How to Manage the Alzheimer’s Patients in Our Prisons

Best Practices in Sick Call Management

Nursing Care of End-Stage Liver Disease

National Conference Preview
NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE

Learn... from peers and leaders in the field
Discover... new products and services in the exhibit hall to help you to avoid costs and overcome problems

Explore... emerging evidence-based practices
Immerse... yourself in programs, people and activities—all for professionals like YOU in correctional health care

October 26-30, 2013 • Renaissance Nashville Hotel

Learn more at www.ncchc.org. Or email info@ncchc.org.
CorrectCare® is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, law and corrections.

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.

Features

6 Spotlight on the Standards: Health Training for Correctional Officers
8 How to Manage the Alzheimer’s Patients in Our Prisons
12 Best Practices in Nursing Sick Call Management (Part 1)
16 Nursing Care of End-Stage Liver Disease in the Correctional Setting
19 Critical Commandments in Correctional Health Care (Part 2)

Departments

2 NCCHC News
3 National Conference Preview
4 News Watch
20 Journal Preview: HIV Services Often Differ From Policy and Best Practises
28 CCHP Page
29 Field Notes
31 Classified Ads and Ad Index
32 Standards Q&A

BOARD OF DIRECTORS

Judith Robbins, LCSW, CCHP-A (Chair)
National Association of Social Workers
Renee Kanan, MD (Chair-Elect)
American College of Physicians
Carl C. Bell, MD, CCHP (Immediate Past Chair)
National Medical Association
Patricia N. Reams, MD, CCHP (Secretary)
American Academy of Pediatrics
Thomas J. Fagan, PhD, CCHP (Treasurer)
American Psychological Association
Edward A. Harrison, CCHP (President)
National Commission on Correctional Health Care
Patricia Blair, JD, CCHP
American Bar Association
Eileen Couture, DO, CCHP
American College of Emergency Physicians
Kevin Fiscella, MD
American Society of Addiction Medicine
Joseph Goldenson, MD
American Public Health Association
Eric Handler, MD, MPH
National Association of County and City Health Officials
Robert L. Hilton, RPh, CCHP
American Pharmacists Association
Joflene Kerns, BSN, CCHP
American Correctional Health Services Association
Ilse R. Levin, DO
American Medical Association
Douglas A. Mack, MD, CCHP
American Association of Public Health Physicians
Nicholas S. Makrides, DMD
American Dental Association
Pauline Marcussen, RHIA, CCHP
American Health Information Management Association
Edwin J. Megarges, PhD, CCHP
International Association for Correctional and Forensic Psychology
Charles A. Meyer, Jr., MD
American Academy of Psychiatry and the Law
Eugene A. Migliaccio, DrPH
American College of Healthcare Executives
Ronald C. Moomaw, DO
American College of Neuropsychiatrists
Robert E. Morris, MD, CCHP
Society for Adolescent Health and Medicine
Peter C. Obez, PA-C
American Academy of Physician Assistants
Joseph V. Penn, MD, CCHP
American Academy of Child and Adolescent Psychiatry
Peter E. Perroncello, MS, CCHP
American Jail Association
George J. Pramstaller, DO, CCHP
American Osteopathic Association
Sherill B. J. Roberts
National Sheriffs’ Association
David W. Roush, PhD
National Partnership for Juvenile Services
Jayne Russell, MED, CCHP-A
Academy of Correctional Health Professionals
Steven Shelton, MD, CCHP-A
Society of Correctional Physicians
Ryong Suh, MD
American College of Preventive Medicine
Ana Viamonte Ros, MD
Association of State and Territorial Health Officials
Patricia Voermans, MSN, CCHP-RN
American Nurses Association
Barbara A. Wakeen, RD, CCHP
Academy of Nutrition and Dietetics
Henry C. Weinstein, MD, CCHP
American Psychiatric Association
Nancy B. White, LPC
American Counseling Association
Ronald Wilborg, MBA, CCHP
National Association of Counties

Cover design by Jill Cooper; cover image © AP Photo/Rich Pedroncelli

Copyright 2013 National Commission on Correctional Health Care. Statements of fact and opinion are the responsibility of the authors alone and do not necessarily reflect the opinions of this publication, NCCHC or its supporting organizations. NCCHC assumes no responsibility for products or services advertised. We invite letters of support or criticism or correction of facts, which will be printed as space allows. Articles without designated authorship may be reprinted in whole or in part provided attribution is given to NCCHC.

Send correspondence to Jaime Shinkus, Editor
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614
Phone: 773-880-1400, Fax: 773-880-2324
info@ncchc.org; www.ncchc.org
R. Scott Chavez Memorial Library Takes Root

Scott Chavez, PhD, MPA, CCHP-A, was a man who loved reading, learning and sharing his knowledge with others. The former NCCHC vice president viewed his work—with the Commission and in academia—as an opportunity to educate others for the betterment of all.

When Chavez died in March after a short illness, there was an outpouring of condolences from his colleagues and friends. A common theme was his mentorship and how he selflessly gave of his time and energy to help correctional health professionals and their facilities in their quest for improvement.

In recognition and appreciation of Chavez’s contributions to correctional health care during his quarter century of involvement in this field, the NCCHC board of directors has established a memorial library in his honor. Housed at the NCCHC offices, the library contains materials related to the history of correctional health care and the work that Chavez and like-minded colleagues did to raise the quality of care.

The board invites the public to donate materials to this effort. Such materials might include books, journals, letters, memorabilia, posters, photgraphs and other items that have historical value. Cash donations are also accepted. These tax-deductible donations will help to preserve the history of correctional health care and trace its progress over the years. Donors will receive a letter acknowledging their gift to NCCHC.

To make a donation, send your materials to NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614. For inquiries or for shipments that may require special handling, write to Amy Graves at amygraves@ncchc.org.

NCCHC Awarded NIC Grant to Develop Mental Health Curriculum

The National Institute of Corrections, the training division of the Department of Justice, has selected NCCHC to develop a curriculum on Planning and Implementing Effective Mental Health Services in Jails. This 18-month project dovetails with NCCHC’s recently completed Correctional Health Care Executive Curriculum Development project, also funded by NIC.

The cooperative agreement will create a program to train participants in the purpose, functions and operational complexities surrounding housing and treatment for inmates exhibiting signs and symptoms of mental illness. For mental health and custody professionals, being able to manage and treat these inmates can improve staff and public safety; reduce recidivism and help discharged inmates become productive members of society. The curriculum and pilot program will be completed by March 2015.

“NCCHC continues to be at the forefront of finding solutions to mental health issues in jails and prisons,” said Board Chair Judith Robbins, LCSW, CCHP. “The Commission has educated thousands of mental health professionals over the past 40 years and has introduced a specialty certification program (CCHP-MH) to recognize the specific knowledge required to work in mental health care in jails and prisons. NCCHC was clearly the right choice for this opportunity.”

Learn more about the project at www.ncchc.org/nic-mental-health-curriculum.

Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 27</td>
<td>Accreditation Committee meeting</td>
</tr>
<tr>
<td>Oct. 26-30</td>
<td>National Conference on Correctional Health Care, Nashville, TN</td>
</tr>
<tr>
<td>Oct. 27</td>
<td>CCHP exam, Nashville, TN</td>
</tr>
<tr>
<td>Nov. 6</td>
<td>CCHP exam, Sacramento, CA</td>
</tr>
<tr>
<td>Nov. 8</td>
<td>Accreditation Committee meeting</td>
</tr>
<tr>
<td>Nov. 15-16</td>
<td>CCHP exam, Phoenix, AZ</td>
</tr>
<tr>
<td>Feb. 22</td>
<td>CCHP exam, multiple regional sites</td>
</tr>
<tr>
<td>April 5-8</td>
<td>Spring Conference on Correctional Health Care, Atlanta, GA</td>
</tr>
</tbody>
</table>

For the complete list of CCHP exam dates and sites, see www.ncchc.org/cchp/calendar.

New Study Packages for Specialty Certification Candidates
The NCCHC catalog now offers two discounted packages of publications that are recommended reading for those taking the CCHP-Mental Health exam or the CCHP-RN exam. Depending on the package, the discounts can save you from 16% to 20% compared to the cost of buying each book separately. Find product descriptions online at http://www.ncchc.org/reference-sets.

More PREA Resources Online
The PREA Resources section of NCCHC’s website now offers video presentations from our Correctional Health Care Leadership Institutes and Correctional Mental Health Care Conference, both held in July. One addresses what health care leaders need to know about the Prison Rape Elimination Act, the other, trauma-informed care for inmate victims of rape. Find them at www.ncchc.org/video-presentations.

Welcome to New Staff Member!
Carmela Barhany has joined NCCHC as sales manager, assisting advertising and conference exhibition clients. She previously worked as advertising sales director for the University of Chicago, and prior to that held a similar position with the American Medical Association. Contact her at sales@ncchc.org or 773-880-1460.
The National Conference is the largest educational event in the world for correctional health care and features the most comprehensive and highest quality programming you’ll find anywhere. With sessions featuring the latest research, cost-effective solutions and interactive discussions, this program is designed to meet your needs and exceed your expectations. This is your opportunity to learn, network and share, choosing from more than 100 exceptional sessions, preconference seminars, expert panels and roundtables on every facet of correctional health care.

Preconference Seminars With Impact

Adding preconference seminars to your agenda can have a tremendous impact on your educational experience. Plus, get your first look at NCCHC’s 2014 Standards for Health Services for prisons and jails!

Saturday Seminars

• An In-Depth Look at NCCHC’s Standards for Health Services: Choose Jails, Prisons or Mental Health Services
• Nursing Skills Forum: Hands-On Practice in Five Key Skills

Sunday Seminars

• Affordable Care Act and How It Will Affect Correctional Health Care
• Beyond Good and Evil: Inside the Mind of the Psychopath
• Correctional Nursing: Applying the New ANA Scope and Standards of Practice
• Guiding Principles for a Viable Suicide Prevention Program
• Practical Preparation for Initial NCCHC Accreditation
• Prison Rape Elimination Act Training for Health Staff

This FREE session is supported by Grant No. 2010-RP-BX-K001 awarded by the Bureau of Justice Assistance.

You Need to Attend This Conference

Get Inspired! Join nearly 2,000 peers at the best program for correctional health care. Remember why you joined the field and leave energized, inspired and educated.

Engage With Experts! Learn from the country’s top experts, thought leaders and practitioners who are facing the same challenges you face each day. Get the tools, expertise, knowledge and contacts you’ll rely on in the long term.

Find Solutions! There’s no better place to connect with peers and suppliers to the field to find new solutions. Find answers you didn’t even know were available through the educational sessions and exhibits.

What You’ll Get

Continuing Education Credit. Up to 32 hours of CE credit is available to CCHPs, nurses, physicians, psychologists, social workers and others. The maximum number of hours includes attendance at the weekend seminars.

Conference Proceedings Online. Download or print the proceedings before you leave home.

Opening Ceremony and Keynote Address. Join us Monday morning for the most prestigious awards in our field as well as an inspiring address by Risa Lavizzo-Mourey, MD, president and CEO of the Robert Wood Johnson Foundation.

Breakfast Roundtable Discussion. Meet with your peers, enjoy breakfast and discuss challenges and solutions. Roundtables will address a variety of lively topics.

Outstanding Exhibits
Find cost-effective solutions, new products and ideas. Visit 100 exhibits showcasing medical services, supplies and equipment, pharmacy services, health care management ... plus more of what you need to be effective in 2014.

Exceptional Value

Sign up for 18 hours of stellar continuing education designed specifically for correctional health professionals. There’s nowhere else in the world where you’ll get such valuable information, irreplaceable networking and contacts with experts and peers. Add in preconference sessions and take home up to 32 hours of the CE you need.

Essential Education

With 100 concurrent sessions, the National Conference offers up to 32 hours of continuing education to cover every aspect of correctional health care. From administrative and legal issues to triage, disaster planning, juvenile issues, quality improvement and more, you’ll find the specialized information you need to face the challenges you see on the job every day. Critical topics addressed include:

• Affordable Care Act: What impact will the ACA have on your current and long-term funding and resources? Learn how it will be implemented in corrections and what changes will be necessary at your facility.
• Nursing Issues: From a seven-part nursing leadership track to hands-on practice and ANA standards, this conference is the place to be for nurses in correctional health care.
• Clinical Care: Providing the best quality patient care under difficult conditions demands knowledge and dedication. Get up to date on treating chronic conditions, managing pain, preventing illness and more.
• Mental Health Care: More than a dozen sessions are offered to help you manage difficult issues such as ADHD, administrative segregation, self-injury, use of the DSM-5 and more.

