By Jeremy Travis, JD, MPA, & Anna Sommers, PhD

By most measures, prisoners are burdened by health concerns at levels far higher than in the general population. They exhibit markedly higher rates of HIV and AIDS, tuberculosis, hepatitis C and mental illness. They have significant histories of alcohol and substance abuse, and higher levels of addiction. (See NCCHC’s report to Congress on the Health Status of Soon-to-be-Released Inmates, online at www.ncchc.org/pubs/sfrh.html.) Yet, unlike most Americans, prisoners have access to a health care system, paid for by taxpayers, that attends to a wide range of their health needs. They are typically screened for a variety of illnesses at admission, and can call upon this health care system to respond to needs ranging from routine illnesses to kidney dialysis and even heart transplants.

There is a second reality of imprisonment in America that puts the health profile of prisoners in a unique relationship to the American system of health care: Virtually all prisoners return home, bringing with them their health concerns. Except for those few who die in prison, all prisoners return to live again in free society. In recent years, “prisoner reentry” has received substantial attention among policymakers, practitioners and researchers, generating a widespread interest in new approaches to managing the inevitable return of large numbers of prisoners.

Fourfold Increase
In a time called by some the era of “mass incarceration,” the phenomenon of prisoner reentry today is quite different than it was just 30 years ago. Since the early 1970s, the nation has witnessed a fourfold increase in the rate of incarceration, resulting in a prison population of 1.3 million.

Given the inevitability of reentry, it is not surprising that the size of the annual reentry cohort also has grown substantially. In 2002, an estimated 630,000 individuals left our state and federal prisons, more than four times the number who made similar journeys 25 years ago.

Once they return home, the odds are high that they will return to prison. Within three years, two-thirds will be rearrested for serious crimes and one-half will be returned to prison. The large numbers of individuals with high rates of health problems who are sent to prison, return home and then, in many cases, are sent to prison again, pose both challenges and opportunities for health care providers, both those in correctional settings and those in the community.

A primary shortfall in practice to date is the absence of mechanisms to help addicted inmates, especially those who already participate in community-based OTPs, to help addicted inmates.

It also will smoothe the transition when the inmates are released, says addiction counselor Nancy White, MAC, LPC, an NCCHC board member who manages an integrated program for patients, including former inmates, diagnosed with chronic mental illness and substance abuse problems. “We know that opioid treatment relieves the narcotic craving that addicts describe as a major factor leading them to relapse and continued illegal drug use. If an inmate is released into the community already receiving opioid treatment, our communities should be much safer to live in.”

New Standards
As with health services accreditation, NCCHC standards are the foundation of the OTP program. The NCCHC Standards for Opioid Treatment Programs in Correctional Facilities are based on federal regulations but address the special nature of care provided in correctional facilities as well as the necessarily limited focus of such treatment in this setting. OTPs actively seeking accreditation by NCCHC are eligible for technical assistance consultation, funded by SAMHSA, that assesses current operations and itemizes what may be necessary to comply with the standards.

An OTP seeking accreditation from NCCHC need not be in a facility whose health services are accredited. To learn more about this program, e-mail NCCHC at OTPInfo@ncchc.org or call (773) 880-1460, ext. 294.
Commission on the Move

The National Commission on Correctional Health Care is moving its headquarters office to a new building this summer. Effective June 14, you’ll find us unpacking boxes and hanging pictures at a newly renovated two-story building on Chicago’s north side, about half a mile south of our current office. Our phone and fax numbers will remain the same. Here’s how to reach us:

1145 W. Diversey Parkway, Chicago, Illinois 60614
Phone (773) 880-1460 • Fax (773) 880-2424
E-mail info@ncchc.org • Web www.ncchc.org

Odds & Ends

• CE for psychologists. NCCHC has received approval from the American Psychological Association to provide continuing education credit to psychologists. The timing couldn’t be better: We always offer a mental health health track at our Spring and Fall conferences, we’re also hosting a two-day program dedicated to mental health topics this summer. To be held in Las Vegas on Sunday and Monday, July 11-12, the meeting will enable participants to earn up to 13 hours of credit. Learn more about the meeting on page 15.

• Juvenile Standards. After a great deal of care to review, revise and review again, NCCHC’s 2004 Standards for Health Care Services in Juvenile Detention and Confinement Facilities have been finalized and are now in production. A summary of changes vs. the 1999 version, along with a timeline for compliance, can be found on page 18. To order your copy, use the form on that page.

• More resources. In addition to the juvenile Standards, NCCHC has recently added several resources to its publications catalog. For product descriptions and ordering information, visit the Publications section of our Web site.

Health Assessment & Physical Examination, 2nd Edition, With CD Rom, by Mary Ellen Zator Estes, RN, MSN, CCRN; published by Delmar Learning; $75.95.

Treating Substance Abusers in Correctional Contexts: New Understandings, New Modalities, editor Nathaniel J. Pallone, PhD; published by Haworth Press; $39.95.

English & Spanish Medical Words & Phrases, 3rd edition; published by Lippincott Williams & Wilkins; $28.95.


Calendar

May 22-25
Updates in Correctional Health Care, Chicago
May 23
CCHP and CCHP-A proctored examinations, Chicago
June 25
Accreditation Committee meetings: Health Services and Opioid Treatment Program
July 12
CCHP proctored examination, Las Vegas
August 21
CCHP proctored examination, multiple sites (see page 4 for locations)
October 29
Accreditation Committee meetings: Health Services and Opioid Treatment Program
November 13-17
National Conference on Correctional Health Care, New Orleans
November 14
CCHP and CCHP-A proctored examinations, New Orleans

Las Vegas, Nevada

Mental Health in Corrections: Improving Treatment to Change Lives

July 11-12 • Paris Hotel

More than ever, correctional mental health professionals face enormous challenges in identifying and treating the growing numbers of individuals with mental health and substance abuse disorders in their facilities. This special two-day conference will focus on best practices in key areas as well as collaboration with community agencies.

Among the topics to be addressed are medication management, suicide prevention, life skills training, discharge/transitional planning, psychiatric rehabilitation, personality disorder treatment, gang management, sex offender treatment, impulse control methods, use of segregation, mental health staffing, drug and mental health courts, and more. To learn more turn to page 15, or visit our Web site at www.ncchc.org.

Congratulations to Barbara A. Wakeen, RD, on being honored by the American Correctional Food Service Association with its President’s Award, which recognizes her outstanding service to ACPSA and to it president. Wakeen represents the American Dietetic Association on the NCCHC board.

Board Member Update

NCCHC is pleased to welcome Peter E. Perroncello, MS, CJM, to its board of directors as representative of the American Correctional Association, for which he serves as president.

I am excited to join the NCCHC board and represent the people who toil, often without thanks, in the jails of America,” says Perroncello, who is a Certified Jail Manager through the AIA.

Perroncello is superintendent of detention and jail operations for the Bristol County Sheriff’s Office, a four-facility, 1,500 bed system in North Dartmouth, MA. He also is an experienced trainer and does training consulting for both the AIA and the National Institute of Corrections Jail Center.

In his role as NCCHC board member he is participating on the program committee, which establishes the educational curricula for conferences.

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Paradigm Shift: From Quality to Systems Excellence

By John M. Harrison, RN, BSN, MHSA

T

he mere men-

tion of the

word “quality”

usually evokes an

uncomfortable,

almost visceral

reaction of the

management

and staff

members alike.

Staff often lament,

“All those quality people do is create

more work for me and never make

my job better. I wish they would just

let us do our jobs.” Many managers

also have negative feelings about

quality efforts, viewing mandated

activities as an expense with no tan-
gible benefit, other than meeting the

requirements of regulations and

accreditation standards.

Unfortunately, quality has earned

this reputation for a reason. The

approach of most quality programs is
to identify “outliers,” a professional

version of the blame game. The goal

is to identify whoever was noncompli-
ant and take “corrective action.”

This is evident today with the prolif-

eration of retrospective record

reviews with check sheets whose tal-

lied results are communicated to the

staff through corrective action plans

purported to address the problem.

The results of these compliance-

focused drivers of quality have been

short-term and are not focused on

the true quality needs or necessary

improvements.

Despite the negative feelings about

quality programs, the professionalism

of health care employees has kept

the quality of health care today at

high levels. The Institute of Medicine

stated in its 2001 report, “Crossing the

Quality Chasm” that these profes-
sionals’ “courage, hard work, and

commitment...are the only real

means of stemming the flood of

errors that are latent...”

Importantly, the report also states

that the root of problems with health

care quality lies in outmoded systems

of work, not with workers. By some

mechanical flaws, not people

flaws, cause 80% to 90% of errors.

A Change of Focus

Therein lies the need for change to

systems-based quality—the paradigm

shift to systems excellence. In health

care, the overarching business goal

of systems excellence is to deliver
effective care while using resources

and time as efficiently as possible.

The paradigm shift has already

begun. Outside forces from the man-
facturing and other business worlds

(such as the Lean/6Sigma Group) are
demanding improved quality as a
nonnegotiable requirement for

health care contracts. Health care

organizations that have inculcated a
business excellence culture as their

driving organizational management

force are finding that the culture

change has had a positive impetus on

their ability to improve the effective-

ness of care delivered as well as the

business health (the bottom line)

through improvements in efficiency,

use of resources (human and physi-
cal) and employee retention, and

through decreased waste.

No off-the-shelf “soup-de-jour” pro-

gram will resolve all of the quality

issues in an organization. Each orga-
nization is unique in its problems,

resources, population requirements

and contractual/mission require-

ments. Management and quality pro-

fessionals must customize the quali-

ty prgmm to meet the unique needs

and requirements of the organiza-
tion and its customer base.

Departmental functional silos (ver-
tical management) must give way to

product/service delivery systems

(horizontal management). Quality

professionals must vacate the “quali-
ty department” and join the manage-

ment team, mentoring both manage-

ment and staff on how to continually

improve individual processes and sys-
tems to create a positive impact on

services and products.

Clinical quality (the outcomes of

the care provider’s decision processes

in developing a plan of treatment)

must be differentiated from the qual-

ity of the support services that

implement and sustain that treat-

ment plan (to include medication

administration, lab testing, etc.).

These decision-making systems and

support systems each impact clinical

outcomes but in a different manner.

It is essential for top management
to identify and measure key process-
es and systems. Managers and

employees must accept the fact that

without measurement, a process can-

not be effectively managed. When a

task (process) is not performed as

defined by the procedure manual,

the deviation usually occurs for one

of two reasons—either the process
does not work as structured/ designed

by management so the staff develop

a work-around, or the staff do not

know how to perform the process

correctly. Both causes are manage-

ment’s responsibility to identify and

address. Measurement is nec-

essary to identify when processes are

not producing the desired results.

Measures of productivity, effective-

ness and efficiency must become

tools used by frontline employees,

not the “quality nurse,” to evaluate

their processes and enhance efforts
to improve effectiveness and elimi-
nate unnecessary work and waste.

Employee feedback to management

on how to further improve the pro-

cess is vital. This direct involve-

ment fosters a work environment in

which employees actively seek to

improve processes when measures are

not within acceptable parameters.

