The Graying of America’s Prisons

Corrections Copes With Care for the Aged

BY JAIME SHIMKUS

You’re only as old as you feel? That timeworn adage certainly holds true for the 50-year-old inmate who, body wracked by years of hard living and neglect of health care, now attends clinics for diabetes and hypertension and can barely move when his angina flares up. If he lives in Florida, the state department of corrections defines him as “elderly,” and that’s exactly how he feels.

And he’s not alone. The statistics are sobering. On January 1, 2001, state and federal prisons housed 113,358 inmates age 50 or older, a 173% jump from 41,586 such inmates in 1992. And the proportion of these older inmates has risen, to 7.9% of the overall prison population in 2001 compared to 5.7% in 1992.

These figures come from a recent report, Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates, commissioned by the National Institute of Corrections and prepared by the Criminal Justice Institute. (See page 16 to learn how to obtain the report.)

Given the national demographic, crime and sentencing trends that have contributed to the increase in elderly prison inmates, their numbers likely will continue to rise. Inevitably, this poses great challenges for correctional systems, not only in determining what services to provide and how, but also how to pay for them.

Accelerated Aging

Who qualifies as elderly? While definitions vary among correctional institutions, a CJJ study in 2001 found that, among the 22 state agencies (of 49 responding) that had a working definition of the term, the average first qualifying age was 55. Some states used degree of disability in their definitions rather than chronologiocal age. The NIC report also points out that the elderly population overlaps with two other categories of special needs patients—chronically ill and terminally ill—that also require enhanced services.

Whatever the definition, the transformation to “elderly” is accelerated among prison inmates compared to the general population. According to the NIC report, this faster physiological aging adds 11.5 years, on average, to inmates’ chronological ages after age 50.

Factors behind this phenomenon include the stress that new inmates experience as they try to survive incarceration, avoid confrontation with inmates and staff, and cope with financial pressures related to imprisonment; withdrawal from substance abuse; lifelong histories of high-risk behaviors; and inadequate health care before incarceration.

For those who have lived behind bars awhile, add to that list debilitating stresses related to reduced human interaction, lack of privacy, loss of self-esteem, fear of dying in prison, and even fear of being released from prison.

The most common signs of health deterioration among inmates over age 50 include higher rates of incontinence, sensory impairment, impaired flexibility, respiratory illness, cardiovascular disease and cancer, according to studies cited by the NIC report. As in the free world, the most common chronic diseases are arthritis, high blood pressure, ulcers, prostate problems and heart disease, though these are more concentrated in correctional settings.

Of course, older inmates also experience typical age-related problems: cognitive impairment, reduced vision and hearing, muscle mass loss, incontinence, dietary intolerance and general vulnerability, and, related to the above, collateral emotional and mental health problems.

Not surprisingly, per capita costs of incarcerating elderly inmates have soared, according to the NIC report, to an average of $60,000 or $70,000 per year compared to about $27,000 per inmate in general population.

Looking at health care alone, overall spending increased by 27% from 1997 to 2001.

Seeking Solutions in Florida

States everywhere must deal with rising numbers of elderly inmates, but perhaps nowhere is the situation as pressing as in Florida. A favored destination for retirees, the state out-ranks all others in percentage of residents age 65 or older: 17.6% vs. 12.4% in the U.S. as a whole. It also has the nation’s top 12 counties with the highest percentages of citizens in this age group. Given that Florida ranks fourth in terms of total state correctional population, these percentages translate to some hefty numbers.

The striking statistics don’t stop there. While inmates age 50 or older make up about 8% of prison populations on average, in Florida the figure is 10% and is projected to reach 14% by 2009. Further, as overall prison populations have grown at the Florida Department of Corrections, likewise admissions of elderly inmates have trended steadily upwards in recent years. At present, about 7,700 DOC inmates are at least 50 years old.

This is straining the system, says Terro Marshall, MPH, CHPA, who’s with the DOC’s Office of Health Services and provided the statistics cited above. She adds that, on average, elderly inmates use more than three times as much health care resources than their counterparts under age 50. Further, the budget model used in Florida does not factor in the additional costs of providing health care to this contingent of older inmates.

