members receive JCHC (print and online) as a member benefit. To obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
Notes From the Board Chair

By Edwin I. Megargee, PhD, CCHP

As a correctional health professional, you may have been asked the classic question, “What is a nice person like you doing working in a place like that?” If you are like me, you responded with the equally classic answer, “I don’t know. I am just lucky, I guess.”

As we all know, correctional health care poses unique challenges. In corrections, we have to be aware of and abide by strict ethical and legal guidelines with due regard for security regulations, client welfare and confidentiality while working in complex and often crowded conditions. Correctional health professionals deal with a broad range of patients who present with a diverse array of physical and mental health issues. Because most of our clients return to their communities, their care and treatment has a major impact on public health and public safety.

Although the challenges are many, there are few careers that can be more fulfilling. I have been involved in corrections as a practitioner and researcher since 1959, when I first signed on at the Alameda County (CA) Probation Department Guidance Clinic.

In the early years, many considered a position in corrections to be not quite respectable. Too often, colleagues in other settings assumed there must be something the matter with people like us who dealt with criminals or worked in correctional facilities. Today, correctional health professionals get much more respect than we did 54 years ago.

Much of this recognition is thanks to the work of the National Commission on Correctional Health Care. In the 1980s, the National Commission developed standards stipulating the essential requirements for health services in prisons, jails and juvenile training facilities and established a program of voluntary accreditation of facilities that became the gold standard for quality throughout the nation.

I have been fortunate enough to have been associated with NCCHC since 1986. In 1990, we inaugurated the Certified Correctional Health Professional program. CCHP certification offers a unique opportunity for health care professionals to demonstrate that they have the knowledge of national standards and evidence-based best practices for health care delivery to patients in correctional settings.

Since the CCHP program began, more than 6,500 professionals from a broad array of disciplines have completed the CCHP application process and passed the examination. After three years in the program, CCHPs in good standing are eligible to apply for advanced certification (CCHPA), which requires a more detailed application and a four-hour proctored essay examination.

The CCHP program has begun offering specialty certification evaluating whether CCHPs have the credentials and the clinical knowledge needed to practice their particular disciplines in correctional settings. The examination for registered nurses has been developed and the first CCHP-RN certificates were awarded in 2010. Additional specialty certification programs for other disciplines are underway.

For those of us lucky enough to have careers in corrections, CCHP certification is tangible recognition of our knowledge and competence.

Edwin I. Megargee, PhD, CCHP, chairs the CCHP board of trustees. He also represents the International Association for Correctional and Forensic Psychology on the NCCHC board.

CCHP Exam Dates

February 23 Multiple regional sites
April 21 Denver, CO
July 21 Las Vegas, NV

We are seeking additional sites for regional exams as well as CCHPs to proctor the exams. If you would like to participate, contact the director of certification at 773-880-1460 or cchp@ncchc.org. Learn more at ncchc.org/cchp.
Exhibitor Opportunity

2013 Spring Conference on Correctional Health Care
April 20-23 • Denver

Nearly 1,000 correctional health professionals will convene in Denver in April, geared up to advance their knowledge and skills while earning continuing education credit. The NCCHC 2013 Spring Conference is a premier professional event for these highly motivated individuals, who also come for the outstanding networking and the opportunity to connect with valued partners in the exhibit hall. Over three days of exhibit hall activities, these decision makers and influencers will explore new ideas and proven solutions for managing the complex operational and clinical demands of health care delivery to inmates. Your company’s presence will make an impact, both on-site and long after the meeting ends.

Vast Marketplace
With more than 2.2 million people incarcerated in the United States, it is a huge, costly endeavor to provide constitutionally mandated health care to these individuals. And as inmate populations grow older, their health care needs—and related expenditures—are rising. As in the community, services span the spectrum, from acute care to chronic disease management to routine care, including dental and mental health, along with substance abuse treatment, prevention and health education. That’s a big challenge—and a big opportunity for companies that serve this market.

Build Relationships With the Best
Our multidisciplinary audience is a microcosm of the health care field at large. They are the leaders—and emerging leaders—in this field. Connecting with these influential professionals extends your reach to the departments, facilities and staff they work with every day.

The Value of Personal Contact
• To make an initial, face-to-face visit with a potential customer, the cost: without an exhibition lead is $1,039, on average. With an exhibition lead, it’s only $215!
• 61% of marketers considered exhibiting as the best means to effectively build brand image, and 63% considered in-person events as the best tactic to generate qualified leads. Source: Forrester Consulting Services on behalf of American Business Media

Exhibitor Benefits
• Three days of exhibit hall activities
• Two full conference registrations per 10’ x 10’ booth
• Discounted full registration for up to 5 additional personnel
• 50-word listing in the Final Program (deadline applies)
• Electronic attendee lists for pre- and post-show marketing
• Discounts on ads in the meeting programs and CorrectCare
• Lead retrieval technology available for rental on-site
• Opportunity to participate in raffle drawings
• Priority booth selection for the 2014 National conference

Sponsorship Opportunities
Enhance your presence and maximize marketing dollars through these outstanding opportunities.
• Premier programming: Educational sessions and breakfast/luncheon programs give attendees a fresh experience while giving your company exclusive exposure.
• Final proceedings: Marked with your company’s name, the proceedings enable attendees to continue their learning with the speakers’ PowerPoint presentations.
• Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
• Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
• Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

Registration Information
The NCCHC 2013 Spring Conference is the premier event where you can meet with key contacts and raise your profile, so reserve your space now. Standard booth sizes are 10’ x 10’, double-size and premium spaces are available. For an Exhibitor Prospectus with details and a reservation form, email NCCHCexhibits@ncchc.org or call 773-588-4692.
EMPLOYMENT

San Francisco Bay Area
Santa Clara Valley Medical Center. Challenging and exciting; help build medical home for those without one. Seeking BC/BE internist for a small group practice within a large safety net system. Work with underserved population in a correctional setting, re-entry clinic and county hospital. Affiliated with Stanford University; multiple teaching and research opportunities. Competitive salary, outstanding benefits.
Contact Alexander. Chyorny@hhs.sccgov.org.