Bringing It Home

Correctional health care will under-

go this paradigm shift. Consider the

intake medical assessment. This key

activity is a horizontal system com-
prising multiple individual processes

and subprocesses that cross depart-

ments and functions. It is designed
to provide the desired result: an in-
depth, accurate medical assessment of
every newly arriving inmate. This

result includes the development of a

treatment plan, with requisite orders

and activities, to ensure high quality
care during and chronic conditions.

Other key medical systems include

sick call, infectious disease manage-

ment and chronic care. Each system

and its subprocesses must be ana-

lyzed to identify gaps, delays, rework

and efficient flow. Employees who

perform the work, and those of other
disciplines, such as corrections offi-
cers, must partake in developing the
analyzing the analysis and the processes.

Involvement of all staff, to include

security staff who control movement

of the agency where he is employed.

Additionally, cutting pills might

violate prescribing laws that require

medication to be administered as pro-

scribed, even by the nurse, let alone

by nonlicensed staff. Cutting pills is

actually dispensing and probably

should only legally be done by a phar-
macist. Once that personnel cost is

factored in, there is no cost benefit.

I would not recommend that agen-
cies try to cut costs by cutting pills.

Better, and certainly safer, to focus

on contractual issues with suppliers.

Kevin M. Hepler, MD, MBA

Medical Director, Pennsylvania Dept.

of Public Welfare, Office of Children,

Youth and Families, Harrisburg, PA

Note: Dr. Hepler’s remarks are his pro-
fessional opinion rather than a policy

of the agency where he is employed.

Continued on page 20
Correctional MD Brings His Commitment to the Board

BY KRISTIN PRINS, MA

A quick look through Joseph Paris’ CV reveals a rich and diverse history. First there’s the list of credentials—PhD, MD, CCHP, FSCP—which signals impressive academic and professional achievement.

Another thing that stands out is his birthplace. Far from the peach trees of Georgia, where he now lives, Paris was born and raised in Argentina. He came to the U.S. in the 1960s for doctoral research in biochemistry; he stayed to study medicine at Boston University and later start a family.

But it’s the newest item on the CV that’s most exciting for the CCHP program: his recent appointment to the board of trustees. With nearly 20 years in correctional health care and 13 years as a CCHP, Paris is a strong leader who is sure to prove invaluable to the board’s work.

Making a Difference

In 1985, after a few years of private practice, Paris began consulting in internal medicine at a large prison hospital in Florida. “My correctional initiation coincided with the availability of the first antiretroviral, AZT,” he says. “I realized that I could be much more useful to inmate-patients than to my former private patients. There was a challenge and an opportunity to make a huge difference in my new patients’ lives.”

Paris’ correctional initiation was not an easy one, however. In an open letter titled “What I Should Have Said That Night—Thoughts on the Armond Start Award,” published in CorrDocs, the newsletter of the Society of Correctional Physicians, Paris writes, “If I had come prepared with a list of those to thank… I would have had to start with a nurse in Florida who patiently corrected my mistakes when, as a rookie in a state prison, I made mistakes on passes, medication administration processes and many other things that I now take for granted.”

What Paris doesn’t take for granted is continual improvement in the correctional health care field: He knows firsthand what it takes to make change happen. While he saw that many of his colleagues were satisfied with the status quo, he instead sought to improve procedure. “I was happy devising better systems, processes and policies to ensure that every patient got his or her due.”

The Total Package

Paris sees in certification both personal and professional improvement. CCHPs can network with each other, share concerns and tips, and demonstrate to themselves and others their professionalism and dedication to the cause of correctional health care. “CCHP certification is about inner satisfaction. It’s part of the total professional package,” he says.

For Paris, the total package is a multifaceted one. A medical/administrative track led him to his current position as medical director of the Georgia Department of Corrections. His interest in systemic improvements to correctional medicine has led to membership and leadership roles with numerous boards, societies and committees. He has served as president of the Florida chapter of the American Correctional Health Services Association, a founding member and past president of the Society of Correctional Physicians, was appointed a founding member of the editorial committee of Thrice Magazine, serves on the Correctional Medical Institute board, and is a charter board member of the Correctional Medical Directors Association. Paris also has a busy schedule publishing and presenting his work.

Asked what he hopes to achieve on the CCHP board, Paris says his “most cherished goal” is to help unite the profession. “Correctional health care workers need to labor towards a common goal: to better the health care of all incarcerated persons. But we face myriad affiliations and professional organizations. More than anything else, I want to be a healer and a leader striving for a way to reunite all of us.”

Professional goals aside, Paris also has many personal interests and hobbies, including playing piano. With commitments like his, one wonders how he has time to pursue any of them! But he makes time for what’s important to him. For instance, he finds that playing music at home with his wife of 30 years, Mary Rose, four children and friends is “a great way to finish a good day.”

Kristin Prins, MA, is the professional service assistant at NCCHC.
Correctional Health Info Online
After a major overhaul, the CDC’s correctional health Web site is better than ever. Operated by the agency’s National Center for HIV, STD and TB Prevention, the site’s mission is “to foster collaboration between public health organizations and the criminal justice system” by serving as a repository of correctional health care information. The site has six major sections, each with information and resources from federal and nonfederal entities. The six sections: About Correctional Health (introductory material); Health Issues in Corrections (e.g., infectious disease, chronic disease, women’s health); Special Topics (e.g., reentry, substance abuse); Key Tools (for health care delivery system management); Get Involved (listservers, policy statements, newsletters); and Links. Go to www.cdc.gov/nchstp/od/cccwg.

State Health Care Costs Outpace Budgets
From 1998 to 2001, state corrections budgets grew 8% per year, on average, outpacing overall state budgets by 3.7%. At the same time, correctional health care costs grew by 10% per year, and made up 10% of all corrections expenditures. These figures come from a recent TrendsAlert report from the Council of State Governments. Intended to educate state officials about the problem of health care costs, the report sheds light on the factors driving costs higher and presents policies and practices to help them deal with it. Among the policy options discussed are inmate co-pay, telemedicine, privatization, early release, utilization review, drug cost reductions, PPOs and HMOs, and others. Find a link to the report at www.csg.org/CSG/Products/trends+alerts.

Sharps Safety Workbook
Just one accidental prick with a contaminated needle can cause a health care worker to contract hepatitis, HIV or other bloodborne diseases. Even if disease is not transmitted, the exposure leads to costly prophylactic measures and can take a huge emotional toll on the worker. To help prevent such occurrences, the CDC has developed a workbook to educate health care personnel about steps they can take to protect themselves. The book also targets administrators in its quest to foster a “culture of safety.” Titled Sharps Safety: Be Sharp. Be Safe, the book is available online at www.cdc.gov/sharpsafety.

Unlocking Telehealth’s Potential
While noting that tens of thousands of Americans now access health care remotely from medically underserved areas, including prisons, a report by the U.S. Commerce Department’s Office of Technology Policy also finds that the nation has realized only a fraction of the potential for the technology to improve access and quality of care while reducing cost. The report identifies longstanding policy barriers—legal, financial, regulatory, organizational and process—and suggests a framework for advancing the adoption and application of telehealth technologies. Titled Innovation, Demand and Investment in Telehealth, the report is posted online at www.technology.gov/reports.htm.

Best Practices for Electronic Records
To further its goal of advancing electronic health information management (dubbed e-HIM), the American Health Information Management Association has issued best practice guidance in six key areas, including e-signatures, document management, core data sets and speech recognition, and plans to develop additional practice standards. The guidance reports are available online at www.ahima.org/infocenter/chim.

Latest Correctional Facility Census
The Bureau of Justice Statistics has released its 2000 Census of State and Federal Correctional Facilities. Among the highlights:
• In the five years from midyear 1995 to midyear 2000, the number of adult correctional facilities rose 14%, from 1,464 to 1,668.
• The number of privately operated facilities under contract with state or federal authorities to house prisoners grew by 140% (to 264), while the number of inmates in these facilities rose 45%.

Find the report at www.ojp.usdoj.gov/bjs/abstract/cf00.htm.

In the News

See You in Seattle!
NSA 2004, Seattle
June 26 - 30, 2004

Soak up the NSA Conference Experience
• Seminars
• Special Events
• Technology on Display
• Networking and Information Sharing

The National Sheriffs’ Association’s 64th Annual Conference & Exhibition in breathtaking Seattle will be an event for the entire criminal justice community.

For registration information, go to www.sheriffs.org
Call for Volunteers

Participating on a committee of the Academy of Correctional Health Professionals is one of the best opportunities for you to become more involved in your profession. As a committee member you will not only help the growth of the organization, but also enhance your leadership skills and abilities; strengthen your professional network; and establish new personal friendships that will last a lifetime.

Committees provide member oversight of the programs and activities of the Academy. Although each committee has its own charges and responsibilities, each acts as a strategic entity of the full board. Members are expected to participate fully in the work of the committee; provide thoughtful input to its deliberations; focus on the best interests of the Academy and the committee; and work toward fulfilling the committee's goals.

If you would like to be considered for appointment to a committee, please complete and submit the form below to Academy headquarters by fax, (773) 880-2424. You may also access an online volunteer form at www.correctionalhealth.org. If you have more questions, please contact us toll-free at (877) 549-2247.

Member Get a Member

Another way to help advance the Academy—enabling it to grow and, thus, offer more benefits and services for you—is to participate in our Member-Get-a-Member campaign.

For each new member you recruit, your name will be entered into a raffle to win Academy Bucks, which may be redeemed toward the purchase of Academy or NCCHC products such as publications as well as conference registration fees.

Here’s how it works:

- You must be a current member of the Academy to participate.
- Complete the Member-Get-a-Member prospect form online at www.correctionalhealth.org or, if you prefer, call us at (877) 549-2247 and we’ll send you a form.
- Your prospects will receive a membership kit and a letter that mentions your referral. We’ll send a copy of the letter and application to you. It’s your responsibility to make sure your prospects complete the application.
- If your prospects ask why they should consider joining, let them know about the many benefits, such as...
  - Journal of Correctional Health Care. Receive a free subscription to this quarterly publication with 400+ pages of original research each year. Each issue includes a self-study examination to earn continuing education credit.
  - Shared Interest Groups. These small, focused gatherings and online discussions foster education, information sharing and idea exchange with your peers.
  - Networking Opportunities. Share ideas and resources with others in the correctional health care field.
  - Education and Publications. Receive member discounts on Academy- or NCCHC-sponsored conferences, seminars and publications.
  - Web Site. The members-only section of our site offers access to an online membership directory and other features.

To receive credit for recruiting a new member, we must receive your prospect’s completed application and membership dues no later than October 1. To learn more about the campaign, visit the Academy online at www.correctionalhealth.org.

Join the Academy of Correctional Health Professionals today!

Please indicate on which committee(s) you would like to serve. If you are interested in more than one committee, please rank your preference, with 1 being most interested and 4 being least interested.

- Education
- Membership and Recruitment
- Mentoring
- Shared Interest Groups

Please return this form to the Academy of Correctional Health Professionals via fax (773) 880-2424 or submit it online at www.correctionalhealth.org.

New Benefit for Members!

Future of issues of CorrectCare will be available on the NCCHC Web site. Academy members, however, will continue to receive printed copies of this important publication in the mail.

Not a member? Join the Academy today by filling out the application card on the cover of this issue (or use the one below), or sign up online at the Academy Web site. To ensure uninterrupted service, send your membership application today!