Preconference Seminars With Impact

Adding preconference seminars to your agenda can have a tremendous impact on your educational experience. Plus, get your first look at NCCHC’s 2014 Standards for Health Services for prisons and jails!

Saturday Seminars

• An In-Depth Look at NCCHC’s Standards for Health Services: Choose Jails, Prisons or Mental Health Services
• Nursing Skills Forum: Hands-On Practice in Five Key Skills

Sunday Seminars

• Affordable Care Act and How It Will Affect Correctional Health Care
• Beyond Good and Evil: Inside the Mind of the Psychopath
• Correctional Nursing: Applying the New ANA Scope and Standards of Practice
• Guiding Principles for a Viable Suicide Prevention Program
• Practical Preparation for Initial NCCHC Accreditation
• Prison Rape Elimination Act Training for Health Staff

This FREE session is supported by Grant No. 2010-RP-BX-K001 awarded by the Bureau of Justice Assistance.

All events take place at the Nashville Convention Center.
Visit our website for complete details, including a preliminary program, schedule at a glance, travel and housing information, registration rates and policies, and online registration.

www.NCCHC.org/national-conference
Rapid HIV Test Approved by FDA
The Food and Drug Administration has approved the first rapid HIV test for the simultaneous detection of HIV-1 p24 antigen as well as antibodies to both HIV-1 and HIV-2 in human serum, plasma and venous or fingerstick whole blood specimens. Approved for use as an aid in the diagnosis of HIV-1 and HIV-2 infection, the Alere Determine HIV-1/2 Ag/Ab Combo test is also the first FDA-approved test that independently distinguishes results for HIV-1 p24 antigen and HIV antibodies in a single test. Detection of HIV-1 antigen permits earlier detection of HIV-1 infection than is possible by testing for HIV-1 antibodies alone. "This test helps diagnose HIV infection at an earlier time in outreach settings, allowing individuals to seek medical care sooner," said Karen Midthun, MD, director of the FDA’s Center for Biologics Evaluation and Research. "Earlier diagnosis may also help to reduce additional HIV transmission."

Residential Recovery Court Aims to Reduce Recidivism
Tennessee has opened its first statewide, intensive residential facility for people with substance abuse or mental health issues. The goal is to end the cycle of hospitalization, incarceration and homelessness that afflicts many people who wind up in the criminal-justice system because of their addictions. The 100-bed facility is situated in an annex of the Morgan County Correctional Complex. The Tennessee Department of Correction estimates the average daily cost to house a prison inmate at about $67. The Recovery Court program will average $35 per person per day while providing more treatment services. It also is expected to save the state money by reducing recidivism. Legislators also allocated funds to create eight similar facilities across the state.

Poor Oral Health a Risk Factor for HPV Infection
Good oral health may reduce the risk of human papillomavirus infections in the mouth and subsequent HPV-related cancers, according to a study in Cancer Prevention Research (Aug. 23) and described in ADA News. HPV infection is the cause of 40% to 80% of oropharyngeal cancers, according to the researchers, who examined the relation between oral health and oral HPV infection and the interactive effects of oral health, smoking and oral sex on oral HPV infection. Data came from 3,439 participants aged 30-69 in the 2009-2010 NHANES study. The analysis found that poor oral health is an independent risk factor for oral HPV infection, irrespective of smoking status and oral sex behavior.

High Blood Sugar Linked to Dementia in Nondiabetics
Diabetes is a known risk factor for dementia, but in a study that tracked 2,067 elderly adults over nearly seven years, nondiabetics whose glucose readings averaged 105 to 120 mg/dL had an increased risk of dementia of 10% to 20%. The dementia risk was also higher among diabetics whose average glucose levels remained high. The study appeared in the Aug. 8 issue of the New England Journal of Medicine and was reported by Reuters. Every incrementally higher glucose level was associated with a higher risk of dementia in people who did not have diabetes, the lead researcher said. The study did not assess whether interventions to reduce glucose levels would decrease the risk.

At Wexford Health, we take our responsibilities seriously. That’s why we have been a trusted partner to more than 250 correctional facilities across the country, helping them to control costs without sacrificing quality of care, cutting corners, or inappropriately denying services. The pride we take in meeting your needs is plain to see.
Provide the care without the delivery costs.
Reduce the time it takes to see a provider.
Improve access to specialists.
Preserve security.
Correctional officers are a vital part of the process for delivering health care to inmates. Not only do they facilitate the work flow, they also represent many eyes and ears throughout the facility to alert health staff to inmates with possible health issues. Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations and understand their part in the early detection of illness and injury.

Standard C-04 focuses on a health training program for correctional officers. The intent of the standard is to promote the training of correctional officers to recognize when the need to refer an inmate to a qualified health care professional occurs and to provide emergency care until he or she arrives.

Training can be accomplished in a variety of ways, including classroom training, roll-call in-services, electronically or any combination of these methods. Health staff may have a role in the training or it could be conducted entirely by correctional staff who are qualified to instruct on such topics. Regardless of the method for training or who is responsible, the standard requires that correctional officers who work with inmates receive health-related training at least every two years. The training program must be established or approved by the responsible health authority in cooperation with the facility administrator.

Components of a Training Program

This standard outlines required components of the training program. These are the minimum requirements and additional topics can and should be added when appropriate. Cardiopulmonary resuscitation training should be provided by an approved body such as the American Red Cross or American Heart Association or by an individual possessing a current instructor’s certificate from an approved body. Generally, courses provided by an approved body will cover another component required by the standard: recognizing the need for emergency care and intervention in life-threatening situations such as a heart attack.

It is not uncommon for inmates who take medication or who have chronic illnesses to be housed in general population, away from health staff. Therefore, it is imperative that officers are able to recognize acute manifestations of certain chronic illnesses such as asthma, seizures and diabetes as well as adverse reactions to medications. Officers must also be able to recognize and alert health staff to inmates with symptoms of intoxication and withdrawal for early intervention and treatment.

Instruction in precautions and procedures with respect to infectious and communicable diseases ensures that officers are knowledgeable in preventing the spread of these diseases to other inmates, staff and visitors. In addition to understanding the proper procedure for handling infectious wastes, officers who work in facilities that have negative air pressure rooms should know how to protect themselves and others when respiratory isolation is indicated.

Another required component of a health training program is the administration of first aid. Courses are available through the previously mentioned approved bodies and may vary in their content. A good first aid component may be tailored to include topics that are common to your facility. For example, facilities with a high number of diabetic patients may want to include first aid response for diabetic emergencies. It is a requirement of the juvenile standards that child care workers assigned to outside programs such as forestry camps or routine outdoor recreation are current not only in CPR and first-aid training, but also in the prevention of heat-related illnesses.

Inmates with mental illnesses are common in correctional facilities and officers should be educated on recognizing the signs and symptoms of mental illness and procedures for suicide prevention. It is recommended that mental health staff review the training curriculum regarding these topics and offer communication skills for managing inmates with mental disorders.

The last required component of the training program is instruction in the procedures for appropriate referral of inmates with health complaints to health staff. This topic may be taught separately or can be referenced throughout the program with the other required components.

Other Requirements

Once the health training program is in place, an outline of the course content, including the length of the course, should be kept on file.

A certificate or other evidence of attendance must be kept on-site for each employee.

Lastly, it is important to note that although it is expected that 100% of correctional staff or child care workers who work with inmates or juveniles are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift in jails and prisons and 85% in juvenile facilities are current in their health-related training.

Having a well-developed health training program provides correctional officers with the knowledge to assist health staff in preventing, and responding when necessary, to adverse events within the facility.

Tracey Titus, RN, CCHP, is NCCHC’s accreditation manager. To contact her, write to accreditation@ncchc.org.

The complete Spotlight series is available in the Standards and Guidelines section at www.ncchc.org, along with an archive of Standards Q&A columns. For more in-depth information about the standards, attend one of the preconference seminars held at NCCHC’s annual spring and fall conferences.
Beyond a reasonable doubt... Medi-Dose® and TampAlerT®

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They’re tamper-evident, ultraviolet inhibitant and minimize errors and pilferage. Plus Medi-Dose contains no metal or glass!

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitant polyethylene, with either regular or child-resistant screw caps. Each cap contains a tamper-evident seal. And TampAlerT contains no metal or glass!

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

There’s no doubt about Medi-Dose and TampAlerT, proven in correctional facilities for over 30 years.

Medi-Dose®, Inc.
EPS®, Inc.
Responding to pharmacy packaging needs around the world

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.medi-dose.com
E-mail: info@medi-dose.com
By the year 2050, there will be more than 88 million people over the age of 65 in America. As the aging population increases, so will the prevalence of Alzheimer’s disease and other forms of dementia. Currently, Alzheimer’s affects more than 5 million people in America; many are inmates in prison.

The onset of Alzheimer’s is often gradual, and the disease process can last from three to 20 years. The Alzheimer’s victim may initially experience mild confusion and forgetfulness. However, as the disease progresses, the victim becomes incapable of performing routine tasks like bathing and dressing, and may begin to get lost in once-familiar surroundings; wandering becomes a serious safety issue at this point (not so much in a prison).

Personality and behavioral changes often occur to such a degree that agitation, anger, and combativeness become a common reaction to mild environmental factors. Toward the last stage of the disease, confusion is so profound that family and friends are no longer recognized, and the victim eventually becomes totally dependent on others for all activities of daily living.

Unfortunately, the federal and state governments across the nation are in budget crisis. It’s unreasonable to expect that correctional agencies will start building Alzheimer’s living environments with the special design features needed to accommodate inmates with cognitive impairments. That leaves you with only one option: develop and implement comprehensive dementia care training programs that teach staff and caregivers how to effectively manage and communicate with cognitively impaired inmates.

Communicate With R-E-S-P-E-C-T

Effective communication with confused inmates starts when staff and caregivers realize they need to change the way they communicate, because they cannot change the way the confused inmate communicates with them. The key to helping inmates with Alzheimer’s avoid frustration and achieve better communication is by speaking to them with R-E-S-P-E-C-T.

R = Reassure

A confused inmate will feel safer and can pay better attention with constant reassurance. Avoid startling the inmate and never approach suddenly; quietly and cheerily say “Good morning” as you near him or her. Always speak in a soft tone. Address him by name and introduce yourself as often as needed. This gentle reminding is actually a measure of comfort that caregivers can offer the inmate.

Help focus attention by maintaining eye contact and applying gentle touch to his hand or arm when needed. Never tower over or talk from behind a confused inmate; instead, face the inmate and communicate eye to eye. For example, when a confused inmate is sitting, kneel down until you’re eye-to-eye and then begin talking. Hearing aids and glasses should be worn and working properly to facilitate communication. Always reassuring the inmate will help
him relax and be more receptive to communicate.

E = Environment
Confusion can cause an inmate to be hypersensitive to disruption and the prevailing climate around him. Try to create and maintain the most soothing environment possible to help reduce disruption. Conversations should be held in areas free of distractions. Background noise such as radios or televisions, too much light, too little light, sunrays piercing through a window or hot and cold temperatures will interfere with the inmate’s ability to concentrate.

Agitation is often a result of something in the environment that overwhelms a confused inmate. When the first signs of agitation are observed, quickly look around the room to identify a cause. Then eliminate the cause. For example, if bright light is shining through a window, pull the drapes or blinds to see if the inmate starts to relax. However, if a precipitating cause can’t be identified, escort the inmate to another room. Often, a simple room change will distract the inmate and facilitate relaxation. A calm, soothing environment will help the inmate remain relaxed throughout the day.