With a crisis looming, the DOC administration decided to examine...
Two years ago, NCCHC, in its report to Congress on the Health Status of Soon-To-Be-Released Inmates, found that very few correctional health systems had well-developed, effective transitional health care planning programs. We recommended to Congress that the few programs that did foster continuity of health services be identified, analyzed and replicated. Over the past year, the Commission, funded by the JEHT Foundation, has conducted a search for excellent models and best practices in community reentry.

The Searching for Common Ground project is designed to explore, understand, stimulate and facilitate best practices in community reentry.

Unfortunately, policies and procedures too often are not followed and as a result services may be inadequate. Even when a discharge policy provides for a supply of medication, and those inmates identified as medically needy by definition with release anticipated within 90 days will have a comprehensive, collaborative, cooperative aftercare plan completed and placed in the health services record no later than 30 days prior to the anticipated date of release.

The NCDC policy manual states the following standard for Aftercare Planning for Inmates in Health Services: “Every inmate who is identified as a recipient of mental health or developmental disabilities services and those inmates identified as medically needy by definition with release anticipated within 90 days will have a comprehensive, collaborative, cooperative aftercare planning form and, if appropriate, a 30-day supply of medication. The name, address and phone number of a provider with a specific appointment is in place before the inmate is discharged.

The NCDC Aftercare Planning is one example of a coordinated effort to improve inmate reentry. In the coming months, the SCG project will publish reports and articles on the best transitional practices it has found. In addition, the project will bring national experts to speak on these issues at NCCHC’s upcoming National Conference in New Orleans. It is through sharing of information and planning that the SCG project will achieve its goal of improving the collaboration, coordination and continuity of care among health care programs in jails and prisons, urban communities, public health agencies and local, state and federal governments.

Kleante Caruso, MSN, CCHP, was named one of the 10 best nurses in the Houston area by the Houston Chronicle. She was recognized for spearheading a baby-visit program for new mothers and their babies in UTMB’s prison health care system, where she is director of nursing. Caruso represents the American Nurses Association on NCCHC’s board.

• Carl C. Bell, MD, CCHP, will deliver the keynote address at this year’s National Conference. He has written a book, The Sanity of Survival: Reflections on Community Health and Wellness, newly published by Third World Press, as well as a chapter in a new edition of the Comprehensive Textbook of Psychiatry by Kaplan & Sadock.

Bell represents the National Medical Association on NCCHC’s board. To learn more about Bell and the conference, see page 18.
Medicaid a Must for New Releasees

Editor’s note: In the Spring 2004 issue (page 15), CORRECTCARE reported that the Centers for Medicare and Medicaid Services has advised states to suspend but not terminate benefits for Medicaid recipients who become incarcerated in public correctional institutions, and to initiate enrollment for inmates who will be eligible for coverage upon release. This issue’s guest editorial contributor discusses the significance of CMS’s recommendation and concludes with a recommendation of his own.

BY THOMAS J. CONKLIN, MD, CCHP-A

The first two or three weeks are critical for newly released inmates who are functioning in a marginal fashion or who require medication or other treatment to function optimally in the community. Those who are unable to hurdle some significant barriers following discharge will not make it in the community and will end up returning to jail or prison. But discharge planners agree that it is nigh impossible to provide the services that releasees need without active Medicaid coverage. The granting of Medicaid privileges that will be active on the day an inmate leaves prison or jail is the most important development to date in assuring and enhancing care for the physical, mental and substance abuse needs of those being released.

One concern about CMS’s suggestion that states suspend but not terminate Medicaid during incarceration is that it may not be strong enough. The suggestion is not a mandate nor does it require response. Nevertheless, the validity and value of making Medicaid available at the moment of discharge are so powerful that I hope all states adopt this policy. This would be a mighty step toward the goal of removing former inmates from the ranks of U.S. residents who lack health insurance.