For more information, please call our national headquarters office toll-free at (877) 549-2247 or e-mail us at academy@correctionalhealth.org.
Antibiotics for Pharyngitis? Rethink Your Protocols

BY JEFFREY KELLER, MD

I have practiced medicine for over 18 years and have gotten a lot of CMEs over that time. The lectures I enjoy most tend to be those exposing the myths of modern medical practice. You know the ones that I mean. They are the lectures comparing some common medical practice with the literature only to find that the practice doesn’t work—accepted wisdom about its efficacy is a myth. Just prior to its lamentable demise, the Western Journal of Medicine had a regular series devoted to debunking medical myths.

Myth busting like this is part of the overall movement toward evidence-based medicine, which, in a nutshell, states that we should compare everything we do as doctors with the scientific evidence of its effectiveness. When we do that, we will find there is a solid base in the evidence for only some of the things we do. Some of our practices have inadequate support in research—nobody really knows why they are truly effective. And some of what we do is flat out contradicted by the evidence. Every year, important research emerges that should make us change the way we practice medicine. Too often, however, we do not change.

We all know doctors who seem frozen in time; practicing medicine the way it was taught to them in medical school and residency. We ask ourselves, “Why is he still doing that?” However, that doctor is most of us. If we critically compare many of our habits with the medical literature, we invariably will find that we ourselves have habits we should abandon.

Failure to change practice based on new findings has been identified by many sources as a major problem with modern medicine. There is a gap, sometimes of many years, between what is known and what is practiced. Over the years, some information in medicine’s knowledge base is verified, and some is refuted. Whenever a new “fact” is added to the overall medical knowledge base through good and repeated research, it usually takes many years until that knowledge is incorporated into most physicians’ practice.

Case in Point

Even a casual review of medical textbook and the literature will bring to light several well-documented medical facts that are not widely reflected in the practices of U.S. physicians. One area getting a lot of press is the overuse of antibiotics. We doctors still think antibiotically. We all too often prescribe antibiotics (and very often expensive antibiotics) for viral illnesses such as pharyngitis, bronchitis and sinusitis despite the enormous amount of literature undermining the practice.

We all have heard about the emergence of resistant bacteria as a consequence of our national overprescription of antibiotics. We don’t so often hear of another downside to prescribing unneeded antibiotics—it is expensive. In fact, most evidence-based medicine principles are like that—if you adopt them, you will save money. What could be better? We provide better medical care to our patients and save money to boot!

One great example is evidence-based treatment of pharyngitis, the infamous “sore throat.” The subject of literally hundreds of published articles, this seems to be one of the single most studied topics in medicine. Fortunately, the Centers for Disease Control and Prevention in Atlanta has published an excellent review article along with recommendations that can serve as a basis for your facility’s “sore throat protocol.” Titled “Principles of Appropriate Antibiotic Use for Acute Pharyngitis in Adults,” the article was published March 20, 2001, in the Annals of Internal Medicine, along with similar guidelines for the treatment of sinusitis and bronchitis. (The articles are available via the CDC Web site at www.cdc.gov/drugresistance/community/technical.htm.)

In the pharyngitis article, the CDC makes the point that only about 10% of sore throat cases are caused by group A beta-hemolytic streptococcus (the so-called “strept throat”). Almost all of the remaining 90% of cases are viral in origin. Despite this, 75% of adults who present to a doctor with a sore throat will be prescribed antibiotics! What is the rate of antibiotic prescriptions for sore throat at your facility? It would be worth the effort to pull the last 100 charts where the chief complaint was sore throat and see how many of these patients received antibiotics.

Recommended Practice

The CDC recommends that antibiotics be limited to those patients who are most likely to have strep throat based on four easily evaluated clinical findings: (1) tonsillar exudates, (2) tender anterior cervical lymph nodes, (3) fever and (4) absence of cough. You then use these four criteria to determine who gets antibiotics in one of the following ways:

1. If the patient has 0, 1 or 2 of the criteria, no antibiotics should be prescribed. If a patient has 3 or 4 criteria, then antibiotic treatment may be used. I prefer this strategy at my jail because it does not require the use of rapid strep screens, which cost $5 to $10 each.

2. If you prefer to use the rapid strep test, the CDC recommends no treatment for patients with 0 or 1 criterion, and rapid strep testing for those with 2, 3 or 4 criteria. You then treat those where the rapid strep test comes back positive.

The CDC recommends throat cultures not be routinely performed. This is important because many lab facilities routinely follow up all rapid strep screens, whether positive or negative, with a $60 culture. Throat cultures should be reserved for special circumstances, such as tracking epidemic outbreaks of streptococcal fever, or if there is a suspicion of another bacterial pathogen, such as gonococci.

Finally, the antibiotic preferred by the CDC for the treatment of strep throat is plain penicillin. Not amoxicillin. Not Keflex. Definitely not Augmentin! If the patient is penicillin allergic, erythromycin should be used instead. This point is important enough to repeat: Do not use expensive, broad-spectrum antibiotics to treat routine strep throat.

These guidelines do not apply to complicated patients, such as those who are immunocompromised or those with other significant medical problems, such as COPD or a history of rheumatic fever. The guidelines also assume the practitioner will carefully exclude other serious throat disorders, such as peritonsillar abscesses or epiglottitis. Still, at my jail, the guidelines apply to over 95% of the patients who present to our medical clinic with sore throat.

A Typical Patient

Here is how the guidelines apply to a typical case. A healthy 35-year-old male presents to the jail medical clinic with a sore throat. His temperature is 97.6 F. He has large red tonsils but no exudate. He has 2+ tender anterior lymphadenopathy. He has been coughing frequently. Physical exam shows no evidence of abscess or other complications. This patient has only one of the CDC’s four clinical criteria. According to the CDC guidelines, he should not have a rapid strep screen performed nor a prescription for antibiotics. Instead, he would be treated symptomatically with acetaminophen, increased fluids and rest.

I encourage everyone to read the CDC report. It is concise, well-written and authoritative. The four basic clinical criteria are easy to incorporate into a clinical decision model or a flow chart for your facility. If your facility adopts these guidelines, the quality and consistency of your medical care for sore throat will improve and your medical costs will fall.

Jeffrey Keller, MD, is president of Badger Correctional Medicine, Idaho Falls, ID. Reach him by e-mail at badgermed@datawave.net.
Prostate Cancer and Black Men
Prostate cancer is a leading cause of death among African American men, yet more than half of those surveyed recently did not view themselves as at risk of this disease. According to the National Medical Association, which sponsored the nationwide study, some 5,300 African American men died from prostate cancer in 2003, and more than 27,000 were diagnosed with it. Compared to white men, this population is diagnosed with the disease at least 60% more, and is more than twice as likely to die of it, the report said. “Unfortunately, in the African American community there’s not enough of the awareness that tends to lead to early diagnosis. Knowing the risk factors and symptoms, and getting screened is an important start,” said Gerald Hoke, MD, urology section chair of the NMA. Find more information at www.nmanet.org/pr_031804.htm.

Managing Viral Hepatitis Coinfection
The HCV-HIV International Panel has issued a consensus statement on the management of patients coinfected with HIV and hepatitis C. Published in the March 1 issue of AIDS, the Inter- national AIDS Society journal, the article, “Care of Patients With Hepatitis C and HIV Co-infection,” is posted at www.medscape.com/viewarticle/467365. The site also features an interview with lead author Vicente Soriano, MD, an infectious disease expert and hepatologist, at www.medscape.com/viewarticle/469674.

Syphilis on the Rise
After dropping throughout the 1990s the number of confirmed cases of primary and secondary syphilis in the United States has risen each year since 2000, reaching 7,082 in 2003, according to data presented at the National STD Prevention Conference in Philadelphia in March and reported by Reuters Health. This is a 3.2% increase over 2002. Further, the rate per 100,000 people is now 2.5, compared to 2.1 in 2000. Men who have sex with men account for some 60% of the cases in 2003, say researchers from the CDC. The resurgence in that group is worrisome because syphilis is linked with higher likelihood of HIV infection.

TB Cases Decline Slows
Tuberculosis cases in the U.S. fell by an average 6.8% annual drop from 1993 to 2002. Despite the nationwide decline, rates did increase last year in 19 states, including California, New York and Texas. Further, rates are four times higher among the foreign-born population, which now accounts for more than half (53.3%) of the national case total. Rates of multi-drug-resistant TB also are higher among the foreign-born. Published in the March 19 issue of MMWR, the report notes disparities in rates among minority populations, and calls for “targeted interventions for populations at high risk,” among other measures. Find the report at www.cdc.gov/mmwr/preview/mmwrhtml/mm5310a2.htm.

Protocols to Confirm Rapid HIV Tests
If your facility is now using one of the reactive rapid HIV tests approved by the Food and Drug Administration over a year ago, be sure to check out the CDC’s protocols for confirmation of these tests: www.cdc.gov/mmwr/preview/mmwrhtml/mm5310a7.htm.

FDA Cautions About Antidepressants
While noting that “it is not yet clear” whether antidepressants contribute to the emergence of suicidal thinking and behavior, the FDA has issued a caution about the need to monitor patients on such drugs for worsening depression and suicidal thoughts and actions. Close monitoring is especially important at the beginning of treatment or when doses are changed. The action was prompted by studies suggesting an increased risk of suicidal tendencies among youth taking antidepressants.

The agency has initiated an expert review of behaviors reported in those studies. It also has asked the makers of 10 antidepressants to include stronger warnings in product labeling. Learn more in an FDA Talk Paper at www.fda.gov/bbs/topics/answers/2004/ans01283.html.

Lit Review
The following articles pertinent to correctional health care can be found via the National Library of Medicine’s PubMed search and retrieval system at www.pubmed.gov.

• Treating Drug Using Prison Inmates With Auricular Acupuncture; A Randomized Controlled Trial; A.H. Berman, U. Lundberg, A.L. Krook, C. Gyllenhammar; Journal of Substance Abuse Treatment; March.

• On the Role of Correctional Officers in Prison Mental Health; J.A. Dvoskin and E.M. Spiers; The Psychiatric Quarterly, Spring.

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**Juveniles in Jails: Different Models, Similar Outcomes**

**BY JAIME SHIMKUS**

Increasingly, county jails are responsible for housing juveniles. In some cases it’s because the juveniles are being adjudicated as adults. In others, it’s simply the structure that administrators think best. Whatever the reason, providing health care to juveniles in adult settings requires special considerations, not the least of which is understanding how to apply NCCHC’s health care standards.

In general the key to providing adequate health care for youth confined in facilities primarily intended for adults is to treat them as a “special needs” population, paying close attention to guidance in the adult standards that speaks to the needs of adolescents (see box below).

That’s the approach taken at the Wyandotte County Detention Center, Kansas City, KS, which houses about 40 juveniles, primarily male, under the same roof as but separate from the adults. Although the adult and juvenile units are under separate administration, a single health care team, employed by contractor NaphCare, is responsible for provision of physical, mental and dental health care for both sides.

Because of the need to segregate the adult and youth populations, the juvenile detention center, as it is called, has its own nursing office to handle routine medical needs, says health services administrator Donna McCurry, RN, NP. The designated “juvenile nurse” is actually a dual-purpose position filled by a supervisory level nurse who moves between the two sides.