S = Specify
Don’t add to confusion by discussing complex themes and topics. Stay concrete. Use small words and sentences as well as nouns and proper names. Pronouns such as his, hers, them and they should be avoided because they lead to speculation and erroneous interpretation. Never ask multiple-choice questions; instead, present questions in a manner that requires a yes/no answer. Multitask situations should be communicated, and completed, one step at a time. If the inmate doesn’t understand what is being said, repeat it exactly the way it was first presented. Being specific will prevent heightening confusion and improve comprehension.

P = Prepare
One of the most important aspects of caring for an inmate with Alzheimer’s is helping him get through the day without becoming overwhelmed. Often the inmate will display personality changes and resist activities of daily living. If the task is changing clothes, start by setting up the room and clothing before beginning. For example, lay out the clothes in a logical sequence: undergarments, socks, shirt, pants, and shoes. Give one-step instructions and complete each step before beginning the next.

When an inmate with Alzheimer’s feels agitated, he becomes more confused and less able to understand the cause-and-effect relationship of his behavior. Resistance, anger or combativeness may become the inmate’s way of nonverbally communicating that something is wrong. Therefore, it’s critical to anticipate inmate needs and routinely assess the inmate for hunger or thirst, pain, constipation or a simple need to go to the bathroom. By planning to eliminate stressors throughout the day, knowing what the inmate likes or dislikes and anticipating needs, it’s possible to reduce and prevent feelings of being overwhelmed and frustrated.

E = Encourage
To encourage conversation, never make a confused inmate feel pressured. Listen actively and focus undivided attention on what the inmate is saying. Smile often, nod and place a hand on his shoulder to help him stay focused. The inmate may lose his train of thought and stop in mid-sentence. Start the inmate again by repeating the last few words he said. Additionally, confusion will cause the inmate to have trouble finding the right words to communicate thoughts, and the inmate may describe a thing he can’t name, or substitute words that have a similar sound or meaning to what he is trying to describe. Try to guess what the inmate wants to say when he struggles to find words. If the first guess is wrong, guess again. Guessing usually reveals what the inmate wanted to say.

If the inmate appears too overwhelmed, disinterested and unable to focus, you can encourage further communication by telling the inmate you’ll be back in a few minutes and that you look forward to speaking to him again. After 10 or 15 minutes try again. If nothing seems to be working, check to see if you might be interfering with effective communication.

C = Check Yourself
Inmates with Alzheimer’s can be sensitive to the prevailing emotional climate within their surroundings. Again, it’s critical to remain calm and soothing in order to reduce their confusion and prevent agitation. Part of “checking yourself” includes not assuming the inmate isn’t capable of insight or comprehension, and then not including him in decisions. Ask, offer, suggest and encourage the inmate’s participation by always involving him in decision making regardless of how confused he appears. And frequently evaluate the way you’re communicating.

Are you being impatient and rushing the inmate? Are you actively listening? Are you arguing or contradicting? Are your body postures negative (rolling eyes, finger pointing, turning body away when spoken to, shaking head or sighing)? Even a confused inmate is still able to notice rude and demeaning behavior. Always be kind and respectful, and maintain positive behavior with the inmate.

T = Thank
Every inmate will respond better when treated with respect. Developing rapport with a confused inmate is key to gaining confidence and trust. As trust develops, the inmate will be more comfortable allowing others to spend time with him. As the comfort level increases, the inmate’s desire to cooperate will also increase, making it easier to complete tasks throughout the day. So always be appreciative to the inmate and frequently thank him for spending time with you, regardless of whether or not communication goes well.

Improving Relationships
When correctional staff and caregivers strive to make effective communication a priority, they create an environment that allows inmates to be more independent, less agitated

continued on page 10
and more comfortable to allow their residual strengths to surface and improve effort, ability and desire to communicate. By communicating with R-E-S-P-E-C-T, not only will the inmate with Alzheimer’s communicate better, but also your relationship with that inmate will improve.

Behavior Management
Efficient behavior management is also achieved through effective communication. “Sundowner’s syndrome” is a malady common in people with dementia and it occurs as night falls. Throughout the day, confusion, environmental and sensory stimulations and frustrations build up and inmates become increasingly confused. This incremental buildup causes anxiety and agitation, which may lead to pacing, wandering, even combativeness. It’s important that staff are taught that keeping inmates involved, within their cognitive capability, in a structured daily program will help prevent anxiety and agitation from escalating throughout the day.

As their memory and judgment progressively fail, it becomes more difficult for Alzheimer’s inmates to express their needs; often, feelings and concerns are expressed physically. To keep inmates comfortable and content, staff must know to routinely assess agitated inmates for pain, constipation, infection, hunger or thirst, or need to go to the bathroom. Aggression will increase when their basic needs aren’t met—a normal, human nature reaction, even for those who have no dementia.

Handling aggressive behavior is one of the most difficult aspects of dementia care. Again, avoid startling agitated inmates and don’t approach them suddenly. Always approach from the front and stay at a safe distance to respect their immediate need for personal space. Inmates with dementia can be hypersensitive to disruptions or to the prevailing emotional climate within their surroundings. Therefore, maintaining a calm and soothing environment, as much as possible, is essential in the effort to reduce confusion and agitation. Removing inmates from areas that create overwhelming feelings often calms them immediately. Always simplify instructions and use distraction by redirecting to another topic or activity.

The best way to prevent aggressive behavior is to know the inmates and to anticipate their needs, and to help them avoid stressors throughout their day. Another important indicator of quality Alzheimer’s care is a commitment to continuity of care by having the same staff or caregivers work with the same inmates.

Train Staff Now
Alzheimer’s disease is becoming the health care challenge of the future. And so it is with the inmates in our prisons. Taking care of those inmates will be increasingly difficult for the system, and we must carefully prepare to do our very best to provide the level of care that will be expected of us.

Lack of funds throughout the nation translates to an inability to build special facilities for Alzheimer’s inmates, nor can we expect funding for additional equipment or Alzheimer’s-related resources. Unless staff can be trained to correctly handle those patients, we may be seen as not meeting their health care needs. There will be lawsuits; dealing with those inmates will create problems for staff, as well as in the general population.

The best way to approach this eventualty is to start training staff now. The methods for dealing with dementia or Alzheimer’s are logical and essentially simple. Staff can be brought up to speed quickly. Better get started today, because any day now you’ll have many Alzheimer’s inmates. And you really need to be prepared. For your well-being, as well as the inmates’.

Jaime Todd, MBA, LNHA, is the chief support executive for California Correctional Health Care Services, Sacramento. For more information, contact him at jtaandarlene@verizon.net.

Activities of Daily Living
ADL care is easier when staff realize they need to adapt all tasks to the inmate’s highest level of functioning. Staff must understand that the inmate’s participation in tasks is more important than completing the task. Staff must also remember to always thank the inmate for participating in ADL care, regardless of how much the inmate completes.

Dressing
Preferably, have matching tops and bottoms, then lay out clothing in a logical sequence: undergarments, socks, shirt, pants and shoes. Based on decline in inmate’s motor skills, it may be preferable to have clothing with Velcro, large front snaps or large zippers to make dressing easier. Loose-fitting clothing with elastic around the waist makes dressing much easier for the staff and inmate. Clothes that are 100% cotton will not retain urine odor after washing. Slip-on shoes or hook-and-loop closure type shoes are also easier to put on.

Grooming
Make sure the bathroom area is clean and uncluttered before starting and lay out grooming articles within easy reach. It’s important to encourage independence and have the inmate complete as much of the task as possible. Large-print instructions posted next to the mirror or pictures of people performing the task may cue the inmate to complete the task. To overcome visual deficiencies, have a magnifying mirror, if possible. Often loss of strength and lack of coordination requires specially designed grooming implements to compensate for gripping or twisting difficulties.

Oral Care
Proper oral hygiene is important to maintaining adequate nutrition. Inmates with pain from toothaches or poorly fitting dentures will lose interest in eating, which may contribute to digestion problems and constipation. That’s why brushing teeth and cleaning dentures must be done daily, preferably after meals. If inmates are unable to follow simple directions, simply show the inmate how to open toothpaste, apply to brush and how to brush.

Experienced staff know to carry an extra toothbrush so they can demonstrate if necessary. Use a child-size toothbrush if inmates are fearful of objects being placed in their mouths, as well as children’s toothpaste that can be swallowed. If the inmate is absolutely resistant to brushing, have oral swabs soaked in mouthwash available. Sometimes inmates are more receptive to alternative ideas and soaking a soft washcloth in mouthwash is temporarily acceptable until an opportunity for better oral care arises. Dentures must be removed and checked daily. After removing the dentures, it’s important to check the inmate’s mouth for sores or signs of irritation. Check for odor, red gums, sores and lesions. Make sure the dentures fit properly; refer to dental if they don’t.
When you choose Corizon as your partner, you will work hand-in-hand with a skilled team that has the proven ability to face the unique challenges of correctional healthcare.

With nearly 35 years of innovation expertise in both jail and prison environments, we are prepared to partner with you in customizing a healthcare plan to fit the needs of your organization.

There is a reason we are the industry leader.

www.corizonhealth.com
Most correctional settings use the nursing sick call process to triage patient complaints, implement treatment interventions and schedule access to advanced provider services. This requires highly developed assessment skills, autonomous decision making and clinical reasoning, making NSC a highly rewarding nursing activity. It can also be a risky practice for the same reasons.

Access to Care
Due to the limitations on movement and the inability to seek out care and treatment as they would in the free world, inmates must rely on an organized system of care that addresses the need for both immediate and non-emergency health care access. It is critical that this system be explained to the inmate at the time of intake, both orally and in writing, and that inmates with language and literacy issues can understand the procedure to access sick call.

The plan for nonemergency access to medical, dental and mental health services should allow the inmate to refer him- or herself for preliminary evaluation and should ensure that inmates are seen in a reasonable period of time. Generally, a reasonable amount of time would result in resolution of a sick call request within 24 to 72 hours; however, all requests should be reviewed by a qualified health professional upon receipt to ensure urgent requests are prioritized.

Nursing sick call is one way that many correctional systems address access to basic health care needs. In most cases, nurses are on-site 24/7 or at least daily, so nurses are the gateway to all health services and to a higher level of care when needed.

Nursing Protocols
Well-developed nursing protocols are critical to a successful nursing sick call program. Many state nursing boards offer guidelines to help in the development of protocols, and many correctional systems are happy to share protocols when asked. But however you get started, it is critical that for each state, you research the nursing board regulation for scope of practice requirements in the use of protocols, as all states are not the same.

For nurses to properly address inmate requests, protocols must be developed that authorize the nurse to assess the patient complaint, collect the necessary subjective and objective data and provide interventions based on guidelines developed by a collaborative team that includes the responsible physician and the nursing administrator. This collaborative approach will ensure that all disciplines provide input into the appropriate use of each protocol. Important steps in the development of protocols include the following:
- A specific protocol should be developed for each condition or complaint.
- Each protocol should specify what subjective and objective data need to be collected during the patient evaluation, and allow for the nurse to determine whether different or additional information is needed.
- Protocols that address emergency response must also provide a sequence of steps to be taken to evaluate and stabilize the patient until a clinician is contacted and orders received for further care.
- Protocols should set parameters that direct the nurse when to call for advice from the physician and what information to have available when those calls are placed. Specific considerations such as time frames for referral, addressing multiple complaints and training of nurses on the use of protocols are important features to consider.
- A range of interventions that are appropriate to the nursing scope of practice should be included with each protocol. Some facilities use nursing protocols that allow nurses to provide prescription medication for certain non-emergent conditions following rigorous training and evaluation. Note that NCCHC standard E-11 Nursing Assessment Protocols, designated as an "Important" standard for purposes of accreditation, does not support this practice and will need to be sacrificed if the practice is used.

Development of protocols is an important key feature of nursing sick call, but do not forget that an annual review is required to ensure that each protocol meets the current practice standard in place for each condition. Additionally, protocols need to be reviewed and updated when formulary changes occur or new OTC medications are added to the commissary, and when a new medical director is in place to ensure approval from the responsible physician.

Finally, remember that there will be conditions when a specific protocol is not obvious. In those cases referral to a higher level of care is appropriate, in a time frame based on parameters set by the responsible physician.

Patient Education
All nursing encounters should include patient teaching, which is part of the nursing standard of care. Many times after careful assessment of the patient complaint you will determine that the best and only intervention might be education regarding the patient’s condition, lifestyle or self-care options.