Holistic Approach

Health insurance alone isn’t enough to enable many releasees to thrive. A holistic approach, one that blends together medical, dental, mental health and substance abuse treatment, is essential. Just as important is the provision of adequate social support, which includes housing, shelters, medication and numerous other services that require payment if the service is to be rendered. Unfortunately, social and health agencies often don’t talk to one another and don’t coordinate services, to the detriment of patients and their ability to function in the community. In fact, former inmates frequently recidivate because the “system” of care is too interrupted and lacks unification. To its credit, CMS has asked states to coordinate health services provided during incarceration with Medicaid services, but clearly, coordination among community-based social and health services is essential, as well.

The Inevitable Next Step

While CMS has made a major step, other steps must follow, and I hope that eventually Medicaid coverage will be provided without interruption to inmates both during and after incarceration.

Some will question the utilization of government funds to improve the health and well-being of inmates. What those doubters must realize is that of the eight million people who are in the correctional system every year, 98% return to the community with their health problems, which have been either addressed or ignored. Problems that are ignored often fester and worsen, and the cost to the public to give emergency and other required care later is far more than it is to diagnose early and to prevent complications or extension of the disease.

Providing high quality care in correctional facilities benefits society large, and extending Medicaid to inmates would have the same effect. While correctional health care providers strive to address inmates’ health problems to the best of their ability, most jails and prisons receive inadequate funding through the appropriations process. This results in lack of proper staffing, equipment and supplies necessary to provide a community standard of care.

If jails and prisons could charge Medicaid for health services provided, no longer would they rely solely on appropriations. This would eliminate the disparity between those facilities that have an adequate health care budget and the overwhelming number that do not. Medicaid would level the field for all players and, for the first time, enable all to provide a true community level of care. By far, this would be the most important advance in our field. Nothing else could do as much to improve the way that correctional health care functions and the services we offer to our patients.

At a meeting national in scope that was convened recently in Washington, DC, the one item that received the greatest level of consensus among the public health officials and correctional and public health care experts who attended was the following: We must provide a seamless garment of services for the poor, the disadvantaged, the homeless and the incarcerated. An active Medicaid card would go a long way toward creating a system of services that is uninterrupted whether the patient be in the community, in a jail or in a community corrections program.

Thomas J. Conklin, MD, CCHP-A, is the director of health services at Hampden County Correctional Center, Ludlow, MA, which is renowned for its success in bridging the divide between correctional and community health agencies. To access HCCC’s award-winning Public Health Model for Correctional Health Care, visit the Web at www.mpha.org/hccc.html.

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Betty Hron: A Captain in the Corrections ‘Krewe’

BY KRISTEN PRINS, MA

When it comes to no-nonsense fun, New Orleans doesn’t mess around. And those who know longtime resident Betty Hron, RN, CHC-P, agree that her straightforward attitude is right at home in “the biggest small town in the world.”

A true-blue “friend of the Commission,” Hron has contributed to the correctional health care field in countless ways, not least of which is her hard work as a volunteer at NCCHC conferences. Those who attend this year’s National Conference in her hometown surely will see her, perhaps distributing registration materials, moderating sessions or simply pitching in wherever she can.

Getting Involved

Hron’s professional experience is extensive. She was the health services administrator at Jefferson Community Correctional Center in Louisiana for 23 years. She was a member of the medical expert team for the federal magistrate in the Eastern District of Louisiana for about 10 years, and has served as an expert witness for both defense and plaintiff in federal civil rights lawsuits in several states.

During an accreditation survey of Hron’s facility in the early 1990s, the surveyor she was working with suggested that she get involved with the National Commission. So she did. Hron soon became a surveyor for NCCHC, and has been a lead surveyor since 1993. She recalls that the experience was a bit less refined than it is today. “There was no training then; you just went out and did it. You got the forms and you filled them out. And you prayed a lot.”

In 1992, Hron was in the second “class” of CCHPs. But she didn’t stop there. At the time, the CCHP program required re-examination every three years. “Instead of taking the CCHP exam again in 1995, I decided to sit for the Advanced exam,” she says. “It was one test or the other, so I thought, ‘Why not?’”