When care is needed from a physician, psychiatrist, dentist or other professional, again the provider visits the juvenile detention center rather than having the youth visit the adult health office.

The health care team takes care to meet the differing requirements for youths vs. adults. For instance, while health assessment for adults takes place within 14 days, as specified by jail standard J-E-04, the time frame for youths is seven days, in keeping with the juvenile standards.

Also, the clinicians have developed individual treatment plans for each youth, as required in jail standard J-G-01 Special Needs Treatment Plans.

**Two Groups of Youths**

Sometimes the arrangement is more complicated. In Stuart, Florida, for example, the Martin County Jail houses two distinct groups of juveniles in separate residences. A small group of youths (usually about six or eight) charged as adults lives in the jail proper, though segregated from the adult population. For accreditation survey purposes, the “jail” standards apply, rather than those for juvenile facilities.

However, the sheriff’s department also operates a military style boot camp for about 90 males under age 18. Although the boot camp is within the jail’s secure perimeter, it was not included in the last jail survey (this may change in the future) and instead has followed standards for health services in juvenile facilities.

Before the youths are sent to the boot camp, which is under the jurisdiction of the Division of Juvenile Justice, their health records are reviewed to ensure that they are fit for the program.

A single health services team, employees of contractor Wexford Health Sources, is responsible for care of the jail inmates (adults and youths) as well as the boot camp, says health services administrator Bernice Schuyler, RN. A nurse is assigned to the boot camp 20 hours per week, mornings from Monday through Friday. Due to staff turnover Schuyler is handling boot camp duties at present.

Jail nurses cover the boot camp at other times, distributing medications and responding to emergencies. Likewise, the physician, dentist and mental health professionals visit the boot camp as needed, sending the youth off-site for treatment when necessary (e.g., for dental care).

**Different Needs**

Besides being attuned to the standards that apply to youth, the two health services administrators note differences in the youths’ health care issues and needs. For instance, at booking the correctional staff are trained to pay attention to bruises, says Schuyler. At McCurry’s jail, the youth receive quite a bit more time from mental health professionals. At both jails, the youths’ diets reflect their greater nutritional needs.

Yet other issues emerge at the boot camp. Because of the strenuous regimen, athletic type injuries are more common. Even so, the youths don’t complain much, says Schuyler, adding that “Sometimes I’ll go down just to say hello.”

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Anxiety Management Takes the Pain Out of Dental Care

BY SUSAN RUSTVOLD, DMD, MS

Jenny sat in the dental office only because the nurses insisted at her intake physical exam that she do so. She had entered the state corrections system taking antibiotics and NSAIDs prescribed in the county jail to treat several necrotic teeth and abscesses. She had a history of methamphetamine use that had contributed to widespread severe dental decay. She also acknowledged that a high level of dental anxiety had caused her to avoid dental treatment in the past.

Dental anxiety is common among Americans, with about half experiencing at least moderate anxiety and 10% in the “severe” category. Among prison inmates, however, the rate of severe anxiety soars, reaching 80% for women in Oregon prisons, according to an informal review of that population.

It makes perfect sense: Patients who report high dental anxiety describe a sense of personal space infringement while in a prone and vulnerable position, unable to communicate orally while an authority figure with sharp metal instruments hovers above inflicting discomfort and warning about dental hygiene.

Nearly all dental phobia stems from traumatic experiences such as not being listened to in the dental chair, especially if not numb enough; being pushed around psychologically; and being given no control over the experience.

Stressful enough in the general population, such circumstances are even more upsetting for inmates and especially female inmates, many of whom have a history of physical or sexual abuse. In fact, recent studies confirm a connection between such history and extreme dental anxiety.

Such intense anxiety has negative consequences. Patients are more likely to miss appointments, and if they do show up, they are tense and difficult to treat, taking up to 20% more chair time. They have negative attitudes about dentistry and convey these attitudes in and out of the dental office. Incidentally, the dental staff absorb some of this stress and negativity.

More detrimental, phobic patients may self-medicate with marijuana, narcotics or other substances to deal with their dental pain or with the appointment itself.

This leads to a vicious cycle where current and recovering substance abusers are likely to have severe dental disease. Abuse of drugs such as methamphetamine, cocaine, tobacco and opiates causes decreased saliva production, and is often associated with high sugar intake, poor oral hygiene and high incidence of caries and periodontal disease.

Managing Anxiety
Models of human conditioning tell us that things learned in times of intense emotion are profoundly felt and difficult to “undo” without dealing with that gut-level feeling.

But to manage gut-level phobia, it first has to be recognized, and that’s where dentists sometimes come up short. Studies have shown that trained dental workers, including dentists, failed to recognize high anxiety in patients more than 50% of the time.

Fortunately, a number of tools exist that can help to gauge their patients’ anxiety. These include patient questionnaires, the Dental Anxiety Scale (DAS) and the Dental Concerns Assessment (DCA) (see citations below). These tools produce reliable results. Used alone, simple patient questioning and the DAS each have about 80% accuracy, and this figure increases when both are used together. The DCA, for example, takes 5 to 10 minutes to do, while the DAS can be completed in about a minute.

Use of these standardized instruments not only quantifies patients’ anxiety, it also opens the door to discussion about it. In some cases, that’s all that is needed to temper their anxiety.

Jenny and I agreed that this would be a get-acquainted appointment. She was asked to complete two written instruments, the Dental Anxiety Scale and the Dental Concerns Assessment. We then discussed her responses to these questionnaires.

As we talked about her anxiety, I asked Jenny what she had been doing above the pain, and she replied sheepishly, “That’s why I’m here.” She had been seeking Vicodin through illegal means to relieve her intense dental pain. Finally, she felt comfortable enough and reassured to agree to return to have the three necrotic teeth removed.

Managing Anxiety
Not every case of dental anxiety is so easily resolved, however. When more concrete anxiety management is needed, relaxation training may be a useful approach. This encompasses behavioral techniques such as controlled abdominal breathing (slow and deep); meditation, suggestive relaxation therapy or self-hypnosis; and biofeedback. Environmental comfort can be enhanced by providing a neck pillow and music or relaxation recordings.

This will have a soothing effect on autonomic nervous system pathways by lowering heart rate, pulse, adrenalin levels and breathing rate while improving blood flow to the body surface and to the digestive tract.

Another approach, known as cognitive restructuring training, aims to help patients identify and correct errors in thinking that generate anxiety and depression.

If necessary, anxiety can be managed pharmacologically. Drugs that might be appropriate for this purpose include Vistaril, Buspar, benzodiazepines such as Triazolam and Valium, and antidepressants such as Zoloft and Trazadone.

For patients who suffer from the highest levels of anxiety/phobia (a score of 15 to 20 on the 20-point Dental Anxiety Scale), even medications might not suffice. In 2% to 3% cases the help of a mental health therapist might be required. This is seen most often when the patient cannot or will not talk about the fear, is extremely difficult or hostile, has unmanaged panic attacks or anxiety disorder, or has a history of abuse.

Respect and Empathy
It’s important not to blame the victim. After all, many people who suffer from anxiety then become anxious about being anxious! Instead, dentists should recognize their own role in causing dental anxiety.

It is imperative that dentists believe patients who say they are not numb, and that dentists be resourceful and skillful in administering supplemental local anesthesia injections, particularly of the mandible.

Further, by using the dental anxiety instruments, which enable patients to articulate their fears, and by treating them with respect and empathy, allowing a measure of control, we can facilitate their learning coping skills that will continue after their release.

Bettina sent a standard inmate request form to the dentist stating that a tooth had fractured. She was called to the dental clinic a few days later, and had time to fill the fractured tooth with a silver amalgam overlay. Bettina mentioned that she would be released soon and had feared that the tooth might have become painful if it were not restored.

She also said she had carried that, to treat the pain, she might have relapsed in her recovery from heroin. As she left the clinic, she thanked us.

Citations
• Dental Anxiety Scale-Revised (DAS-R): Corah, 1969
• Dental Concerns Assessment: Clarke, 1993, revised 1998

Susan Rustvold, DMD, MS, is a dentist with the Oregon Department of Corrections; she formerly chaired a university department of behavioral sciences. This article is adapted from her presentation at the Sixth National Conference on Correctional Health Care last October in Austin. Reach her by e-mail at srustvold@pdx.edu.

Rustvold has prepared two supplemental documents on this subject; they are posted on the NCCHC Web site at www.ncchc.org/pubs/ correctcare.html.
Newest Group of CCHPs Makes History

Congratulations to the newest class of 330 CCHPs, which represents the largest group to take the certification test in the program’s history. That number may be staggering, but, given the value of professional certification, it’s not surprising, says Peter C. Ober, PA-D, JD, CCHP, chair of the CCHP Board of Trustees. “Each of these CCHPs now has a better understanding of the complexities of correctional medicine, correctional standards and the philosophy and mission of NCCHC.” But certification doesn’t benefit CCHPs alone, he adds. “Now they’ll take what they’ve learned back to the field. This many new ambassadors can only have a strong positive impact on correctional medicine.”

The benefits of becoming certified are many, but most CCHPs accept the challenge for more intangible reasons. According to new CCHP Janice Bray, MD, “I had years of experience in legal psychiatry, but no direct jail psychiatric work experience. CCHP was fantastic in allowing me the accurate perspectives and guidelines that I needed to approach my job with confidence. The test experience was very productive. I enjoyed every hour spent on completing the exam. It was personally and professionally gratifying!”

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Juvenile Correctional Facility
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Contra Costa Health Services
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Lydia Ortiz, RN, CCHP
San Bernardino County Department of Probation
Redlands
Carlos A. Peace, RN, CCHP
Central Juvenile Detention & Assessment Center
Loma Linda
Richard W. Saxton, MD, CCHP
Juvenile Justice Institutions Mental Health Team
Sacramento
Kathleen Shamway, RN, CCHP
Central Juvenile Hall San Bernardino
Colton
Acel K. Thacker, MA, CCHP
Pelican Bay State Prison, California DOC
Crecent City
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San Bernardino County Probation – CJH
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Irene Mary Weir, RN, CCHP
San Bernardino County Juvenile Hall
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Kern Medical Center
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West Valley Juvenile Detention & Assessment Facility
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California Department of Corrections
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State of Connecticut Judicial Branch
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New Haven Community Correctional Center
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Yale Medical School
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Constance Weiskopf, PhD, CCHP
University of Connecticut Health Center
Farmington
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Lake County Sheriff Corrections Bureau
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Pinellas County Jail
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Halifax Medical Center – Volusia County Corrections
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Halifax Medical Center
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Rogers State Prison  
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Georgia Correctional Health Care  
Cochran

Winona L. Kauwe, RN, CCHP  
Women’s Community Correctional Center  
Waimanalo

Abigail Medrano, RN, BSN, MSN, CCHP  
Women’s Community Correctional Center  
Kailua

Steven Garrett, MD, CCHP  
Idaho Correctional Center – CCA  
Boise

Arthur J. Lee, MA, CCHP  
Idaho Correctional Center  
Boise

Jeffrey A. Scharr, RN, CCHP  
Idaho Correctional Center – CCA  
Boise

Lillian J. Wilcox, RN, CCHP  
Idaho Correctional Center  
Nampa

Misty Clemens, MA, CCHP  
St. Louis City Justice Center  
Belleville

Tamara J. Cox, MPA, CCHP  
CDIC/Chicago Department of Public Health  
Chicago

Michelle M. Devito, BSN, CCHP  
Cermak Health Services of Cook County  
Homer Glen