The goal of patient education has changed from telling the client the best actions to take to now assisting clients in learning about their health care to improve their own health. Two important principles for providing patient education are simplicity and reinforcement. Although it is tempting to teach the patient everything we know about a given topic, in the name of simplicity we need to avoid doing that. Realistically, it is far better to choose three or four essential concepts about a topic and teach those.

Some facilities use preprinted educational material to hand out to patients, but remember that handing the patient a sheet of paper does not fully meet the needs of all patients. What if they can’t read, or don’t comprehend what
is written? What if they want to ask questions after they are done with reading?

Health literacy is the capacity to obtain, process and understand basic health information and services to make appropriate health decisions. According to the U.S. Department of Education, only 12% of English-speaking adults in the United States have proficient health literacy skills. The impact of limited health literacy disproportionately affects lower socioeconomic and minority groups.

Remember that you might be the first health care professional to take the time with this patient in helping him or her understand what you might consider basic information. Use that time wisely and the payoff for your patient will be long lasting.

**Documentation**

Documentation of patient care given is a professional and legal requirement, but the primary reason for complete, timely nursing documentation is that it is a communication tool. Moreover, documentation provides a legal record of patient assessment and treatment. Documentation can serve as legal evidence to demonstrate that the standard of care was met.

SOAP format is the most commonly used documentation format in correctional health care. It is a simple method of documentation well-suited to the ambulatory, episodic and varied nature of NSC. The initials stand for subjective, objective, assessment and plan.

Subjective data is information given by the patient. Often a neglected part of the assessment, a complete subjective assessment is crucial and should determine the subsequent objective assessment. In our case study, the nurse gathered information about patient symptoms that had been present for two months. But a review of the family medical history yielded valuable information that led the nurse to suspect that the patient’s symptoms might be related to diabetes as well as hypertension. It was this information that led the nurse to conduct a head-to-toe assessment and fingerstick glucose testing rather than a focused assessment.

Objective data is the hands-on physical examination and reports of physical data like lab reports. There is nothing magical about physical assessment—you cannot just look at a patient and see his or her physical signs and symptoms. Objective assessment needs to be methodical, thorough and hands-on.

Assessment is probably the least understood part of the format. For SOAP documentation, assessment is the nurse’s decision about the cause of the patient’s complaint. As a best practice, the assessment should contain some differential diagnoses—other diagnostic considerations, including a worst-case scenario, that will help nurses avoid the tunnel vision that can result when a nurse selects a particular nursing protocol. It can be tempting to make the patient’s assessment findings “fit” a selected protocol.

Finally, the plan is how the nurse will address the findings. The diagnosis and plan need to be consistent with the subjective and objective assessment. Furthermore, the plan should contain time frames, such as when the patient will see an advanced provider or when the patient should return to NSC if treatment is not effective. In our case study, the assessment findings pointed to health problems that are beyond the nurse’s legal ability to order additional diagnostic tests or provide treatment, so the patient was referred to a physician the same day.

---

**Case Study**

A 50-year-old African-American male submitted a sick call slip saying, “I just don’t feel right.” When seen in NSC, the patient gave the following information:

- I’m tired all the time and can’t keep up with my job in the kitchen. I need a job where I don’t have to work so hard.
- My eyesight is getting worse; I need new glasses.
- I’m losing weight, but I’m not trying to.

**Vital Signs**

Found to be moderately obese with a weight of 263 and height 5’10”; T = 98.20, P = 86, R = 12, BP = 140/85

**Subjective Assessment**

- Symptoms present for two months: in addition to stated complaints, lack of appetite and an upset stomach, attributed to “prison food”
- Past medical history unremarkable; family history included heart disease, hypertension and diabetes in first- and second-degree relatives

**Objective Assessment**

Due to the vague nature of the patient’s complaints related to multiple body systems, the sick call nurse completes a full assessment, with the following findings:

- Assessment findings within normal limits
- Fingerstick glucose (performed because of the patient’s family history of diabetes) = 200

**Nursing Diagnosis**

Potential complication, hyperglycemia, elevated BP

**Plan**

The patient was referred urgently to a physician for a medical work-up.

continued on page 14
Tired of not having a life of your own? Has your practice been affected by recent health care changes? Working for Wexford Health Sources, Inc. will enable you to have a rewarding career, as well as have your life back.

The Benefits:
- Company-paid medical malpractice insurance
- Generous paid-time off program that combines vacation and sick leave
- 40-hour workweek
- Majority of on-call is phone-only
- No completing insurance forms and waiting for reimbursement
- No costs associated with private practice
- Annual review with performance increase
- Paid holidays
- Comprehensive health insurance through Blue Cross Blue Shield
- 401(k) retirement saving plans
- Company-paid short-term disability
- Healthcare and dependent care spending account
- Full health, dental and vision benefits
- Annual review with performance increase
- Paid holidays
- Comprehensive health insurance through Blue Cross Blue Shield
- 401(k) retirement saving plans
- Company-paid short-term disability
- Healthcare and dependent care spending account
- Full health, dental and vision benefits

Nationwide opportunities available in:
- Maryland
- West Virginia
- Pennsylvania
- Mississippi
- Southern Florida
- Illinois

Contact one of our Physician Recruitment Consultants:

MD & WV – Kelly Walker, kwalker@wexfordhealth.com: 1-800-903-3616 x247
PA – Jennifer Tutich, jttutich@wexfordhealth.com: 1-800-903-3616 x313
MS – Shanda Briddell, sbriddell@wexfordhealth.com: 1-801-991-4160
FL – Marissa Solomon, msolomon@wexfordhealth.com: 1-800-903-3616 x258
IL – Rebecca Kokos, rkokos@wexfordhealth.com: 1-803-831-8770

Wexford Health Sources is an Equal Opportunity Employer.

Sue Smith, MSN, RN, CCHP-RN, is a correctional nurse educator based in Ohio; Kathryn Wild, MPA, RN, CCHP, is an independent consultant based in California. To contact the authors, email Smith at nsuesmith48@yahoo.com and Wild at kwild@usa.net.
Specialty certifications for qualified mental health professionals and registered nurses

**CCHP-MH** Correctional mental health professionals face unique challenges. They must provide effective, efficient care to a high-acuity population while facing strict security regulations, crowded facilities and myriad legal and public health concerns. Specialty certification recognizes dedication to quality service delivery. Eligibility is extended to qualified mental health professionals as defined by NCCHC’s Standards for Mental Health Services.

**CCHP-RN** Specialty certification makes a difference—to the patients whose care is provided by certified correctional nurses, to employers who desire top-notch nurses on staff and to the nurses who attain the credential. CCHP-RN certification recognizes registered nurses who have demonstrated the ability to deliver specialized nursing care in correctional settings.

Advanced certification for seasoned professionals

**CCHP-A** The CCHP-Advanced program recognizes CCHPs who have demonstrated excellence, commitment and contribution to the field of correctional health care and their relative discipline or profession. Advanced certification requires at least three years of participation in the certification program, completion of a detailed application and demonstration of extensive experience in and 360-degree knowledge of correctional health services delivery.
Nursing Care of End-Stage Liver Disease in the Correctional Setting

by Richmond James Rada, MSN, RN, CCHP

End-stage liver disease is the final stage of liver injury. Over time, continuous liver damage leads to abnormal or pathological changes in the liver, including fibrosis (the scarring process that represents the liver’s response to injury) and the formation of regenerative nodules. Progressive hepatic fibrosis with resultant distortion of hepatic architecture and formation of regenerative nodules results in liver cirrhosis.

Many conditions can cause repeated liver injury, including chronic alcoholism, hepatitis infection, chronic heart failure, hepatobiliary obstruction and metabolic conditions. However, in the correctional setting, the most common causes of cirrhosis are hepatitis infection (primarily hepatitis C) and chronic alcoholism. Studies show that one in every three HCV-infected persons in the United States passed through the jail or prison systems. A history of chronic alcoholism is also very common among inmates. With current trends, it is projected that more and more incarcerated individuals will have liver damage at the time of their commitment, and some of these inmates already have ESLD or will develop ESLD.

ESLD is a complex disease process with several sequelae and complications. Good understanding of liver function and the pathophysiology of liver disease helps to identify the causes of ESLD complications in order to develop appropriate nursing care plans (see table).

It is very challenging to develop nursing care plans for ESLD patients. The sections below outline applicable nursing diagnoses, actions and responsibilities in caring for ESLD in a correctional setting. Medication adherence is essential, so drugs commonly prescribed to treat various sequelae and complications of ESLD are also noted.

Interdisciplinary communication and a collaborative treatment approach are also very important. Correctional nurses must cooperate with other disciplines such as mental health, dietitian, pharmacist, primary care provider, specialist, pastoral care and other allied health professionals as well as custody officers in the development and implementation of an individualized and comprehensive care plan.

Hepatic Encephalopathy

Nursing Diagnosis: Risk for the following: diarrhea, imbalanced fluid volume, falls and injury

Common Medications: Lactulose to draw ammonia from the blood into the colon for excretion; rifaximin to decrease intestinal bacteria that form ammonia

Nursing Action and Responsibilities
- Medication nurse should ensure that patient takes lactulose as prescribed. Lactulose dose is titrated to produce at least three bowel movements a day. Give patient adequate supply of tissue paper per your institution’s policy. Notify the prescribing provider immediately if patient starts refusing lactulose due to diarrhea or other reasons.
  - If patient complains of diarrhea, hold the dose of lactulose. Do not give antidiarrheal drug using an established protocol for diarrhea. Notify the prescriber. The lactulose dosage maybe decreased or a few doses skipped before restarting.
- Provide health instruction on the importance of lactulose adherence in the management of ESLD.
- Assess and document patient’s neurological status frequently. Observe for behavioral changes, confusion, disorientation, changes in level of consciousness and unexplained falls or injuries. Ask patient about changes in sleeping pattern such as hypersomnia or insomnia.
- Assess for inability to follow directions or nonadherence to the treatment plan, which may also reflect encephalopathic changes. Instruct patient to perform simple tasks and observe how long it takes to perform the task or if the task is done correctly. Ask patient to repeat health instruction you provided. Ask questions.
- Notify the primary care provider (PCP) of any abnormal neurologic findings.
- Refer to mental health staff to rule out mental illness as the cause of behavioral changes.
- Educate custody officers to watch for these neurological changes and refer the patient immediately to health staff.

Esophageal and Upper Stomach Varices

Common Medications: Beta blockers such as propranolol to reduce portal blood pressure

Nursing Action and Responsibilities
- Monitor for signs of upper GI bleeding such as black tarry stool (melena), coffee ground or fresh blood emesis. Rupture of varices is a medical emergency and the patient could die of hemorrhagic shock.
- Assess patient for signs and symptoms of hypotension secondary to beta blockers such as light-headedness, syncope, dizziness or low blood pressure (< 90 systolic and < 60 diastolic). Notify the prescribing provider as the dose may need adjustment.
- Ensure that patient goes to routine esophagogastroduodenoscopy for monitoring the status of varices and sometimes for banding the varices to prevent rupture. Become familiar with pre- and post- EGD care.

Ascites and Lower Extremities/Scrotal Edema

Nursing Diagnosis: Excess fluid volume, risk for electrolyte imbalance, risk for imbalanced fluid volume, risk for impaired skin integrity

Common Medications: Diuretics such as furosemide and spironolactone
Nursing Action and Responsibilities

- Weigh patient weekly and obtain abdominal circumference. Inform the PCP if patient begins to have unusual weight gain or the abdominal girth increases.
- Assess the abdomen for distention.
- Assess patient for shortness of breath, especially during sleep, due to the fluid pressure to the diaphragm.
- Assess lower extremities and scrotum for presence of edema. Inform the PCP if edema and/or swelling worsen.
- Observe patient for signs and symptoms of hypotension and fluid/electrolyte imbalances such as low potassium as well as dehydration secondary to diuretics.
- If the volume of fluid in the abdomen is large, the patient may undergo a paracentesis to remove the fluid. Be familiar with pre- and postparacentesis care.