Public Health Seattle & King County — An Employer that Embraces Diversity
Invites Applications for the Position of Jail Health Physician
Salary $139,736.61 - $177,121.57 Annually
Rare natural beauty, a flourishing metropolis, world-class educational systems, vital neighborhoods and a dynamic cultural and creative arts scene are just some of what ranks Seattle as one of the most livable cities in the country. Enjoy a temperate climate and a landscape surrounded on all sides by water and mountains.
We are currently recruiting for a physician in our Jail Health Services Division of King County Public Health. Our physicians provide direct patient care to jail inmates. Other responsibilities include participation in quality improvement / quality assurance programs to support Jail Health Services care goals; medical oversight, consultation, and management of specialized health care programs for Jail Health Services.
Extensive benefits package, which is second to none, includes: health, dental, and vision benefits for employee, family and domestic partner; defined contribution retirement plan (WA State Public Employees Retirement System); generous leave benefits; paid CME at $1000 per year; paid license / DEA / Board certification costs; no malpractice premiums.
Graduation from an accredited medical school, valid license to practice in the State of Washington, a current DEA registration and be Board eligible/certified in Family Practice or Emergency Medicine. *Board eligible candidates are required to obtain board certification within two years of hire.
View and apply for this position at: http://www.kingcounty.gov/healthservices/health/jobs.aspx. For information about the position, contact Nancy Barnum at (206) 263-8327 or nancy.barnum@kingcounty.gov. For information about the application process, please contact Reeshema Lewis, Human Resources Associate, at (206) 263-8413.
Public Health Seattle & King County is an Equal Opportunity Employer.

About CorrectCare™
CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.
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Expert Advice on NCCHC Standards

by Scott Chavez, PhD, MPA, CCHP-A

Triage in the Pods

Q: I am the interim clinical manager in a jail. We currently use a triage system in which inmates submit a written paper to request services. We have been doing a pilot program where we send a nurse to the women's pod five days a week to respond to general, non-emergent requests for services (colds, medication refills, minor symptoms, etc.). We also have an urgent care area that would handle emergent situations. We would like to do this with all of our pods. In reviewing the jail standards, I believe this would meet standards, but before we proceed, we would like your input.

A: Having a nurse triage complaints directly at the housing unit is certainly an acceptable method. However, three caveats must be considered. The first is access. Consider this triage system for seven days a week instead of five. If you plan to use a bifurcated system (personal triage Monday through Friday, written slips Saturday and Sunday), you may be creating some problems for access. Bifurcated systems are confusing for staff and inmates and may increase the risk of someone not being able to get their health needs known during the weekend. The second caveat is documentation. The standard requires that inmate requests are documented, so the triaging nurse needs to maintain a log of triaged complaints. The third caveat is privacy. All due caution should be taken to ensure that the triage encounter is performed with some privacy so that the inmate feels unencumbered when relating his or her health issues.

'Clinically Indicated' Health Assessments

Q: We are doing option two of the Initial Health Assessment standard (E-04). As the standard requires, all inmates receive a comprehensive receiving screen at intake. Medications are verified and continued from this screening. Anyone identified as having an acute or unstable condition is immediately admitted to the infirmary for follow-up. All other patients who need the initial health assessment are scheduled with a mid-level provider, who works Monday through Friday. For the stable patients who need the health assessment, if they come in on Friday and are seen on Monday, would that exceed the two days specified in the standard? It seems that for the stable patients, especially because we are continuing all medication treatments from intake, we would be meeting community standards.

A: First, you did not indicate who conducts the intake screening. To qualify for option two (Individual Assessment When Clinically Indicated), standard E-04 requires that a licensed health care professional conduct a comprehensive receiving screening.

In your process, individuals who have significant health problems are sent to the infirmary (it is assumed that the initial health assessment is done within two days). However, you have created a classification of "stable clinically significant finding." NCCHC does not recognize this classification. By definition, if one has been found to have a clinically significant finding—whether acute or chronic, stable or unstable—they are treated the same and hence are to have the initial health assessment within two working days.

Option two is meant to focus resources on patients with the greatest health needs. If the enhanced receiving screening process identifies individuals with any deviation from the normal that significantly affects their health, safety and welfare, then it is expected that the initial health assessment be done within two working days. "Working day" is defined as any day of the week except Sunday, public holidays and, in some cases, Saturday. Thus, a Friday admission would need the initial health assessment to be done on Monday.

Scott Chavez, PhD, MPA, CCHP-A, is NCCHC's vice president and liaison to the policy and standards committee. Send your question to accreditation@ncchc.org.
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