Raymond A. Ige, BSN, CCHP  
Cermak Health Services of Cook County  
Chicago

Carla L. Jenkins, RN, CCHP  
Cermak Health Services of Cook County  
Chicago

Kimberly Outlaw-Clay, RN, CCHP  
Cermak Health Services of Cook County  
Chicago

Jeannine Payne, BSN, CCHP  
McLean County Detention Facility  
Lexington

Frederick D. Quinn, MS, MJ, CCHP  
Cook County Juvenile Temporary Detention  
Chicago

Bruce Sloan, DDS, CCHP  
DuPage County Jail  
Carol Stream

Karen L. Stoche, LPN, CCHP  
Advanced Correctional Healthcare  
Peoria

Venetia A. Vallury, MD, CCHP  
Cook County Juvenile Detention Center  
Chicago

Barbara Howe, RN, CCHP  
South Bend Juvenile Correctional Facility  
New Carlisle

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South Bend Juvenile Correctional Facility  
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Bethesda

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Montgomery County Detention Center  
Fort Meade

Donna Plante, RN, CCHP  
Eastern Correctional Institution  
Salisbury

William H. Baby, DO, CCHP  
Maryland Department of Public Safety & Correctional Services  
Towson

Lisa Davis, RN, CCHP  
Correctional Medical Services  
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Patricia J. Hennessy, RN, CCHP  
Downeast Correctional Facility  
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Tania L. Robert, CCHP  
Mountain View Youth Development Center  
Charleston

Margaret Hudson-Collins, MD, CCHP  
Wayne County Jail  
Grass Point Park

Gwen D. Lianer, MSN, CCHP  
Kent County Correctional Facility  
Grand Rapids

Elizabeth W. Patterson, RN, CCHP  
Wayne County Jail  
Detroit

Rens J. Sandraire, DO, CCHP  
Wayne County Jail  
Bloomfield Hills

Doris Patricia VanVuren, AND, BA, CCHP  
Lavonia

Jason A. Yacob, MD, CCHP  
Kent County Correctional Facility  
Hollidale

Rhonda Amann, RN, BSN, CCHP  
Correctional Medical Services  
Jefferson City

Gale E. Bailey, RN, CCHP  
Moberly Correctional Center  
Moberly

Thomas A. Baker, MD, CCHP  
Correctional Medical Services  
Jefferson City

Christine Gavett, OD, BO  
Moberly Correctional Center  
Harrisburg

Robert Marshall Hampton, MD, CCHP  
Moberly Correctional Center  
Columbia

Karen Jacoby, RN, CCHP  
Correctional Medical Services  
Amawasu

Kari Ann Jean-Gilles, CCHP  
Correctional Medical Services  
St. Louis

Adrienne D. Johnson, RN, CCHP  
Missouri Department of Corrections  
Jefferson City

Linda S. Johnston, BS, CCHP  
Correctional Medical Services  
Ballwin

Arthur S. Keiper III, MD, CCHP  
Boonville Correctional Center  
Columbia

Dana D. Meyer, RN, CCHP  
Correctional Medical Services  
Bowling Green

William J. Miller, CCHP  
Correctional Medical Services  
St. Peters

Carol A. Specers, RN, CCHP  
Correctional Medical Services  
O’Fallon

Jennifer A. Walters, CCHP  
Correctional Medical Services  
St. Louis

Hubert Filippi Williams, BS, CCHP  
Correctional Medical Services  
St. Louis

Launda Dodson, RN, CCHP  
Central Mississippi Correctional Facility  
Byram

Beverly J. Overtorn, RN, BSN, MSN, CCHP  
Corrections Corporation of America  
Clarksville

Laura Patricia Junes, RN, CCHP  
Montana State Prison  
Deer Lodge

Tanya Wilkerson, RN, CCHP  
Montana State Prison  
Deer Lodge

Paula V. Smith, MD, CCHP  
North Carolina Department of Correction  
Cary

Richard A. Walters, MSN, ANP, CCHP  
Griven Correctional Institution  
Greensville

Christina S. Bauer, LPN, CCHP  
Ocean County Department of Corrections  
Toms River

Marian Bibby, RN, CCHP  
Monmouth County Correctional Institution  
Farmingdale

Rosario C. Bescar, BSN, RN, CCHP  
Correctional Medical Services at Northern State Prison  
Jersey City

Era M. Caldwell, LPN, CCHP  
Monmouth County Youth Detention Center  
Freehold

Christine Devaney, RN, CCHP  
Monmouth County Correctional Institution  
Freehold

Deborah Franzoso, LPN, CCHP  
Ocean County Jail  
Toms River

Bernice M. Friesch, MSW, CCHP  
Northern State Prison  
Somerset

Michelle Gaito, MA, CCHP  
Ocean County Department of Corrections  
Howell

Gaye Ingenito, RN, CCHP  
Ocean County Department of Corrections  
Brick

JoAnn F. Ligori, RN, CCHP  
Correctional Medical Services  
Hillborough

Shirley Ousley, RN, CCHP  
Monmouth County Correctional Institution  
Freehold
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<td>New CCHPs (continued from page 12)</td>
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</table>
NEW CCHPs (continued from page 13)

Irma Carranza, CCHP
Bexar County Adult Detention Center
San Antonio

Donna Childs, CCHP
Bexar County Adult Detention Center
San Antonio

Diane Del Boucque, LVN, CCHP
Wackenhut Corrections Corp. – Kyle
Kyle

Lucia Diaz, LVN, CCHP
Wackenhut Correctional Facility
Seguin

Mandy Goldin, CCHP
UTMB TDCJ Hospital
LaMarque

Maria E. Gomez, MA, CCHP
University Health System – Corrections
San Antonio

Lovenia Green, RN, CCHP
UTMB
Texas City

Martha Gutierrez, CCHP
Adult Detention Center
San Antonio

Judy Harper, LMSW, CCHP
Bexar County Adult Detention Center
San Antonio

Brenda S. Leal, MA, CCHP
Bexar County Juvenile Detention Center
San Antonio

Sherman McMorris, MEd, CCHP
Harris County Jail
Sugar Land

Lydia Mesquita, MSW, CCHP
Correctional Health Care Services
San Antonio

Maria Theresa O’Carroll, LVN, CCHP
Bexar County Juvenile Detention Center
San Antonio

Debra M. Osterman, MD, CCHP
Harris County Jail
Cypress

Sylva A. Portules, CCHP
Correctional Health Care Services
San Antonio

Rhonda M. Quinones, BA, CCHP
Bexar County Adult Detention Center
San Antonio

Carol A. Ridge, RN, CCHP
UTMB TDCJ Hospital
Galveston

Maria T. Soliz, CCHP
Correctional Health Care Services
San Antonio

Edward Spiller, LMSW, CCHP
Bexar County Jail
San Antonio

Frances M. Stephens, LVN, CCHP
Wackenhut Corrections Corp.
San Antonio

Nilah W. Stewart, MSW, CCHP
Correctional Health Care Services
San Antonio

Alan R. Strickland, LVN, CCHP
Cyndi Taylor Krier Juvenile Correctional Treatment Center
Kirby

Patricia Kay Tamplin, LVN, CCHP
Rusk County Sheriff’s Office
Tyler

Barbara Ann Taylor, LVN, CCHP
Bexar County Adult Detention Center
San Antonio

Vivian Flores Torres, MA, CCHP
Correctional Health Care Services
San Antonio

Cruz H. Vallarta, LVN, CCHP
Cyndi Taylor Krier Juvenile Correctional Treatment Center
San Antonio

Yvette Marie Velasquez, LVN, CCHP
Cyndi Taylor Krier Juvenile Correctional Treatment Center
San Antonio

Isabel H. Walsh, RN, MSN, CCHP
UTMB TDCJ Hospital
Galveston

Ada L. Westbrook, LVN, CCHP
Bexar County Adult Detention Center
San Antonio

Utah

Alma Lake, LFN, CCHP
Utah County Sheriff’s Department
Spanish Fork

Sally Randall, RN, CCHP
Utah County Sheriff’s Department
Spanish Fork

Albert H. Wiggan, LFN, CCHP
Utah County Sheriff’s Department
Spanish Fork

Virginia

Robert R. Bradley Jr., MSW, CCHP
Serenity House
Newport News

Luciano Gualda-Rivera, CCHP
Department of Justice Health Services
Prince George

Dawn Hansom, EMT, CCHP
Penmansend Creek Regional Jail
King George

Timothy F. Joost, RN, MS, CCHP
Virginia Department of Juvenile Justice
Richmond

Katherine Lynch, CPT, CCHP
Chesapeake Community Services Board
Chesapeake

Diane Purks, RN, CCHP
Penmansend Creek Regional Jail
Spotsylvania

Joseph Riddick, MBA, CCHP
Virginia Department of Juvenile Justice
Richmond

Angela B. Stroud, LFN, CCHP
Penmansend Creek Regional Jail
Milford

Washington

Alan T. Bailey, RN, CCHP
Washington State Penitentiary
Walla Walla

Rebecca J. Bay, MD, MPH, CCHP
FEC Sea Tac BOP
Seattle

Carole Brown, RN, CCHP
Spokane County Jail
Spokane

Daren M. Chilapa, BS, CCHP
Washington State Penitentiary
Walla Walla

Mary E. Coomes, RN, CCHP
Benton County Jail
Kennewick

Kieth Corn, RN, CCHP
Washington State Penitentiary
Walla Walla

Richard C. Cross, RN, CCHP
Washington State Penitentiary – DOC
Walla Walla

Bruce P. Leonard, PA-C, CCHP
Washington State Penitentiary
Walla Walla

Grant E. Degar, MD, FACP, CCHP
Whatcom County Jail
Bellingham

Daniel Delp, PA-C, CCHP
Washington State Penitentiary
Walla Walla

Ronald W. Fleck, MD, CCHP
Washington State Penitentiary
Walla Walla

Judy Ford, RN, CCHP
Multnomah County Detention Center
Vancouver

Anthony Gambone, PA-C, CCHP
Washington State Penitentiary
Walla Walla

Colleen S. Gutmann, RN, CCHP
Correctional Nursing Services Inc.
Kennebunk

Beverly J. Knodel, RN, BSN, CCHP
McNeil Island Correction Center
Olympia

Richard S. Krebs, MD, CCHP
Whatcom County Jail
Bellingham

Gail Frances May, LFN, CCHP
Benton County Jail Correctional Nursing
Plymouth

Melinda S. Michalkie, RN, CCHP
Columbia River Correctional Institution
Vancouver

Robert C. Mitchell, PA-C, CCHP
Washington State Penitentiary
Walla Walla

Deborah J. Park, LFN, CCHP
Whatcom County Jail
Ferndale

Helen Schoefen, RN, CCHP
Whatcom County Jail
Bellingham

Wisconsin

Shari L. Heinz, BSN, CCHP
Fox Lake Correctional Institution
Fox Lake

Donna L. Kowalske, RN, MSN, CCHP
Milwaukee County Jail Health Services
Brookfield

Judith K. Orserboth, RN, CCHP
Pierce County Jail
Ellsworth

Jeanne Reinart, BSN, RN, CCHP
Monroe County Jail
Tomah

Barbara A. Ripani, DDS, MPH, CCHP
State of Wisconsin DOC
East Troy

Linda J. Shatza, BSN, CCHP
Ethan Allen School
Delafield

West Virginia

Francesa A. Terrero-Leibol, PA, CCHP
US Penitentiary – Big Sandy
Huntington
Mental Health in Corrections

Improving Treatment to Change Lives

The rising prevalence of mental health problems within correctional populations poses serious difficulties on many levels. While societal trends are turning jails, prisons and juvenile facilities into de facto mental health institutions, these facilities are neither designed nor, in many cases, sufficiently prepared or funded to deal with the number or intensity of mental conditions commonly seen. The solutions will be complex, but, at their most fundamental, they will require more advanced capacity for identifying, treating and monitoring individuals with mental illness. As well, greater coordination and integration of efforts between correctional systems and community health care agencies will be required to aid inmates’ transitions into the community.