Professional Growth

Hron sought certification for a simple reason: It helped her do her job better. She says that the professional effort required to obtain and maintain certification provides individuals with the resources they need to understand the complex array of legal and medical issues in this field and to deal competently with daily challenges.

While this is patently important, Hron believes that perhaps the greatest benefit of the CCHP program is that it creates a network of dedicated professionals, an “ever-increasing group of individuals in corrections who are a never-ending source of ideas, solutions and problem-solving resources.” She, of course, is a key part of that network.

She also enjoys the work she does on accreditation surveys: “It gives me an opportunity to share much of the knowledge I have gained over the last 25 years.” She does this with the hope that she will help others avoid mistakes she has made. Despite her years of experience, Hron says she still learns something new on each survey. Call it the ever-changing nature of the field.

One of the greatest changes Hron has seen in the field over the past 20 years has been the expansion of mental health services (and their even greater need) in correctional facilities. “While there used to be custodial mental health care in the community, those people now end up in jail. Fortunately, the system is getting much better at dealing with that.”

Retired but Not Retiring!

In the future, Hron would like to see required national standards for correctional health care. But she knows that it will be a long time before we get there, and that educating the public will be vital. “When the general population thinks of corrections, it’s not something they think we should spend money on.” She believes that emphasizing the public health component is crucial to this education and an eventual national commitment to improved care in corrections.

For now, Hron, who is retired from her HSA job, continues to support the field through surveying. She’s not willing to give up that CCHP credential yet, either! Her commitment is sustained by the deep-rooted feeling that those in the field can “actually make a difference in an otherwise depressing environment. And the very rare thank you that does come [from those we serve] makes the effort more than rewarding.”

Editor’s note: For those who don’t know, “krewe” is the term for a club that participates in the annual Mardi Gras parade in New Orleans.

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We Couldn’t Have Done It Without You

On August 21, the CCHP exam was administered to approximately 60 candidates at test sites across the country. The generosity of the following individuals and organizations helped to make it a tremendous success. Thanks!

Jaye Russell, MEd, CHC-P
Joseph Scalzo, DDS, CHC-P
Gale Steinhauser, MD, CHC-P
Mariana County Correctional Health Services, Phoenix, AZ
Kathy Walters, RN, CHC-P
Captain Gary Younger
Douglas County Detentions, Castle Rock, CO
Bette James
Dianne Rechtine, MD, CHC-P
Central Florida Reception Center, Orlando, FL
Clyde Maxwell, MBA, CHC-P
John Miles, MPA
Iris Smith, MPH, PhD
Rollins School of Public Health
Emory University, Atlanta, GA
John Tarrant, DMD, CHC-P
CorrectCare, Inc., Lexington, KY

Exam sites are being sought for January 22 and July 16, 2005. If you are interested in hosting a CCHP examination at your facility or in volunteering to proctor an exam, please contact Paula Hancock at cchp@ncchc.org.
Board to New CCHPs: Congratulations, and Welcome!

The proctored examination for CCHP certification made its debut at the NCCHC Updates Conference in May, followed by 10 other sites in August (see list on page 4). Designed to enhance the professional quality and prestige of the credential, the new administration method shouldn’t faze dedicated professionals who want to take the next step in their careers, as these 18 new CCHPs can attest. The CCHP board of directors extends a hearty congratulations to all of them!

May 23 Exam

James M. Austin, RN, NP, MSN, CCHP
Sacramento County Sheriff’s Department
Sacramento, CA

Sunil Babu, MBBS, CCHP
New York Medical College
Valhalla, NY

Mark D. Bonnell, MD, CCHP
Federal Medical Center Rochester
Rochester, MN

Renata D. Ellington, BS, MSEd, CCHP
Chicago Department of Public Health
Homewood, IL