Infection Such as SBP

Nursing Diagnosis: Risk for infection such as spontaneous bacterial peritonitis

Common Medications: Antibiotic prophylaxis such as ciprofloxacin or TMP-SMX (Septra DS) given daily

Nursing Action and Responsibilities

- Immediately notify the PCP if patient develops fever or temperature > 100 F, moderate to severe abdominal pain or tenderness or changes in mental status.
- Ensure patient adherence with the antibiotic prophylaxis.

Blood Clotting Dysfunction (Coagulopathy)

Nursing Diagnosis: Risk for bleeding

Commonly Prescribed Medications: Vitamin K

Nursing Action and Responsibilities

- Assess for signs and symptoms of bleeding such as gum bleeding, bruise easily, blood in the stool, bleeding varices, blood in emesis.
- Do not prescribe NSAIDs (e.g., ibuprofen or naproxen) using protocol if patient complains of pain. Discuss with the PCP if patient requests new or additional pain medication.
- Review patient medication profile and identify any other medication that increases the risk for bleeding. Low-dose aspirin may be prescribed by the PCP and this is generally safe; however, excess NSAID could lead to bleeding.

Malnutrition, Generalized Weakness and Inability to Perform ADL

Nursing Diagnosis: Imbalanced/inadequate nutrition, impaired liver function, impaired physical mobility, activity intolerance, self-care deficit, risk for falls, risk for injury

Common Medications: High-calorie nutritional supplement, antiemetic drugs if patient complaints of nausea

Nursing Action and Responsibilities

- Assess patient for signs of malnutrition, and monitor

continued on page 18
ESLD Care (continued from page 17)

weight and lab values.
  • Seek dietitian consultation; determine if your institution can provide the dietary requirements for ESLD patients.
  • Educate patient on food choices at the canteen per dietitian recommendation.
  • For loss of appetite, encourage small frequent feedings.
  • Over time, ESLD patients may become unable to perform activities of daily living and daily prison programming. Advocate for transfer to a housing unit where health staff can monitor the patient frequently and assistance can be provided.

Generalized Pain

Nursing Diagnosis: Impaired comfort, chronic pain, activity intolerance

Common Medications: Analgesics such as acetaminophen, narcotics (opioids)

Nursing Action and Responsibilities
  • Assess patient level of pain. Most of the time, pain is described as generalized. Some patients will complain of abdominal pain due to distention. Work with PCP if the pain is not adequately controlled.
  • Do not give NSAIDS due to risk of bleeding.
  • Educate patient on medication compliance and how to request as-needed medication per institution policy.
  • Educate patient of drug side effects. If opioids cause constipation, stool softener may be added to the lactulose.

End-of-Life Decisions and Care

Nursing Diagnosis: Hopelessness, anxiety, powerlessness, risk for spiritual distress, social isolation

Common Medications: Antidepressant if patient is diagnosed with depression. Other psychiatric medications. ESLD is a terminal illness. The only option for survival is a successful liver transplant; however, due to several comorbidities, inmates usually are not candidates for liver transplantation.

Nursing Action and Responsibilities
  • Refer to a mental health professional for signs of depression, thoughts of suicide or other psychiatric symptoms.
  • Encourage verbalization of feelings, provide information and support regarding end-of-life care decisions.
  • Assist in completing forms regarding end-of-life wishes such as advance directives for health care per your state or institution policy.
  • Offer spiritual support based on the patient’s religion and beliefs. Seek assistance of pastoral care services, if available.
  • Ensure that next-of-kin information is documented in the patient’s record and facilitate family/friend visitations per your institution policy.
  • Discuss options for hospice services.

Richmond James Rada, MSN, RN, CCHP, is a nurse consultant with California Correctional Health Care Services, Sacramento. Reach him at richmond.rada@cdcr.ca.gov.

Accreditation: Pursuit of Excellence

RECOGNITION FROM THE MOST RESPECTED NAME IN CORRECTIONAL HEALTH CARE

Get recognized for your quality and commitment
  • Objectively validates the areas in which the health care facility is doing well and areas for improvement
  • Promotes and documents an efficient, well-managed system of health care delivery
  • Educates and trains staff on NCCHC standards
  • Minimizes the occurrence of adverse events, thus reducing health care-related liability
  • Recognizes staff contributions and excellence
  • Helps obtain community support and provides justification for budget requests
  • Protects the health of the public, staff and inmates

No other accreditation comes close to receiving the professional acceptance and recognition that goes with NCCHC health services accreditation.

Isn’t it time you became NCCHC accredited?

For more information on NCCHC accreditation, contact us at:
(773) 880-1460 • accreditation@ncchc.org • www.ncchc.org
Critical Commandments in Correctional Health Care (Part 2)

by Todd Wilcox, MD, MBA, CCHP-A

Correctional systems are rife with difficult institutional problems that impact health care services. To help correctional medical directors and administrators deal with these problems, Todd Wilcox, MD, MPH, CCHP-A, has prepared a list of “critical commandments.” The aim is to identify potential areas of risk that are frequently part of litigation and to offer long-term strategies to address these problem areas. This three-part series presents these commandments, some of which are relevant mainly to jail settings, along with a brief discussion of each.

Thou Shalt Own the Drunk Tank as Thine Own Unit
When inmates arrive intoxicated on alcohol, it is important to gauge the baseline mental status and to perform nursing assessments every two hours. Obtain a full set of vital signs as well as CIWA and Glasgow coma scale scores. Be sure to hydrate and feed the patient. The facility also needs clear guidelines on transferring patients to a higher level of care.

Thou Shalt Implement an Effective Withdrawal Screening and Management Program
For alcohol withdrawal, program components include screenings at least twice daily for five days, with a full set of vital signs and CIWA scores. Track CIWA scores serially and treat to suppress. Use benzodiazepines liberally, and assess and treat for dehydration. Fully assess nonresponders.

In cases of benzodiazepine withdrawal, patients on high doses are extremely prone to complications. Expect a high degree of anxiety, acting-out and self-injury. High doses must be tapered, preferably using long-acting benzodiazepines.

Managing opiate withdrawal includes obtaining a COWS score, assessing for suicidality and assessing and treating for dehydration, with attention to orthostatics, specific gravity on urine, electrolytes, BUN, creatinine and clinical signs. Be alert to comorbidities.

Thou Shalt Ensure All Prisoner Health Requests Are Triage Properly
To conduct triage, a proper scope of license is required. All five vital signs must be completed through face-to-face triage; paper triage is not safe or effective and should not be used. The facility must adhere to triage timelines. Finally, use triage aging reports to determine staffing.

Thou Shalt Understand and Control the Pharmacy Operation
It is essential that prescription orders are executed legally. Ensure that patient medication allergies are checked. For optimal operations, administrators must understand ordering timelines, stock levels, nursing administration practices, packaging practices, medication administration records and nursing documentation, medication return practices and standard-of-care discharge medication practices.

Thou Shalt Understand and Control All Scheduled Drugs
Management of scheduled drugs includes drug storage, accounting, administration, ordering and destruction.

Thou Shalt Develop an Institutional Method for Dealing With Risky Medications
Among the medications that can present risk in a correctional setting are tricyclic antidepressants, anticoagulants (Coumadin, heparin), digoxin, lithium, steroids, controlled substances, immunosuppressive agents and insulins.

Thou Shalt Ensure Medication Security
This includes the physical security of the pharmacy, inventory reconciliation and management of stock and return medications. Medication inventory must be reconciled against billing invoices and against the inmate roster.

Thou Shalt Implement Appropriate Intensive Medical Management Practices
Determine the legal requirements for intensive medical management and the legally defensible documentation for its use. Know the difference between custody use of force and medical use of force, as well as the timelines and restrictions for each. Physical restraints, forced medication and strip cells are all treated the same. Use the least restrictive means, and escalate the use of force only when necessary.

Thou Shalt Make Providers View X-Rays
X-ray reports may be helpful but are frequently incorrect. It is impossible for a provider to determine management of the patient without seeing the actual X-ray.

Thou Shalt Not Allow Health Care Myths to Propagate
How many times have you heard staff repeat myths such as the following? These beliefs jeopardize patient care.

• "It isn’t a seizure because she wasn’t incontinent."
• "His chest pain disappeared with Maalox so it isn’t cardiac in origin."
• "He has no rebound tenderness."
• "She wasn’t postictal so she is faking."
• "If he is trading, selling or not taking his medications, he obviously does not need them."

Todd Wilcox, MD, MBA, CCHP-A, is the medical director for the Salt Lake County (UT) Jail System and a frequent speaker at NCCHC educational conferences. He presented on this topic at the 2013 Correctional Health Care Leadership Institutes, held July 19-20 in Las Vegas.
Correctional Facility HIV Services Often Differ From Policy and Best Practices

Correctional facilities present an important public health opportunity to detect HIV infection in inmates, to facilitate access to HIV care during and after incarceration and to provide prevention interventions. But despite the existence of evidence-based practices and national guidelines for HIV services in correctional settings, it remains challenging for facilities to put these practices into routine use, according to the authors of a study in the October issue of the Journal of Correctional Health Care.

Steven Belenko, PhD, and colleagues report on findings from the Criminal Justice Drug Abuse Treatment Studies, a cooperative research program established by the National Institute on Drug Abuse to study ways to enhance adoption of evidence-based practices in corrections. One of the study protocols is focused on improving delivery of evidence-based HIV services in prisons and jails. Part of the project entailed conducting a survey of corrections agencies and specific prisons or jails within those agencies to ascertain current practices and gaps in HIV service delivery.

In the HIV Services and Treatment Implementation in Corrections study, self-administered surveys were completed by agency administrators (e.g., medical director, chief of clinical services, director of infection control) in nine state departments of correction and two county sheriff’s departments, as well as 37 staff (e.g., HIV counselor, health care unit administrator, institutional health authority) at 23 prisons and 14 jails within these agencies. The agencies were located across all regions of the country and included states with high, medium and low prevalence of HIV infection.

Wide Variations and Gaps in Concordance

Results indicate that policies and practices in HIV prevention, detection and medical care varied widely, with some corrections agencies and facilities closely following national guidelines and/or implementing evidence-based practices. Others had many gaps in the delivery of best practices. In addition, several states had low concordance between responses at the agency level and their respective facilities.

All 11 agencies reported conducting inmate HIV testing, but 5 of the 37 facilities said they did not do HIV testing. Although most agencies and facilities reported having written policies to guide their testing practices, there often was marked variation between the policy and actual practices.

The most common testing policy was opt-in (5 agencies, 29 facilities). Only 3 agencies and 6 facilities used the CDC-recommended opt-out HIV testing, and 2 agencies and 2 facilities reported used risk-based testing. In the vast majority of cases, the HIV testing practices did not adhere to CDC guidelines for regular and discharge testing. Most respondents reported barriers to increased HIV testing that pointed to insufficient resources and procedural reasons.

As to HIV education and prevention, there was a disconnect between the expected policies and actual practice, with all 11 agencies saying they routinely provide these services compared to only 20 of the facilities.

Agency- and facility-level respondents showed greater consistency in policies and practices to guide the care of HIV-infected inmates, as well as for prerelease discharge planning and for continuation of antiretroviral therapy following release. However, actual procedures for ensuring access to ART after discharge were less than optimal.

Study findings suggest several needed improvements in HIV testing, prevention and treatment policies and practices during and after incarceration, the authors say. It is also important to eliminate the discordance between agency policies and facility practices through organization-level strategies to improve policy implementation.
Symptom improvement was established in several pivotal trials
The safety and tolerability of LATUDA were evaluated in pivotal trials and multiple studies up to 52 weeks
The recommended starting dose, 40 mg/day, is an effective dose with no initial dose titration required. The maximum recommended dose is 160 mg/day
- LATUDA should be taken with food (at least 350 calories)
- Dose adjustment is recommended in moderate and severe renal and hepatic impairment patients. The recommended starting dose is 20 mg. The dose in moderate and severe renal impairment patients and in moderate hepatic impairment patients should not exceed 80 mg/day. The dose in severe hepatic impairment patients should not exceed 40 mg/day
- LATUDA should not be used in combination with strong CYP3A4 inhibitors such as ketoconazole or strong CYP3A4 inducers such as rifampin. When coadministered with a moderate CYP3A4 inhibitor such as diltiazem, the recommended starting dose of LATUDA is 20 mg/day and the maximum recommended dose is 80 mg/day

**INDICATIONS AND USAGE**
LATUDA is an atypical antipsychotic indicated for the treatment of patients with schizophrenia. Efficacy was established in five 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

**IMPORTANT SAFETY INFORMATION FOR LATUDA**

**WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS**

See full prescribing information for complete boxed warning.
- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.
- LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Please see additional Important Safety Information, including Boxed Warning, and Brief Summary of Prescribing Information on adjacent pages.
INDICATIONS AND USAGE
LATUDA is an atypical antipsychotic agent indicated for the treatment of patients with schizophrenia. Efficacy was established in five 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

IMPORTANT SAFETY INFORMATION FOR LATUDA

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS
See full prescribing information for complete boxed warning.

• Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.
• LATUDA is not approved for the treatment of patients with dementia-related psychosis.

CONTRAINDICATIONS
LATUDA is contraindicated in the following:

• Any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone.
• Concomitant use with strong CYP3A4 inhibitors (e.g., ketoconazole).
• Concomitant use with strong CYP3A4 inducers (e.g., rifampin).

WARNINGS AND PRECAUTIONS
Cerebrovascular Adverse Reactions, Including Stroke: LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Neuroleptic Malignant Syndrome (NMS): NMS, a potentially fatal symptom complex, has been reported with administration of antipsychotic drugs, including LATUDA. NMS can cause hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available.

Tardive Dyskinesia (TD): The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of TD. If signs and symptoms appear in a patient on LATUDA, drug discontinuation should be considered.

Metabolic Changes

Hyperglycemia and Diabetes Mellitus: Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Dyslipidemia: Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.

Weight Gain: Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Hyperprolactinemia: As with other drugs that antagonize dopamine D2 receptors, LATUDA elevates prolactin levels. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported in patients receiving prolactin-elevating compounds.

Leukopenia, Neutropenia, and Agranulocytosis: Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class. Patients with a preexisting low white blood cell count (WBC) or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy, and LATUDA should be discontinued at the first sign of a decline in WBC in the absence of other causative factors.

Orthostatic Hypotension and Syncope: LATUDA may cause orthostatic hypotension. Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension and in patients with known cardiovascular disease or cerebrovascular disease.

Seizures: LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower seizure threshold (e.g., Alzheimer’s dementia).

Potential for Cognitive and Motor Impairment: In short-term, placebo-controlled trials, somnolence was reported in 17.0% (256/1508) of patients treated with LATUDA compared to 7.1% (50/708) of placebo patients, respectively. Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

Body Temperature Regulation: Disruption of the body’s ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

Suicide: The possibility of suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer’s dementia. LATUDA and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

ADVERSE REACTIONS
Commonly Observed Adverse Reactions: (incidence ≥5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea and parkinsonism.

Please see brief summary of prescribing information on adjacent pages, including Boxed Warning.


FOR MORE INFORMATION, PLEASE CALL 1-888-394-7377 OR VISIT www.LatudaHCP.com.
dyskinetic movements that can develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that (1) is known to respond to antipsychotic drugs, and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on LATUDA, drug discontinuation should be considered. However, some patients may require treatment with LATUDA despite the presence of the syndrome.

5.5 Metabolic Changes
Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes were hypoglycemia, dyslipidemia, and body weight gain. While all of the drugs in the class have been shown to produce some metabolic changes, each drug has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus
Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies support an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Because LATUDA was not marketed at the time these studies were performed, it is not known if LATUDA is associated with this increased risk.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients may require continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Table 1: Change in Fasting Glucose

<table>
<thead>
<tr>
<th>LATUDA</th>
<th>Placebo</th>
<th>20 mg/day</th>
<th>40 mg/day</th>
<th>80 mg/day</th>
<th>120 mg/day</th>
<th>160 mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Change from Baseline (mg/dL)</td>
<td>n=680 n=71 n=478 n=508 n=283 n=113</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum Glucose</td>
<td>−0.0</td>
<td>−0.6</td>
<td>2.6</td>
<td>−0.4</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Proportion of Patients with Shifts to ≥ 126 mg/dL

<table>
<thead>
<tr>
<th>Serum Glucose (≥126 mg/dL)</th>
<th>(52/628)</th>
<th>(117/760)</th>
<th>(127/7449)</th>
<th>(6.8/32472)</th>
<th>(10.0/2680)</th>
<th>(5.6/6108)</th>
</tr>
</thead>
</table>

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in glucose of +1.8 mg/dL at week 24 (n=355), +0.8 mg/dL at week 36 (n=299) and +2.3 mg/dL at week 52 (n=307).

Dyslipidemia

Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics. Pooled data from short-term, placebo-controlled studies are presented in Table 2.
the prescription of these drugs is considered in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in mammary gland neoplasia was observed in a LATUDA carcinogenicity study conducted in rats and mice [see Nonclinical Toxicology (13)]. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans, but the available evidence is too limited to be conclusive.

5.7 Leukopenia, Neutropenia and Agranulocytosis
Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class.

Possible risk factors for leukopenia/neutropenia include pre-existing low white blood cell count (WBC) and history of drug-induced leukopenia/neutropenia. Patients with a pre-existing low WBC or a history of drug-induced leukopenia/ neutropenia should have their complete blood count (CBC) monitored during the first few months of therapy and LATUDA should be discontinued at the first sign of decline in WBC, in the absence of other causative factors.

Patients with neutropenia should be carefully monitored for fever or other symptoms or signs of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count < 1000/mm³) should discontinue LATUDA and have their WBC followed until recovery.

5.8 Orthostatic Hypotension and Syncope
LATUDA may cause orthostatic hypotension, perhaps due to its α1-adrenergic receptor antagonism. The incidence of orthostatic hypotension and syncope events from short-term, placebo-controlled studies was (LATUDA incidence, placebo incidence): orthostatic hypotension [0.3% (5/1508), 0.1% (1/708)] and syncope [0.1% (1/708), 0% (0/708)]. Orthostatic hypotension was defined by vital sign changes (≥ 20 mm Hg decrease in systolic blood pressure and ≥ 10 bpm increase in pulse from sitting to standing or supine to standing positions). In short-term clinical trials, orthostatic hypotension occurred with a frequency of 0.8% with LATUDA 40 mg, 2.1% with LATUDA 80 mg, 1.7% with LATUDA 120 mg and 0.8% with LATUDA 160 mg compared to 0.7% with placebo.

Orthostatic vital signs should be monitored in patients who are vulnerable to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications), and in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), or cerebrovascular disease.

5.9 Seizures
As with other antipsychotic drugs, LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold, e.g., Alzheimer’s dementia. Conditions that lower the seizure threshold may be more prevalent in patients 65 years or older.

In short-term, placebo-controlled trials, seizures/convulsions occurred in 0.1% (2/1508) of patients treated with LATUDA compared to 0.1% (1/708) placebo-treated patients.

5.10 Potential for Cognitive and Motor Impairment
LATUDA, like other antipsychotics, has the potential to impair judgment, thinking or motor skills.

In short-term, placebo-controlled trials, somnolence was reported by 17.0% (256/1508) of patients treated with LATUDA (15.5% LATUDA 20 mg, 15.6% LATUDA 40 mg, 15.2% LATUDA 80 mg, 26.5% LATUDA 120 mg and 8.3% LATUDA 160 mg/day) compared to 7.1% (50/708) of placebo patients. In these short-term trials, somnolence included: hypersomnia, hypersomnolence, sedation and somnolence.

Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

5.11 Body Temperature Regulation
Disruption of the body’s ability to sense core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration [see Patient Counseling Information (17.9)].

5.12 Suicide
The possibility of a suicide attempt is inherent in psychiatric illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

In short-term, placebo-controlled studies in patients with schizophrenia, the incidence of treatment-emergent suicidal ideation was 0.4% (6/1508) for LATUDA-treated patients compared to 0.8% (6/708) on placebo. No suicide attempts or completed suicides were reported in these studies.

5.13 Dysphagia
Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer’s dementia. LATUDA and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

Table 2: Change in Fasting Lipids

<table>
<thead>
<tr>
<th></th>
<th>LATUDA</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Change from Baseline (mg/dL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=660</td>
<td>n=71</td>
<td>n=466</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>–5.8</td>
<td>–12.3</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>–13.4</td>
<td>–29.1</td>
</tr>
</tbody>
</table>

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in total cholesterol and triglycerides of –3.9 (n=356) and –15.1 (n=357) mg/dL at week 24, –3.1 (n=303) and –4.8 (n=303) mg/dL at week 36 and –2.5 (n=307) and –6.9 (n=307) mg/dL at week 52, respectively.

Proportion of Patients with Shifts

<table>
<thead>
<tr>
<th></th>
<th>LATUDA</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cholesterol (≥ 240 mg/dL)</td>
<td>5.3% (30/571)</td>
<td>13.8% (8/58)</td>
</tr>
<tr>
<td>Triglycerides (≥ 200 mg/dL)</td>
<td>10.1% (33/326)</td>
<td>14.3% (7/49)</td>
</tr>
</tbody>
</table>

Weight Gain

Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Pooled data from short-term, placebo-controlled studies are presented in Table 4. The mean weight gain was 0.43 kg for LATUDA-treated patients compared to –0.02 kg for placebo-treated patients. Change in weight from baseline for olanzapine was 4.15 kg and for quetiapine extended-release was 2.09 kg in Studies 3 and 5 [see Clinical Studies (14.1)], respectively. The proportion of patients with a ≥ 7% increase in body weight (at Endpoint) was 4.8% for LATUDA-treated patients versus 3.3% for placebo-treated patients.

Table 3: Mean Change in Weight (kg) from Baseline

<table>
<thead>
<tr>
<th></th>
<th>LATUDA</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (kg)</td>
<td>−0.02</td>
<td>−0.15</td>
</tr>
</tbody>
</table>

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in weight of –0.69 kg at week 24 (n=755), –0.59 kg at week 36 (n=443) and –0.73 kg at week 52 (n=377).

5.6 Hyperprolactinemia

As with other drugs that antagonize dopamine D2 receptors, LATUDA elevates prolactin levels.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotrophin secretion. This, in turn, may inhibit reproductive function by impairing gonadal steroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynaecomastia, and impotence have been reported with prolactin-elevating compounds. Long-standing hyperprolactinemia, when associated with hypogonadism, may lead to decreased bone density in both female and male patients [see Adverse Reactions (6)].

In short-term, placebo-controlled studies, the median change from baseline to endpoint in prolactin levels for LATUDA-treated patients was 0.4 ng/mL and was –1.9 ng/mL in the placebo-treated patients. The median change from baseline to endpoint for males was 0.5 ng/mL and for females was –0.2 ng/mL. Median changes for prolactin by dose are shown in Table 5.

Table 4: Median Change in Prolactin (ng/mL) from Baseline

<table>
<thead>
<tr>
<th></th>
<th>LATUDA</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolactin (ng/mL)</td>
<td>–1.9 (n=672)</td>
<td>–1.1 (n=70)</td>
</tr>
<tr>
<td>Females</td>
<td>–5.1 (n=290)</td>
<td>–0.7 (n=19)</td>
</tr>
<tr>
<td>Males</td>
<td>–1.3 (n=472)</td>
<td>–1.2 (n=51)</td>
</tr>
</tbody>
</table>

The proportion of patients with prolactin elevations ≥ 5× upper limit of normal (ULN) was 2.8% for LATUDA-treated patients versus 1.0% for placebo-treated patients. The proportion of female patients with prolactin elevations ≥ 5× ULN was 5.7% for LATUDA-treated patients versus 2.0% for placebo-treated female patients. The proportion of male patients with prolactin elevations > 5× ULN was 1.6% versus 0.6% for placebo-treated male patients.

In the uncontrolled longer-term studies (primarily open-label extension studies), LATUDA was associated with a median change in prolactin of –0.9 ng/mL at week 24 (n=357), –5.3 ng/mL at week 36 (n=190) and –2.2 ng/mL at week 52 (n=307).