Geared toward mental health care providers working in correctional facilities, this intensive two-day conference will delve into the intricacies of mental health disorders common among correctional populations, best practices for treatment and models of service delivery.

**Educational Program**
Join colleagues for a two-day program on Sunday, July 11, from 9 am to 5 pm, and Monday, July 12, from 9 am to 4 pm. Breakfast and luncheon programs will be provided on both days. The educational sessions are divided into two tracks and include the following titles:
- Nontraditional Roles of Mental Health Providers
- Killing Time: The Psychological Effects of Prolonged Segregation
- Treating and Coping in a High-Stress Environment
- Prescribing Practices in the Correctional Setting
- No Way Out: The Latest in Substance Abuse Treatment
- Getting Acquainted: The New NCCHC Mental Health Care Guidelines
- Evaluation and Treatment of the Violent Mentally Ill Offender
- Mental Health Strategies That Work for Juveniles
- Maintaining Mental Health Costs in Tough Economic Times: Lessons Learned
- Unraveling the Complexity of Schizophrenia
- Differentiating Genuine Needs From Manipulative Behaviors
- Understanding Suicide Prevention in Correctional Facilities
- Manage Effective Opioid Treatment Programs
- Restoration to Competency for Death Row Inmates: An Ethical Dilemma
- Preparing Patients and Establishing Links for Successful Reintegration

**Continuing Education**
The National Commission on Correctional Health Care is approved by the American Psychological Association to offer continuing education for psychologists. NCCHC maintains responsibility for the program. At this conference, participants can earn up to 13 CE hours. NCCHC also has applied for continuing education credit for physicians and nurses.

**Hotel Information**
The program will be held at the Paris Hotel, conveniently located in the heart of Las Vegas. Conference participants will receive a special discount rate of $109. To receive this rate, make your reservation by June 18 and tell the agent that you are attending the NCCHC conference. To make reservations, call the hotel toll-free at (888) 266-5687.

**Registration Information**
For fastest service, register online at www.ncchc.org. Or, fill out the form in the conference brochure and return it to NCCHC. If you don’t have a brochure, you may download it at our Web site, or request one at (773) 880-1460 or info@ncchc.org. Registration must include check or credit card payment. Purchase orders are accepted only from governmental agencies and their contractors and must accompany the registration (a $15 processing fee applies).
**Contract Management: Is It Right for Your Facility?**

**BY HOWARD SALMON**

Healthcare contract management has enabled many prisons and jails to provide healthcare services of a higher quality at a lower cost than they may have been able to do themselves. But this approach isn’t for everyone. Most prisons and jails can attain the same or higher levels of quality and service without the management fees, the loss of local control and flexibility, and the additional layers of management. Yet county and state governments clamor for privatization.

What to do? Weigh your options carefully. This article will discuss how to assess whether contract management is right for you and, if it is, how to establish a solid contract that protects your interests. But first, let’s explore why you might consider outsourcing in the first place.

**Outsourcing Pros and Cons**

Politically, outsourcing of health services has been growing more popular for years. It’s easy to understand why it appeals to administrators. With governments under pressure to control taxes and curb expenditures, and given their concerns about legal liability and risk management, they’re all too happy to let a third party deal with their concerns about legal liability.

Outsourcing firms have better scalability, with fewer bureaucratic obstacles, the loss of local control and flexibility, and the additional layers of management. Yet county and state governments clamor for privatization.

The chief complaints are a perceived “cookbook” approach that lacks flexibility, a focus on profit that relativates quality to a secondary concern, and a loss of control. If the contractor and the client disagree on how to interpret contractual provisions or wish to change them, the wrangling could lead to unanticipated expenses or to inadequate care. If the impasse results in cancellation of the contract, the move back to local control will present a new set of difficulties.

**Contract Considerations**

Openly discuss the pros and cons of outsourcing with corrections authorities. If everybody agrees that it makes sense, then choose a service provider and sign a contract that meets your needs while ensuring your independence. Here are some important points to address:

- Communication: Keep the lines open with frequent (at least monthly) reports and meetings, discussing successes and failures.
- Quality: Require participation in activities such as NCCHC accreditation, quality assurance and utilization review.
- Systems and processes: Quality is best achieved by use of best practices, which generally means consistent approaches to treatment paths, outcomes measurement, monitoring, credentialing and privileging.
- Specify outcomes: Despite the focus on process what you’re really after is outcomes. Set healthcare delivery quality and expense goals that are better than average.
- Reporting: Regular data collection, analysis and reporting will enable you to track performance, identify trends—and take remedial action, if necessary.
- Expense control: Stipulate that if your facility’s expenses must fall within the 35th to 50th percentile among your peers within a specified time frame.

**Quality and Productivity Indices**

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<td>Nursing/hours/100 screens</td>
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<td>Nursing/hours/100 visits</td>
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<td>Cost/prisoner on meds/day</td>
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**Consultants**: You want to have confidence in your outsourcing partners, not shy away from using consultants when needed. An outside perspective can be invaluable.

**Monitoring**

A precursor to reporting is monitoring. To ensure performance, plan from the start for objective contract monitoring, with emphasis on key indices in the areas of finance, quality, and productivity. (See table above for recommended indices to track.) Financial indicators, often expressed as per diem costs, will include items such as salaries, operating expenses, professional services, contracted services and telemedicine. Off-site expenses can mount rapidly, so pay close attention to physician visits, ancillary services and hospital care. In the area of pharmacy, indices to track include statistics on inmates taking prescription drugs, including psychotropics, and usage of nonformulary drugs.

**Moving to quality, many elements should be monitored, including:**

- Accreditation reviews
- Access to care, including specialty clinics
- Credentialing reviews
- Operational review audits
- Quality management programs
- Quality of care
- Utilization management
- Gribances and correspondence
- Peer review activities
- Morbidity/mortality reviews
- Policy and procedure reviews
- Pharmacy and therapeutics
- Infection control activities

**Before You Sign**

Even the best written contract won’t spare you the anguish if the company that countersigns it boggles the job. So do your homework before you sign.

First, assess supplier and sign a contract that makes sense, then choose a service provider and sign a contract that meets your needs while ensuring your independence.

Howard Salmon is a partner at Phase 2 Consulting, Salt Lake City, Utah. E-mail him at hsalmond@phasc2consulting.com.

Salmon presented a session on this topic at the National Conference on Correctional Health Care in Austin last October. To purchased a recording (session #183, Pros & Cons of Managed Health Care Companies), visit Nationwide Recording Services online at www.nrstaping.com/ncchc.
For the fifth year, teens and young adults in detention and confinement centers nationwide demonstrated poignant sensitivity to and understanding of HIV and AIDS. As contributors to NCCHC’s annual Poetry and Poster Contest, they also shared important messages on how to prevent the spread of these diseases.

Confined youth nationwide were invited to design a poster or write a poem related to HIV prevention, and more than 2,500 of them submitted entries. Conducted by NCCHC with support from the Centers for Disease Control and Prevention, the contest reinforces messages about HIV prevention through peer communication within this high-risk group.

A team of 10 judges with diverse backgrounds—art, health care, politics, business, jail administration, and other disciplines—spent hours poring over the entries, finding themselves by turns moved, amused and, sometimes, amazed. Ultimately, for each art form (poster and poem), the judges whittled the entries down to three winners (first, second and third) for each of three age groups (14 and under; 15 to 17; 18 to 21).

The winners were awarded cash prizes and certificates of recognition, and dozens of other youths received honorable mention certificates. The winning entries were displayed at the National Conference on Correctional Health Care, held last October in Austin, Texas. To see all of the winning entries, which are presented in their original form, visit the Web at www.ncchc.org.

First place winner, age 14 and under

My Story

I live on the wild side.
And sometimes make a mistake.
Some are not as big as others,
But this one takes the cake.

I met her dancing at the club,
Boy she like to party.
She got me really drunk you see,
You know I love Bicardi.

We went back to her place,
And one thing led to another.
She took off her bra and panties,
Then I said “Oh Brother.”

It was so fast like NASCAR,
Not knowing I would soon regret it.
In an instant it was all over,
I felt like Andy Petit.

Now I’m stuck with the AIDS virus,
And no one will go out with me.
Longing for the old life,
But that can never be.

So kids if you have unprotected sex,
There’s no telling what will happen.
Let’s stop the AIDS virus,
So know exactly what your tappin.

Second place winner, age 15-17

I am Death Positive

As I enter your blood stream,
I travel through dominantly,
I’ve entered like a dream.
That you have had so commonly,
I ease into your body,
Like a thread through a needle,
Eating away your white blood cells,
Like a leaf to a beetle,
I am not the killer,
But due to my instruction,
Something so insignificant,
Will lead to your destruction,
Once I’ve completed my mission,
Your body just withers away,
Unless I am shared with another,
In your body is where I’ll stay,
No one is fully protected,
I come through bodily fluids,
I am very least expected,
You’ll never say you knew it,
I am slow pain and death,
Dancing on life’s great stage,
But don’t attend my show,
Because I am know as AIDS.

Third place winner, age 18-21

I am Death Positive

As I enter your blood stream,
I travel through dominantly,
I’ve entered like a dream.
That you have had so commonly,
I ease into your body,
Like a thread through a needle,
Eating away your white blood cells,
Like a leaf to a beetle,
I am not the killer,
But due to my instruction,
Something so insignificant,
Will lead to your destruction,
Once I’ve completed my mission,
Your body just withers away,
Unless I am shared with another,
In your body is where I’ll stay,
No one is fully protected,
I come through bodily fluids,
I am very least expected,
You’ll never say you knew it,
I am slow pain and death,
Dancing on life’s great stage,
But don’t attend my show,
Because I am know as AIDS.
Summary Guide to the Changes

2004 Standards for Health Services in Juvenile Detention and Confinement Facilities

1999 Edition: 71 standards, 36 essential (51%), 35 important (49%)
2004 Edition: 72 standards, 40 essential (56%), 32 important (44%)

Numbering System
• Standards are numbered according to type (Y—juvenile), section (A through I), and numerical order within the section.