M. Jacqueline Head, BSW, CCHP
Wayne County Jail
Canton, MI

Edmund S. Jedry, DDS, FAGD, CCHP
San Diego ICE Medical
San Diego, CA

Verliss Keller-Miller, MS, RN, CCHP
Federal Bureau of Prisons
Lewiston, MN

Seijeoung Kim, RN, PhD, CCHP
Hektoen Research Institute
Oak Park, IL

Paul C. Ohai, MD, CCHP
Greensville Correctional Center
Midlothian, VA

Kimberly J. Partridge, RN, CCHP
Mountain View Youth Development Center
Corinna, ME

Victor L. Polk, ADN, CCHP
Cermak Health Services of Cook County
Chicago, IL

Monica G. Roman, BSN, CCHP
Dodge Correctional Institution
Beaver Dam, WI

Robert J. Rose, MD, CCHP
Spokane, WA

Matthew E. Seaman, MD, CCHP
Yakima County Jail
Yakima, WA

Kenneth L. Soyemi, MD, CCHP
Illinois Youth Center Chicago
Westchester, IL

Michael H. Wiener, MD, CCHP
New York City Department of Correction
New York, NY

Christine L. Williams, MPA, CCHP
Division of Immigration Services
Washington, DC

Kiran K. Yalamanchili, MD, CCHP
New York Medical College
Yonkers, NY

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Examinations are offered at various dates and locations throughout the year, including NCCHC’s major annual spring and fall conferences, Updates in Correctional Health Care and the National Conference on Correctional Health Care. In between those dates, the examination is offered at test centers across the country where there is a qualified CCHP candidate and a qualified proctor. We will try to make reasonable accommodations for candidates who are farther than a two-hour driving distance from a test center.

Your next opportunity to take the test (if you haven’t already submitted an application) is January 22. The application deadline is December 1. Sites established so far include San Bernardino, CA, Colorado Springs, CO, Chicago, IL, Billings, MT, Toms River, NJ, Hobbs, NM, Cranston, RI, and San Antonio, TX.

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New Academy Web Site Open for Business

BY PAULA J. HANCOCK, MED

Due to the tremendous success of the Academy since it was launched a few years ago, the needs of our growing membership were quickly outpacing the original capabilities of our Web site. No more: The site has undergone a complete redesign and enhancement that will enable the Board of Directors and volunteer leaders to bring our members the programs and services they have been asking for, and in a more intuitive and user-friendly design.

Behind the scenes, the site’s flexibility enables us to take advantage of advances in Web technology. For instance, the site is now fully searchable and, with the addition of secure pages available only to members, a searchable member database makes networking with your peers easier than ever.

Content-Rich and Robust

The Career Services section provides completely new information and services to Academy members, including information about job openings and the results of a national compensation survey conducted by the National Commission on Correctional Health Care. Resume posting soon will be offered to members looking for new career opportunities. One of the most important tools to professional success is to develop strong mentoring relationships. Information about becoming a mentor or finding a mentor is also available. For those new to correctional health care, descriptions of careers and anecdotes about working in this unique field are provided.

Want to become more involved? The About section of the site provides information on activities of the Board, committees and other volunteer groups. Online nomination and committee sign-up forms as well as electronic balloting make it easier to participate in these leadership opportunities.

Of course the Academy’s core strength lies in its educational offerings. The Education section of the Web site provides information on national conferences, regional seminars and other educational activities such as our Shared Interest Groups. If you’ve already signed up to take part in one of our SIGs, you now have the opportunity to contact other SIG members to discuss issues and trends that affect you in your work. If you haven’t yet signed up for one of the SIGs, do it online!

Also available are other resources such as links to federal agencies and professional associations. In addition, enjoy current and past issues of CORRECTCARE and the Journal of Correctional Health Care. You can even take and submit the Journal self-study exam online.

Members Only

Membership does have its privileges, as the saying goes, and many of the Web site’s new features are available as members-only benefits.

- Searchable membership directory
- Employment opportunities
- Full-text archives of the Journal of Correctional Health Care
- Journal self-study exam
- Mentor contacts
- Much more!

The members-only benefits require users to log in with a username and password. Members will receive written notification of their unique username and password.