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin-dependent in vitro, a factor of potential importance if...
5.14 Use in Patients with Concomitant Illness
Clinical experience with LATUDA in patients with certain concomitant illnesses is limited [see Clinical Pharmacology (12.2)]. Patients with Parkinson's Disease or Dementia with Lewy Bodies are reported to have an increased sensitivity to antipsychotic medication. Manifestations of this increased sensitivity include confusion, obtundation, postural instability with frequent falls, extrapyramidal symptoms, and clinical features consistent with the neuroleptic malignant syndrome.

LATUDA has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical trials. Because of the risk of orthostatic hypotension with LATUDA, caution should be observed in patients with known cardiovascular disease [see Warnings and Precautions (5.8)].

6 ADVERSE REACTIONS

The following adverse reactions are discussed in more detail in other sections of the label:
• Use in Elderly Patients with Dementia-Related Psychosis [see Boxed Warning and Warnings and Precautions (5.1)]
• Cerebrovascular Adverse Reactions, Including Stroke [see Warnings and Precautions (5.2)]
• Neuroleptic Malignant Syndrome [see Warnings and Precautions (5.3)]
• Tardive Dyskinesia [see Warnings and Precautions (5.4)]
• Hyperglycemia and Diabetes Mellitus [see Warnings and Precautions (5.5)]
• Hyperprolactinemia [see Warnings and Precautions (5.6)]
• Leukopenia, Neutropenia, and Agranulocytosis [see Warnings and Precautions (5.7)]
• Orthostatic Hypotension and Syncope [see Warnings and Precautions (5.8)]
• Seizures [see Warnings and Precautions (5.9)]
• Potential for Cognitive and Motor Impairment [see Warnings and Precautions (5.10)]
• Body Temperature Regulation [see Warnings and Precautions (5.11)]
• Suicide [see Warnings and Precautions (5.12)]
• Dysphagia [see Warnings and Precautions (5.13)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The information below is derived from a clinical study database for LATUDA consisting of 2905 patients with schizophrenia exposed to one or more doses with a total experience of 985.3 patient-months. Of these patients, 1508 participated in short-term, placebo-controlled schizophrenia studies with doses of 20 mg, 40 mg, 80 mg, 120 mg, or 160 mg once daily. A total of 769 LATUDA-treated patients had at least 24 weeks and 371 LATUDA-treated patients had at least 52 weeks of exposure.

Adverse events during exposure to study treatment were obtained by general inquiry and voluntarily reported adverse experiences, as well as from results of physical examinations, vital signs, ECGs, weights and laboratory investigations. Adverse experiences were recorded by clinical investigators using their own terminology. In order to provide a meaningful estimate of the proportion of individuals experiencing adverse events, events were grouped in standardized categories using MedDRA terminology.

The following findings are based on the short-term, placebo-controlled premarketing studies for schizophrenia in which LATUDA was administered at daily doses ranging from 20 to 160 mg (n=1508). Commonly Observed Adverse Reactions: The most common adverse reactions (incidence ≥5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea and parkinsonism. Adverse Reactions Associated with Discontinuation of Treatment: A total of 9.5% (143/1508) LATUDA-treated patients and 9.3% (66/708) of placebo-treated patients discontinued due to adverse reactions. There were no adverse reactions associated with discontinuation in subjects treated with LATUDA that were at least 2% and at least twice the placebo rate.

Adverse Reactions Occurring at an Incidence of 2% or More in LATUDA-Treated Patients: Adverse reactions associated with the use of LATUDA (incidence of 2% or greater, rounded to the nearest percent and LATUDA incidence greater than placebo that occurred during acute therapy (up to 6 weeks in patients with schizophrenia) are shown in Table 5.

Table 5: Adverse Reactions in 2% or More of LATUDA-Treated Patients and That Occurred at Greater Incidence than in the Placebo-Treated Patients in Short-term Schizophrenia Studies

<table>
<thead>
<tr>
<th>Body System or Organ Class Dictionary-derived Term</th>
<th>Percentage of Patients Reporting Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System or Organ Class</td>
<td>Placebo (N=708)</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>5</td>
</tr>
<tr>
<td>Vomiting</td>
<td>6</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>5</td>
</tr>
<tr>
<td>Salivary Hypersecretion</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

In the short-term, placebo-controlled schizophrenia studies, data was objectively collected on the Simpson Angus Rating Scale for extrapyramidal symptoms (EPS), the Barnes Akathisia Scale (for akathisia) and the Abnormal Involuntary Movement Scale (for dyskinesias). The mean change from baseline for LATUDA-treated patients was comparable to placebo-treated patients, with the exception of the Barnes Akathisia Scale global score (LATUDA: 0.1; placebo: 0.0). The percentage of patients who shifted from normal to abnormal was greater in LATUDA-treated patients versus placebo for the BAS (LATUDA: 14.4%; placebo: 7.1%) and the SAS (LATUDA, 5.0%; placebo, 2.3%).
Dystonia

Class Effect: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first-generation antipsychotic drugs. An elevated risk of acute dystonia is observed in males and younger age groups.

In the short-term, placebo-controlled clinical trials, dystonia occurred in 4.2% of LATUDA-treated subjects (0.0% LATUDA 20 mg, 3.5% LATUDA 40 mg, 4.5% LATUDA 80 mg, 6.5% LATUDA 120 mg and 2.5% LATUDA 160 mg) compared to 0.8% of subjects receiving placebo. Seven subjects (0.5%, 7/1508) discontinued clinical trials due to dystonic events – four were receiving LATUDA 80 mg/day and three were receiving LATUDA 120 mg/day.

Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA Following is a list of adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2905 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic grounds. Reactions listed in Table 5 or those that appear elsewhere in the LATUDA label are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by organ class and listed in order of decreasing frequency according to the following definitions: those occurring in at least 1/100 patients (frequent) (only those not already listed in the tabulated results from treatment with LATUDA, they were not necessarily caused by it. Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA Following is a list of adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2905 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic grounds. Reactions listed in Table 5 or those that appear elsewhere in the LATUDA label are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by organ class and listed in order of decreasing frequency according to the following definitions: those occurring in at least 1/100 patients (frequent) (only those not already listed in the tabulated results from treatment with LATUDA, they were not necessarily caused by it. Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA Following is a list of adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2905 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic grounds. Reactions listed in Table 5 or those that appear elsewhere in the LATUDA label are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.
Figure 3: Impact of Other Patient Factors on LATUDA Pharmacokinetics

Renal impairment

<table>
<thead>
<tr>
<th>Level</th>
<th>Cmax</th>
<th>AUC</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td>Adjustment not required</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td>Starting dose = 20 mg</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td>Maximum dose = 80 mg</td>
</tr>
</tbody>
</table>

Hepatic impairment

<table>
<thead>
<tr>
<th>Level</th>
<th>Cmax</th>
<th>AUC</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td>Adjustment not required</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td>Starting dose = 20 mg</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td>Maximum dose = 80 mg</td>
</tr>
</tbody>
</table>

Population description

<table>
<thead>
<tr>
<th>Gender</th>
<th>Cmax</th>
<th>AUC</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td>Adjustment not required</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>Adjustment not required</td>
</tr>
<tr>
<td>Asian*</td>
<td></td>
<td></td>
<td>Adjustment not required</td>
</tr>
</tbody>
</table>

*Compare to Caucasian

10 OVERDOSAGE

10.1 Human Experience
In premarketing clinical studies involving 2905 patients, accidental or intentional overdose of LATUDA was identified in one patient who ingested an estimated 560 mg of LATUDA. This patient recovered without sequelae. This patient resumed LATUDA treatment for an additional two months.

10.2 Management of Overdose
Consult a Certified Poison Control Center for up-to-date guidance and advice. There is no specific antidote to LATUDA, therefore, appropriate supportive measures should be instituted and close medical supervision and monitoring should continue until the patient recovers.

Cardiovascular monitoring should commence immediately, including continuous electrocardiographic monitoring for possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with an acute overdose of LATUDA. Similarly, the alpha-blocking properties of bretylium might be additive to those of LATUDA, resulting in problematic hypotension.

Hypotension and circulatory collapse should be treated with appropriate measures. Epinephrine and dopamine should not be used, or other sympathomimetics with beta-agonist activity, since beta stimulation may worsen hypotension in the setting of LATUDA-induced alpha blockade. In case of severe extrapyramidal symptoms, anticholinergic medication should be administered.

Gastric lavage (after intubation if patient is unconscious) and administration of activated charcoal together with a laxative should be considered.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis.
CCHP-MH Specialty Certification Makes a Splash at Mental Health Conference

As reported in the last issue of CorrectCare, the Certified Correctional Health Professional program has developed a specialty certification for qualified mental health professionals. The first public discussion of the CCHP-MH program took place in July at NCCHC’s Correctional Mental Health Care Conference. In addition to NCCHC staff, many members of the CCHP-MH task force were on hand to help spread the word. A concurrent session on the topic drew a large audience eager to learn more about the program and how to apply. The requirements to apply for CCHP-MH certification are as follows:

- The applicant must be a qualified mental health professional as defined by the Standards for Mental Health Services in Correctional Facilities (2008) MH-A-02: “psychiatrist, psychologist, psychiatric social worker, licensed professional counselor, psychiatric nurse, or others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.”
- Prior to submitting an application, the applicant must have current CCHP certification, a graduate level (master’s and above) degree, professional licensure and the equivalent of three years of full-time practice in a correctional environment.

When all elements have been received and the application has been approved, incomplete applications will be kept on file for six months, after which time a new application and fees must be submitted. A candidate must take the exam within one year of the application approval date or the date closest to one year that the next exam is administered.

The purpose of the CCHP–MH exam is to measure knowledge, understanding and application of national standards and guidelines essential to the delivery of appropriate mental health care, legal principles for practicing within a correctional mental health care system, ethical obligations of correctional mental health professionals and these professionals’ role in delivering health care in the correctional environment.

The first exam will be held Oct. 27 at NCCHC’s National Conference on Correctional Health Care (see page 3), and special activities related to the program will also take place at the conference. For a list of other exam dates, as well as the application, please visit www.ncchc.org/CCHP.

CCHP Board Election Results

The votes have been counted and we have a winner: Charles Lee, MD, JD, CCHP, will serve a three-year term on the CCHP board of trustees starting Oct. 27. Now retired, Lee spent 13 years as a health care manager with the California Department of Corrections and Rehabilitation. He also is a physician surveyor for NCCHC. Watch this space for a profile of Lee in a future issue.
Correctional Health Professionals Week
The Academy of Correctional Health Professionals declares Oct. 27 – Nov. 2 as Correctional Health Professionals Week. The declaration states that “Correctional health professionals provide medical, dental and psychiatric care to one of the most challenging patient populations and in some of the most diverse settings within correctional facilities. These professionals face a complexity of acute, chronic and long-term care issues presented by this population. Advancements in medicine and patient care and the challenges of budget constraints, staffing issues and scarce resources contribute to the daily challenges.

“This week is dedicated to all of those special professionals who deliver quality health care to this special population in this work setting. Their commitment, competency and perseverance is recognized and applauded.”

The Academy invites attendees at NCCHC’s National Conference on Correctional Health Care to participate in the “Celebrate With Me” campaign (visit the Academy booth in the exhibit hall for details) and encourages correctional facilities to plan special events to celebrate their health professionals for their dedication and hard work.

American Dental Association
The ADA has launched an initiative to address the U.S. “dental crisis” by reducing socioeconomic disparities in oral health care. In an online survey of more than 1,200 adults, nearly half of lower-income adults said they haven’t seen a dentist in a year or longer, while 70% of middle- and higher-income wage earners have. The goal of “Action for Dental Health: Dentists Making a Difference” is to reduce the numbers of adults and children with untreated dental disease through oral health education, prevention and providing treatment now to people in need of care. Learn more at www.ada.org/8607.aspx.

Society of Correctional Physicians
The SCP board of directors has adopted a position statement concerning restricted housing of mentally ill inmates. It states that “prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment. Inmates who are seriously mentally ill should be either excluded from prolonged segregation status (i.e., beyond four weeks) or the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities and adequate time in an appropriately designed outdoor exercise area.” SCP also recommends obtaining mental health input into the disciplinary process to appropriately move some of these inmates into active mental health housing and programming rather than disciplinary segregation when the mental condition is a mitigating factor in the commission of the infraction.