4 New Standards
• Y-C-02 Clinical Performance Enhancement (I)
• Y-E-13 Discharge Planning (I) (separation of issue from another standard)
• Y-G-02 Management of Chronic Disease (I)
• Y-G-12 Terminal Illness Within the Juvenile Setting (I)

5 Deletions
• Sexually Transmitted Disease and Bloodborne Disease Detection
• First Aid Kits
• Continuing Education for Health Services Administrative and Support Staff
• Direct Orders
• Position Descriptions

2 Standards Split Into 4
• Former Y-29 Pharmaceuticals (E) split into Y-D-01 Pharmaceutical Operations (E) and Y-D-02 Medication Services (E)
• Former Y-36 Mental Health Assessment (E) split into Y-E-05 Mental Health Screening and Evaluation (E) and Y-G-04 Mental Health Services (E)

2 Standards Combined Into 1
• Y-(38) Daily Handling of Nonemergency Medical Requests and Y-(39) Sick Call into Y-E-07 Nonemergency Health Care Requests and Services (E)

Status Changes
• Important to Essential: Y-B-02 Environmental Health and Safety Y-D-05 Hospital and Specialty Care
• Essential to Important: Y-I-06 Right to Refuse Treatment

Significant Changes
• Y-A-06 Continuous Quality Improvement Program (E)
• Y-A-07 Emergency Response Plan (E) (former name: Emergency Plan)
• Y-B-04 Ectoparasite Control (I)
• Y-C-03 Continuing Education for Qualified Health Care Professionals (E)
• Y-C-08 Health Care Liability (I)
• Y-G-09 Orientation for Health Staff (I)
• Y-D-03 Clinic, Space, Equipment and Supplies (I)
• Y-E-12 Continuity of Care During Incarceration (E) (former name: Continuity of Care)
• Y-F-04 Personal Hygiene (I)
• Y-I-03 Access to Custody Information (I) (former name: Sharing of Information)
• Y-I-03 Forensic Information (I)

NUMERIC! NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities

This newly revised edition of NCCHC’s nationally recognized Standards provides guidance in establishing and maintaining constitutionally acceptable health services systems. Compliance indicators articulate expected outcomes in nine areas: governance and administration, environmental safety, personnel and training, health care services and support, juvenile care and treatment, health promotion, special health needs, health records and medical-legal issues.

As with the 2003 editions of the prison and jail Standards, the 2004 juvenile Standards features a more user-friendly format and numbering system; new standards to address current issues such as clinical performance enhancement and chronic care; clear compliance indicators; and appendices that address the legal context for juvenile correctional health care, quality improvement, suicide prevention protocols, resources and references, and more.

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Transition to the 2004 Juvenile Standards

Approval
• In October 2003, the NCCHC board of directors approved the revised juvenile standards upon recommendation of the NCCHC’s standards revision task force, its policy and standards committee and its executive committee.

Publication
• The manuals will be available for purchase starting in May at the Updates in Correctional Health Care conference.
• Each accredited juvenile facility will receive one complimentary copy sent to the attention of the facility’s legal authority.

Protocol for Implementation
• Currently accredited facilities have from June to December 2004 to come into compliance.
• Facilities with initial applications received by NCCHC starting in June 2004 will be held to the 2004 Standards.

TIMELINE FOR TRANSITION

June 2004 to December 2004
• 1999 Standards continue to be the basis of accreditation surveys until June.
• As of June 2004, surveys of juvenile facilities will be under the 2004 revision.
• For a given standard, when a facility’s current policy and practice are found to be in compliance with the 1999 requirements, the facility does not have to change the practice, provided it has a plan to transition to the revised standard by the end of 2004.
• When current policy and practice are found to be in compliance with the 2004 standard’s requirements but not with the 1999 version, the facility does not have to change the practice. The survey report will reflect compliance with the 2004 standard.
• When current policy and practice are not in compliance with the 1999 version or the revision of a standard, the facility’s corrective action should bring it into compliance with the 2004 revision requirements.
• Facilities seeking initial accreditation will be surveyed based on the 2004 Standards.
• Accredited facilities may opt to be surveyed under the 2004 version after discussion with accreditation staff before the site visit.

December 31, 2004
• Accreditation for all juvenile facilities will be based on compliance with the 2004 Standards.
providers alike. Moreover, with respect to prisoners entering the community with communicable diseases, opportunities to minimize the spread of disease have not been seized.

Three Themes
To explore the issues at the intersection of prisoner reentry and public health, the Urban Institute convened a meeting of the Reentry Roundtable. The Institute commissioned papers by some of the nation’s leading researchers and invited a rich mix of corrections administrators, correctional health care providers, community health care agencies, former prisoners, police leaders, state and local policymakers, and advocacy groups for a two-day meeting.

Three themes emerged from the discussions. First, a reentry perspective on the health burdens facing America’s prison population presents an opportunity to think differently about improving health outcomes for returning prisoners, their families and the communities to which they return. Given the inevitability of reentry, every prisoner should be viewed as a future member of free society. Accordingly, the period of time in prison should be viewed as an opportunity to provide health interventions that will yield better health outcomes not only in prison but, equally importantly, after the prisoner’s release.

This perspective places new obligations on prison health practitioners to factor in benefits incurred after release and to communities, rather than tailor treatment to address benefits realized only during incarceration. The reentry perspective also envision different relationships between health care providers in prison and those in the community. For example, correctional health care professionals should work with their colleagues in the community to develop discharge protocols, fixed first clinic appointments after the inmate’s release, and sharing of medical records and treatment plans.

Finally, the reentry perspective would move the public health field toward different strategies for addressing a number of health issues in our society. For example, public health strategies to minimize the spread of hepatitis would start with the recognition that prisoners present high levels of that disease and would take advantage of their period of incarceration to provide screening and appropriate interventions.

A number of researchers and practitioners have embraced the notion that the twin realities of incarceration and reentry present what has been called a “public health opportunity,” but realizing this opportunity will require a new collaborative model between community health and correctional practitioners.

The second theme of the discussion was the value of a public health perspective on the phenomenon of prisoner reentry. The public health community brings valuable concepts, language and practices to the work of criminal justice professionals and others who think about the challenges posed by hundreds of thousands of returning prisoners. The idea of a discharge plan, the concept of continuity of care, the concern for a person’s well-being irrespective of his or her social status—all are useful additions to the criminal justice conversations about reentry.

More specifically, a public health perspective contributes a sharpened focus on mitigating the harmful effects of certain illnesses associated with heightened public safety risk, the touchstone of most criminal justice reform efforts. For example, a detailed discharge plan for a prisoner with mental illness that ensures continuity in medication and treatment could promote better mental health and reduce the likelihood of antiso- cial and criminal behavior. Similarly, a successful prison-based education program that helps inmates avoid risky behaviors associated with the transmission of HIV, such as needle injection, may also reduce the rate of return to drug use.

A third theme emerging from the roundtable discussion was more strategic than substantive. Meeting participants expressed the consensus that a merger of the public health and prisoner reentry perspectives could bring new policy interest and new allies to each policy domain.

The public health and correctional health care communities would benefit from alliances with their criminal justice counterparts who could help quantify, in public safety terms, the effects of evidence-based health interventions with the criminal justice population. The criminal justice professionals and allied community agencies would gain support in their efforts to raise public awareness about the impact of mass incarceration on American society by the language and concepts of public health.

The papers presented at the Reentry Roundtable provided new support for the efforts of researchers and practitioners alike to shed light on the nation’s twin challenges of poor health and high incarceration and reentry rates, particularly in disadvantaged communities that already face too many other burdens.

Editor’s note: This article and updated versions of the papers described above are featured in a special issue of the Journal of Correctional Health Care, Vol. 10, No. 3 (see box above).

Jeremy Travis, JD, MPA, and Anna Sommers, PhD, arc with the Urban Institute, Washington, D.C. Travis is a senior fellow in the Justice Policy Center, and Sommers is a research associate. For correspondence, e-mail asommers@ui.urban.org. To learn about the Justice Policy Center, visit its home page at the Urban Institute Web site, www.urban.org.
Pill-Splitting: Correct, but... Dr. Hepler is correct to state that jail medical personnel should not perform pill splitting. However, my article does not suggest they should! I wrote “...don’t write ‘ranitidine 150 mg one po BID,’ costing $0.68 per day. Instead, write ‘ranitidine 300 mg half po BID,’ for a savings of 53%.” This clearly implies the pharmacist is the one who should do the pill splitting and the dispensing.

Pill splitting is a well-established principle in the pharmaceutical business. It is common practice in regular primary care medicine to write for pill splitting in order to save money. This is why many tablets are scored—to allow easy splitting!

Another important point is that most pharmacies do not charge extra to split pills. At our jail, when we write for ranitidine 300 mg ½ po BID, we get the same fill fee as any other prescription.

I would not only encourage correctional centers to write for pill splitting, I would also encourage readers to have their personal prescriptions written for pill splitting, I suspect that many readers take Lipitor. If your prescription reads Lipitor 80 mg ½ po BID instead of Lipitor 40 mg po BID, you would save $54 a month. Jeffrey Keller, MD President, Badger Correctional Medicine, Idaho Falls, ID

Access to Hospitalization A continuing cause of access problems to hospitals for tertiary care for inmates is the reluctance of some community hospitals to take such patients. This is often particularly troublesome for planned admissions, such as non-acute surgery or childbirth, as opposed to admissions from the emergency room. The use of dedicated beds is one possible solution.

Many hospitals, in my experience, are willing to enter into a contract with prisons or jails to allocate a set number of hospital rooms to institutional patients if they are paid for them, occupied or not. Institutions should know their average count of inmates in “outside” hospitals, so they can predict what is expected. Hospitals are generally willing to reduce their per diem rates under such an agreement, so that corrections can analyze such an arrangement on an annual-use basis. If done right, this is a win-win situation for both hospitals and corrections.

Security also likes this idea. The doubles, such as windows bars, solid doors and the like, advance, which reduces the burden on outposted officers. In larger systems, an entire secure ward may be appropriate. For inmate patients, this reduces logistical problems with continuity of care, both pre- and post-admission, and the need for shackles and the like where the area is already secured.

For primary care providers in corrections, such arrangements also enhance professional dialogue and can help with development of relationships with secondary providers in specialty services. Efforts to integrate correctional health care with community health care will serve both.

As Surgeon General Richard Carmona noted in his remarks in Austin at the 27th National Conference on Correctional Health Care, we need to find better ways to coordinate correctional health with public health. I suggest that this is one of them.

William J. Rold, JD, CCHP-A Correctional health care attorney, New York City, NY
**Expert Advice on NCCHC Standards for Health Services**

**BY B. JAYE ANNO, PhD, CCHP-A, AND JUDITH A. STANLEY, MS, CCHP-A**

### Sexual Assault Reporting Standard

I understand that the federal Prison Rape Elimination Act of 2003 is now in effect in all correctional settings. Does this have any implications for accredited facilities?

A We’re glad that you asked. Compliance with the Prison Rape Elimination Act, which was signed into law in September 2003, falls under the jurisdiction of the correctional authorities, not of health staff. However, one of the act’s provisions requires accrediting organizations such as the National Commission to address facilities’ compliance with the act in their standards. Accordingly, NCCHC has adopted a new standard and in February mailed it, along with information about its implications, to accredited facilities.

### Consent to Release Records

Q As a medical records technician for a county jail, I have received many requests for copies of in-custody health records of released inmates who are suing the county. The requests have no authorization or consent-to-release information. Is a release required?