Can’t wait to get started? Your username is the first initial of your first name and your full last name; for example, John Smith’s username would be jsmith. Your password is your member ID number.

Save a Stamp!

We encourage you to join, renew and update your contact information online. The Membership section of the Web site enables you to take care of these basic business correspondences at your leisure. So visit our Web site and start exploring today!
In the News

Jail Nurse Shot During SWAT Rescue
A nurse taken hostage by four inmates was accidentally shot in the leg and back by the SWAT team that rescued her, according to media reports about the Sept. 5 incident at the Bay County Jail, Panama City, FL. The nurse was in stable condition after surgery. The inmates overpowered a guard and barricaded themselves, the guard and three female nurses in the infirmary. During the 12-hour standoff a negotiator won release of three hostages, but when the fourth was being threatened with torture and death, a knife held to her throat, the SWAT team stormed the building and shot two of the hostage-takers. They were treated and returned to the jail. A third inmate was hospitalized for a self-inflicted drug overdose. Early reports said the inmates were protesting health conditions and/or overcrowding, but later assessments said they simply wanted to escape.

Hasta la Vista, Cigs!
California Gov. Arnold Schwarzenegger has signed a bill banning smoking, snuff and chewing tobacco in state prisons and youth correctional facilities. Tobacco use by inmates was already banned by the California Youth Authority and 13 of the 32 adult prisons run by the Department of Corrections, but the new law also pertains to staff. The bill's author, assemblyman Tim Leslie, said it would "drastically reduce" the $280 million spent annually on tobacco-related health care costs. Critics say it may just drive tobacco use underground and turn it into a lucrative contraband item. Sales of tobacco products to inmates generated about $1 million in tobacco taxes and $370,000 in sales taxes for the state last year.

NIC Assistance on PREA
As called for in the Prison Rape Elimination Act of 2003, the National Institute of Corrections is establishing a "national clearinghouse" to provide information and assistance to correctional authorities responsible for the prevention, investigation and punishment of prison rape. The NIC has created a Web page with resources that include training and education programs and materials, information about grants available, studies and commissions and more. Go to www.nicic.org/prea.aspx.

Demand for CAM
If correctional health services are to deliver a community standard of care, will they soon be offering herbal medicines and body-mind therapies? According to a survey by the National Center for Complementary and Alternative Medicine and the National Center for Health Statistics, 36% of U.S. adults use complementary or alternative medicine. CAM is defined as diverse health care systems, practices and products considered outside the realm of conventional medi-

HIV Grants for Underserved Areas
The Department of Health and Human Services is awarding 49 grants totaling $4.8 million to help organizations in rural, underserved and minority communities increase services for people with HIV or at risk of infection. The awards help service providers strengthen their organizational infrastructure and their ability to serve more people. Find a press release and list of grant recipients at www.hhs.gov/news/press/2004/press/20040825.html.

ABA/CDC Initiative on Public Health
The American Bar Association and the CDC are collaborating to explore legal issues related to preparedness for public health emergencies. The partnership will focus on issues such as how to restrict the movement of people with smallpox while safeguarding their civil liberties, whether health care workers can be compelled to treat people with dangerous infections, and whether protected health information can be released to protect the public.
Study Identifies Erythromycin Risk

Risk of sudden death from cardiac causes was five times greater among patients who took the antibiotic erythromycin concurrently with so-called CYP3A inhibitors—certain calcium-channel blockers, antifungal drugs and antidepressants—compared to patients who did not take the drugs at the same time, according to a study in the Sept. 9 New England Journal of Medicine. No heightened risk was seen when amoxicillin, a similar antibiotic, was taken with those medications. The researchers say the concurrent use of erythromycin and strong inhibitors of CYP3A should be avoided. The study was co-funded by the HHS' Agency for Healthcare Research and Quality.