In other news, SCP’s annual educational conference will be held Oct. 27 in Nashville in conjunction with NCCHC’s National Conference on Correctional Health Care. The day-long event will focus primarily on cancer but also will feature a panel discussion and a luncheon address on hunger strikes. Continuing medical education credit will be offered. Find details at www.societyofcorrectionalphysicians.org.

American Society of Addiction Medicine
In an effort to improve the quality of addiction treatment, ASAM has begun offering associate membership to professionals who spend at least 25% of their time teaching, conducting research or providing clinical care for individuals who are at risk for or have a substance use disorder. Learn more at www.asam.org.

In addition, professionals interested in receiving the top news in addiction medicine are invited to subscribe to ASAM Weekly. This free weekly email newsletter features the latest articles on addiction research, inside scoops on addiction public policy developments and more. Subscribe at http://multibriefs.com/optin.php?asam.

MEDICAL DIRECTOR / PHYSICIAN
CFMG, the leader in correctional health care has immediate openings for Physicians to work full-time to serve in the role of on-site Medical Director for the health care programs in Solano, Ventura & Stanislaus Counties.

Salary is $282,000 per/yr with shared call.
• Solano County position is based in Fairfield, CA
• Stanislaus County position is based in Modesto, CA.
• Ventura County position is based in Ventura, CA.

Responsibilities will include overseeing the quality of medical care, supervising the care & treatment performed by PA’s & FNP’s, & working closely with the Program Manager to facilitate the delivery of care to the incarcerated patient population.

Board Certified or Board Eligible in Internal Medicine, Family Practice or Emergency Medicine is preferred.

Please send Curriculum Vitae to: Elaine Hustedt
300 Foam Street, Suite B, Monterey, CA 93940
Fax: 831-649-8286  E-mail: elaine@cfmg.com
WWW.CFMG.COM
National Conference on Correctional Health Care
October 26-30 • Nashville Convention Center

Participate in the National Conference on Correctional Health Care—one of the world’s largest gatherings of nearly 2,000 professionals and experts covering all aspects of correctional health care. Attendees will come from all segments of the correctional health care community: administrators, medical directors, physicians, nurses, mental health professionals and more to share insights, find solutions and identify best practices. Connect with more decision makers than you could in months of knocking on doors and sending emails. Sign up for a cost-effective exhibition booth today!

Who Attended in 2012?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>43%</td>
</tr>
<tr>
<td>Physician/physician assistant</td>
<td>21%</td>
</tr>
<tr>
<td>Administrator</td>
<td>16%</td>
</tr>
<tr>
<td>Psychiatrist/psychologist</td>
<td>8%</td>
</tr>
<tr>
<td>Social worker, therapist, counselor</td>
<td>5%</td>
</tr>
</tbody>
</table>

Decision Makers With Authority

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>State medical director</td>
<td>4%</td>
</tr>
<tr>
<td>Medical director, director of nursing, other directors</td>
<td>20%</td>
</tr>
<tr>
<td>Health services administrator</td>
<td>13%</td>
</tr>
<tr>
<td>Department manager/supervisor</td>
<td>14%</td>
</tr>
<tr>
<td>Health services, dental or mental health staff</td>
<td>26%</td>
</tr>
</tbody>
</table>

Who Do Attendees Represent?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail facility</td>
<td>40%</td>
</tr>
<tr>
<td>Prison facility</td>
<td>23%</td>
</tr>
<tr>
<td>Private corporation</td>
<td>12%</td>
</tr>
<tr>
<td>State DOC/Agency</td>
<td>11%</td>
</tr>
<tr>
<td>Juvenile detention or confinement facility</td>
<td>4%</td>
</tr>
<tr>
<td>Federal agency</td>
<td>3%</td>
</tr>
</tbody>
</table>

Categories Attendees Recommend or Buy

- Dental care and supplies
- Disaster planning
- Electronic health records
- Health care staffing
- Information technology
- Medical supplies
- Mental health services
- Pharmaceuticals
- Safety equipment
- Suicide prevention
- Dialysis services
- Education and training
- Health care management
- Infection control products
- Medical devices and equipment
- Optometry services
- Pharmacy services
- Substance abuse services
- Treatment programs

Exhibitor Benefits

- Three days of exhibit hall activities
- Two free full conference registrations per 10’ x 10’ booth
- Discounted full registration for up to 3 additional exhibit personnel (per company)
- Direct access to attendees for premium face time
- 50-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and postshow marketing
- Ad discounts for the meeting programs and CorrectCare
- Opportunity to participate in raffle drawings
- Priority booth selection for the 2014 conferences
- Opportunity to attend sessions and earn CE credits
- Exclusive opportunity to become a sponsor or advertiser

Sponsorship Opportunities

Your brand will take center stage with these sponsorship opportunities. These high-profile options ensure branding and recognition throughout the event and are orchestrated to provide maximum exposure for your company. Plus, you gain extra exposure when attendees return home with these meeting mementos. Ask your sales representative to help you maximize your marketing exposure!

- Exhibit Hall reception, lunch or refreshment breaks
- Educational programming
- Internet kiosks
- CCHP lounge host
- Conference bags
- Badge holders
- Show bag insert
- Exhibit hall aisle drop

Become an Exhibitor Today!

The National 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 more information and a reservation form, email sales@ncchc.org or call 773-880-1460, ext. 298. Don’t forget to ask about sponsorships and advertising.
MARKETPLACE

Special Savings! 10% discounts for Academy members (single copies) and bulk purchases of a single item. (Excludes already-discounted items.) Find the complete catalog at www.ncchc.org and order at 773-880-1460.

NCCHC Scrubs
Enhance your professional appearance with these scrub tops featuring the NCCHC logo screen printed on the chest. Made of 65/35 poly/cotton, the reversible scrub top has a traditional full cut, chest pocket on both sides and set-in sleeves. Choose light blue or dark blue. Adult sizes: M, L, XL, 2XL, 3XL. $24

CCHP Tablet Bag
Carry your tablet or e-reader in style with this padded bag adorned with the CCHP logo. Bag features a removable zippered compartment that holds most devices, an exterior sleeve with double 16” reinforced handles, an adjustable shoulder strap, an open front pocket, pen loop and D-ring. $14.

A Practical Approach to Analyzing Healthcare Data
This basic, HIM-focused overview of statistics is meant to orient the reader to data analysis concepts. It offers hands-on tools for starting the analysis process for inpatient, outpatient and physician data and increasing critical thinking skills. Learning exercises use real-life data and problem-solving techniques, and direct readers to research online resources. A CD-ROM is packed with data analysis tools: reference materials, data files, calculators, tracking sheets and more. By Lynn Kuehn, MS, RHIA, CCS-P. AHIMA Press (2010). Softcover, 175 pp. $62.95.

MEETINGS

Hepatitis C & Hepatitis C/HIV Co-infection Treatment Update
Free live national webcast, Wed., Oct. 9, from 12 p.m. to 2 p.m. ET. Part of the biannual webcast series titled The Management of HIV/AIDS in Correctional & Community Settings; hosted by Albany Medical Center. Continuing education credit is available in selected disciplines (1.75 hours). Learn more and register online at www.amc.edu/hivconference.

EMPLOYMENT

Academy CareerCenter
The #1 Career Resource for Professionals in the Correctional Health Community
Looking for a job? This benefit is free to job seekers. Post your resume online and showcase your skills and experience to prospective employers to find the best job opportunities. Hiring? Receive member discounts on job postings and access the most qualified talent pool to fulfill your staffing needs. Hosted by the Academy of Correctional Health Professionals. For information or to access listings, visit http://careers.correctionalhealth.org.

Simplifind your search today at www.ncchc.org.

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.

Subscriptions: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, submit a request online at www.ncchc.org or by email at info@ncchc.org. The magazine is also posted at www.ncchc.org.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, email editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

ADVERTISER INDEX

Bristol-Myers Squibb ................................................................. BC
California Forensic Medical Group ........................................ 29
Certified Forensic Medical Group ...........................................15
Corizon .................................................................................... 11
GEO Group .................................................................................32
GlobalMed ................................................................................ 5
InFocus Lists ..............................................................................30
Journal of Correctional Health Care ....................................... 28
Medi-Dose/EPS .......................................................................... 7
MHM Correctional Services, Inc. ............................................ IBC
National Conference on Correctional Health Care ... IFC
NCCHC Accreditation ............................................................... 18
Sunovian Pharmaceuticals .........................................................21-27
Wexford Health Sources .......................................................... 4
Wexford Health Sources (recruitment) ................................. 14
Satellite Facility Requirements

Q: We have a jail system that consists of a main jail and a satellite about three miles away. This satellite is primarily used for intake and receiving. The health staff at the satellite does mass disaster drills at the main site, and process and outcome studies are also done at the main site. Both sites do man-down drills. Is this sufficient or does the satellite need to do mass disaster drills and CQI studies, as well?

A: The two standards in question are A-06 Continuous Quality Improvement Program and A-07 Emergency Response Plan. The intent of the CQI standard is that a facility uses a structured process to find areas in the health care delivery system that need improvement and that when such areas are found, staff develop and implement strategies for improvement. This includes doing the same for the satellite facilities. The number of process and outcome studies depends on the ADP of the satellite facility.

The intent of the Emergency Response Plan standard is that a facility protects the health, safety and welfare of inmates, staff and visitors during emergencies. Satellite facilities must be included in this process, as well. One mass disaster drill must be conducted annually in the satellite facility so that over a three-year period, each shift has participated. If full-time health staff are not assigned to a particular shift, that shift is exempt from drills. If there are no full-time health staff, drills are not required. The number of mass disaster drills that must be conducted in the satellite facility depends on the staffing plan.

Around-the-Clock RN Staffing

Q: Our jail is evaluating its staffing plan. Do the standards require that registered nurses be staffed at the facility around the clock?

A: No, there is not a standard that requires RNs to be staffed at the facility around the clock. Staffing plans of NCCHC-accredited facilities vary based on facility size and needs. The standard that relates to your question is C-07 Staffing. It requires a sufficient number of health staff of varying types to provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care. The responsible health authority must approve the staffing plan, and the adequacy and effectiveness of the plan should be determined based on the facility’s ability to meet the health needs of the inmate population.

‘Hands-Only’ CPR

Q: Recently we have discussed changing our training program for correctional officers to “hands-only” CPR. We have a large jail with around-the-clock medical staff coverage. Would we still meet the standard if we trained correctional officers to only perform chest compressions until medical staff arrives?

A: The standard in question is C-04 Health Training for Correctional Officers, which requires that correctional officers who work with inmates receive health-related training at least every two years. One element of the training is cardiopulmonary resuscitation. The standards do not give specific guidance on which type of CPR is required (e.g., professional rescuer, community or hands-only). As long as the course you propose using is from a recognized national body such as the American Red Cross or American Heart Association, then it would meet the intent of the standard. [Editor’s note: See Spotlight on the Standards, page 6, for more discussion about standard C-04.]
Managing pharmaceutical costs for large correctional systems is a difficult task. Our pharmacy management team serves as a valuable resource to our prescribing clinicians, providing guidance on prescribing patterns and the latest research on the clinical efficacy of numerous medications. Through training, technical assistance, and one-on-one consultation with prescribers, our pharmacy team helps clinicians make better-informed decisions about medication usage that lowers costs and improves clinical outcomes. Pharmacy team leaders, Dr. Gregg Puffenberger and Vince Grattan engage clinicians in the medication management process by leading best-practices training sessions on site, attending our clients' pharmacy and therapeutics committee meetings, and hosting routine conference calls with clinicians and medical directors.

**Results?** Over the last four years our clients saved $50 million in psychotropic medication costs. One of our client states saved nearly $8 million in a 12-month period as a result of our medication management program.

Delivering correctional healthcare the right way costs less. To find out how, contact Dr. Gregg Puffenberger at 800.416.3649 or gpuffenberger@mhm-services.com.
We discover, develop & deliver innovative medicines that help patients prevail over serious diseases.

Around the world, our medicines help millions of people in their fight against serious diseases.

Bristol-Myers Squibb is a proud sponsor of The NCCHC National Conference on Correctional Health Care October 26-30, Nashville
Please visit us in the exhibit hall.

For more information, please visit www.bms.com