A The general community confidentiality regulations for release of medical records apply to health records of inmates. This is true not only when the request is related to legal proceedings but also in continuity of care matters. Without a subpoena, you need a release of information from the inmate. You can develop a facility-specific release form or accept the inmate’s written request. You also need to check the correctional law in your jurisdiction since additional permissions may be required in some cases (e.g., for psychiatric records, the treating staff may need to advise whether the entire record can be shared given the clinical status of the inmate).

### Food Safety

Q Our state legislature is proposing an exemption for correctional facilities regarding the state’s “food rules” by declaring them not a “food establishment.” As a staff member of the local health district that has inspected the correctional facilities, I want to know what impact that exemption might have on NCCHC’s accreditation of a correctional facility.

A NCCHC awards accreditation to a correctional facility for compliance of the facility’s health services with the applicable Standards for Health Services. All versions (jails, prisons and juvenile facilities) contain standards that address food safety: B-03 Kitchen Sanitation and Food Handlers, B-02 Environmental Health and Safety, and B-01 Infection Control Program. No matter how a state views food operations, the facility must meet our standards on these issues in order to be accredited.

### Review of DNR Orders

Q In standard P-I-04, End-of-Life Decision Making, compliance indicator number 4 regarding health care proxies and living wills requires an independent review by a physician not directly involved in the patient’s treatment, while compliance indicator number 5 states that “DNR orders are reviewed by a medical professional.” What types of providers does the term “medical professional” include?

A In this case, the use of the term “medical professional” was intended to mean only physicians.

For more guidance on how to interpret the standards, visit the Web at www.nccchc.org, go to the Resources & Links section and click on Standards Q&A. There you will find all of the questions and answers from this column for the past three years, arranged by subject.

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Reach the Decision Makers
U.S. correctional institutions house more than 2 million people, many of whom represent medically underserved populations. They receive a broad spectrum of health services ranging from treatment for infectious diseases (e.g., hepatitis, HIV/AIDS, tuberculosis) to management of chronic illnesses (e.g., asthma, diabetes, hypertension) to general health care. They also receive dental care, mental health care, substance abuse treatment and health education. To meet this heavy demand for government-mandated care, correctional facilities spend nearly $86 billion dollars on health care services, supplies and equipment each year. And as inmate populations rise, so do expenditures.

Organizations that offer products or services for this market need to reach the key decision-makers and help them make informed choices. A great way to do that is to exhibit at Updates in Correctional Health Care, which attracts highly qualified attendees with buying power and authority. In addition to the extensive commercial exhibit, this well-attended meeting offers over 30 educational and numerous networking opportunities.

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Exhibit Breaks: The exhibit hall serves as a central meeting point, with scheduled breaks, morning coffee and afternoon snacks that are much appreciated by attendees.

Other Opportunities: Registration bags, lanyards, badges—all are good ways to gain exposure. Have other ideas for sponsorship? We’d love to hear them, so call us!

Registration Information
The rental fee for each 10’ x 10’ booth is $8,000, which includes one full and two exhibit-only registrations.

Additional representatives may register at discounted rates. Advance and on-site promotions of the exhibition include mailings, scheduled breaks, exhibitor prize drawings, and a reception and lunch in the exhibit hall. To learn more, contact director of meetings Deborah Ross at (773) 880-1460, ext. 286, or deborahross@ncchc.org.

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The leading newspaper dedicated to correctional health care, CorrectCare features timely news, articles and commentary on the subjects that our readers care about: clinical care, ethics, law, administration, professional development and more. The quarterly paper is free of charge to members of the Academy of Correctional Health Professionals, as well as to thousands of key professionals working in the nation’s prisons, jails, juvenile facilities, departments of corrections, health departments and other organizations. The paper also is available on the NCCHC Web site. In addition, a special conference issue is distributed to attendees at the National Conference on Correctional Health Care.

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**Mental Health Titles.** Updated to conform with the revised 2003 NCCHC Standards, the new edition of Correctional Mental Health Care: Standards and Guidelines for Delivering Services makes explicit what is implicit in the standards regarding mental health issues and coordination of delivery with health services. Appropriate for prison, jail and juvenile facilities of any size, the manual works well as an independent reference or as an annotated companion to the Standards. Soft cover, 275 pages. $34.95 + shipping and handling.

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The Correctional Mental Health Handbook offers a comprehensive overview of mental health services for correctional populations. The handbook has three major sections: a flexible model for organizing mental health services based on staffing levels, facility mission and local need; typical offender programs and how they are customarily managed; and various clinical and consultative activities offered by mental health professionals. Edited by Thomas Fagan, PhD, and Robert Ax, PhD, experts with over 40 years of experience in this discipline. Published by Sage (2002), hard cover, 576 pages. $69.95 + s/h.

Order online at www.ncchc.org, or call (773) 880-1460.

**Meetings**

Food Service Conference. The American Correctional Food Service Association will host its annual Spring conference April 18-21 in New Orleans. Find the details online at www.acfsa.org, or call (952) 928-4658.

Mental Health Symposium. The Mental Health in Corrections Consortium will host “Mental Health Training for the Correctional Environment: Research, Practice, Results” April 19-21 in Kansas City, MO. Visit www.mhcera.org to learn more, or e-mail hmocy@forest.edu.

AJA Meeting. The American Jail Association’s 23rd Annual Training Conference & Jail Expo will be held April 25-29 at the Birmingham, AL, convention center. To learn more, call (301) 790-3930 or visit www.corrections.com.

Psych Conference. The American Psychiatric Association will hold its annual meeting May 14-18 in New York City. Learn more at www.psych.org, or e-mail aps@psych.org.

Co-Occurring Disorders Programs. The theme of the GAINS Center’s 2004 national conference will be “From Science to Services: Emerging Best Practices for People in Contact with the Justice System.” It’s being held May 12-14 at the Flamingo Hotel in Las Vegas. Learn more online at www.gainscenter.org.

NCCHC ‘Updates.’ Newly renamed Updates in Correctional Health Care to reflect its broad educational programming, NCCHC’s spring conference will take place May 22-25 in Chicago. Learn more online at www.ncchc.org, e-mail ncchc@ncchc.org or call (773) 880-1460.

P.A. Meeting. The American Academy of Physician Assistants will meet June 1-6 for the 32nd Annual Physician Assistant Conference, to be held at the Las Vegas Convention Center. Visit www.aapa.org, or call (703) 836-2272 for details.

Juvenile Services. The National Juvenile Detention Association will host its National Juvenile Services Training Institute June 11-16 at the Sheraton Hotel & Suites, Indianapolis. To learn more, visit the Web at www.njda.com, call (859) 622-6259 or e-mail sherry.scott@ehu.edu.

The 2003 Conference Proceedings book contains hundreds of pages of program abstracts, outlines and handouts from the National Conference on Correctional Health Care held in Austin, Texas. This publication is a great resource whether you attended the conference or not. It’s also the perfect companion to the session audiotapes and CDs available from Nationwide Recording Services. (Visit www.nrstaping.com or call (972) 818-8273, ext. 114.)

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Program Highlights
The meeting offers two full days of more than 40 educational sessions in five tracks—medical, nursing, legal/criminal, mental health care, professional development—plus two days of preconference seminars. Attendees also will enjoy plenty of networking.

Preconference Seminars
• In-Depth Look at NCCHC’s Standards (Prisons/Jails or Juvenile)
• In-Depth Look at NCCHC’s Mental Health Guidelines
• The Correctional Nursing Assessment
• Risk Management in the Correctional Environment
• Mental Health: Where Are We Now (free, but registration is required)

A World-Class Destination
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Restaurants
You’ll never worry about finding a place to eat in Chicago, which has more four-star restaurants than any other U.S. city and thousands of others to suit every culinary taste, every budget, every mood. Soul food, Italian, Chinese, French, Japanese, Mexican, Spanish, Ethiopian, Afghan, Cajun, Persian, Vietnamese, Bohemian, Guatemalan, Lithuanian, Thai...there’s a virtual United Nations of choices.

Museums
Chicago is world-renowned for its diverse collection of museums. Try to visit the Museum Campus, a scenic park that joins the Adler Planetarium & Astronomy Museum, the Shedd Aquarium/Oceanarium and the Field Museum of Natural History. Other notable museums near downtown are the Chicago Historical Society (the city’s oldest cultural institution), the DuSable Museum of African-American History, the Art Institute of Chicago (one of the world’s leading art museums), the Museum of Contemporary Art, and the Chicago Cultural Center.

Conference Objectives
• List major health care issues that commonly affect incarcerated individuals, including HIV, hepatitis, hypertension, diabetes, mental illness and substance abuse.
• Describe current legal, ethical and administrative issues and ways to prevent potential problems that arise in correctional settings.
• Employ new practices for the treatment of major health care issues in order to better manage common medical and nursing problems found in correctional settings.
• Express increased understanding of common correctional health care issues by exchanging ideas with colleagues about new developments in specialty areas.

Continuing Education
NCCHC is approved to provide up to 25 hours of continuing education credit for physicians ($10 fee required), plus APA-approved credit for psychologists and social workers. CCHPs may earn up to 25 hours of Category 1 credit toward recertification. We also have applied for continuing education credit for nurses (up to 30 hours); check the Final Program to confirm approval. Other attendees may request a general certificate of attendance.

Exceptional Exhibits: The Lineup
This is your chance for some face time with all of those companies that support the correctional health care industry. From the opening reception on Sunday evening to the final break and raffle drawing late Tuesday morning, you’ll have plenty of time to talk with the representatives whose products and services can help you to do your job better. The list below is current as of March 29.

Exhibitor Booth No.
Abbott Laboratories 112/110
Academy of Correctional Health Professionals 134
Albany Medical Center 102
American Assn. of Public Health Physicians 233
American Correctional Health Services Association 330
American Diabetes Association 320
AstraZeneca 212
Aeystar Medical Record Solutions 312
AutoMed Technologies 129
Axium Healthcare Pharmacy 127
Boehringer Ingelheim 100
Bristol-Myers Squibb 200/202
Bristol-Myers Squibb Immunology 217/219
Contract Pharmacy Services 231
Correctak 201
Diamond Pharmacy Services 103
Efona 126
Eli Lilly 104
FallSafe Air Safety Systems 105
Federal Bureau of Prisons 203
Gilead Sciences 113
GlucoSmithKline 120/122
Global Diagnostic Services 111
Health Professionals Ltd. 118/116
Henry Schein 109
Humane Restraint Co. 101
Links Medical Products 221
Making the Difference, Intl. 234
Maxim Healthcare Services 308
Merk Human Health 108
MHH Corcorational Services 106
Moore Medical Corp. 237
National HIV/AIDS Clinicians 110
National Institutes of Health 205
NCCHC 132/133
Nokia Group 226
Owen Mumford 208
Pfizer 211/213
Phyto 128
Quick Med 124
Serapis 130
Society of Correctional Physicians 232
Solvay Pharmaceuticals 229
Terumo 209
U.S. Health Services 204
U.S. Medical Group Inc 210
Virologic 223

Find complete conference information and online registration on the Web at www.ncchc.org.
To obtain a preliminary program with registration form, download it at our Web site, e-mail info@ncchc.org, or call (773) 880-1460.