FDA Approves New HIV Combo Drugs

The Food and Drug Administration has approved two fixed-dose combination drugs to treat HIV infection. Such drugs combine different HIV/AIDS drugs in a single medication to simplify treatment by reducing the number of pills and times per day that patients must take them. Both of the new drugs, Epicen and Truvada, are intended for use with other HIV/AIDS drugs. www.fda.gov/bbs/topics/news/2004/new01109.html

Vioxx Withdrawn From Market

Following postmarketing studies that showed an increased risk of heart attacks and strokes in those using the pain and anti-inflammatory drug Vioxx, the drug's manufacturer has voluntarily withdrawn the product from the market. The FDA says it will closely monitor other drugs in this class for similar effects. www.fda.gov/bbs/topics/news/2004/new01122.html

The Importance of TB Control Plans

After bouncing between three jails and a state prison over a nine-month period, a Kansas man symptomatic for tuberculosis finally had testing that confirmed it and was placed in the prison's airborne infection isolation. During his infections period (from symptom onset to diagnosis), 20 weeks of which he was behind bars, he had an estimated 800 contacts, only 318 of which could be identified. What went wrong? None of the jails conducted TB screening, and while the prison admission process did identify the need for further medical evaluation and did conduct a tuberculin skin test, no follow up took place except by chance several weeks later. Summarized in the Aug. 20 issue of the CDC's Morbidity and Mortality Weekly Report, this case underscores the need for effective TB infection control plans (TBICP) implemented by trained employees in jails and prisons, and for information sharing between correctional facilities and local and state health departments, to paraphrase the editorial note that followed the case report. The article also lists bullet-point recommendations for correctional TBICPs. www.cdc.gov/mmwr/preview/mmwrhtml/mm5332a1.htm

Farewell HEPP, Hello IDCR

The former HEPP Report is now the Infectious Diseases in Corrections Report. Launched in September, the revamped report has a new name to reflect its broadened focus on "all infectious diseases that impact the correctional setting" compared to its narrower former focus on HIV and hepatitis. A valuable monthly read for clinicians, the report is sponsored by the Brown Medical School and is edited by correctional health experts Anne DeGroot, MD, and Joseph Bick, MD. Continuing medical education credits are available. As before, subscriptions are free via e-mail, fax or a new, easy-to-navigate format online at www.idcronline.org. It also is distributed to Society of Correctional Physicians members.

Lit Review

• Growth of Mental Health Services in State Adult Correctional Facilities, 1988 to 2000; R.W. Manderscheid, A. Gravesande, I.D. Goldstrom; Psychiatric Services; August.
• Using Psychosocial Interventions Within a High-security Hospital; H. Walker; Nursing Times; Aug. 3.
• Alcohol and Opiate Withdrawal in U.S. Jails; K. Fiscella, N. Pless, S. Meldrum, P. Fiscella; American Journal of Public Health; September.
HIPAA: Does It Impede Mortality Reviews?

BY JEFFREY L. METZNER, MD

A

an April 6 article in Florida Today reported that a sheriff was having difficulty determining whether "a slip-up in medical care could have contributed to any of the five recent inmate suicides at a county jail" due to apparent problems caused by the Health Insurance Portability and Accountability Act of 1996.

According to the article, the county has a contract with a nonprofit agency to provide mental health services at the jail. The sheriff was vague concerning the perceived HIPAA obstacles, but it appeared to imply that the legal representatives of the deceased inmates needed to provide written authorization for the sheriff's department to have access to relevant health care records generated at the jail. The records were needed to assess individual and systemic issues concerning these suicides, all of which occurred within a four-month period. "Because of the HIPAA regulations, we just can't charge in there and gather up every medical record. We have to work with attorneys at each stage of it," the sheriff told Florida Today. "It is definitely slowing us down."

HIPAA, a complicated and often misunderstood federal law, was enacted by Congress in 1996. The Administrative Simplification provisions of HIPAA (Title II) established a process for developing federal rules regarding the transmission and safeguarding of electronically shared health information. The provisions include rules concerning electronic transactions and code sets, security, unique identifiers and privacy. The Privacy Rule (enforceable as of April 14, 2003) established standards for use, disclosure and protection of all health information created by "covered entities." It appears that the sheriff was referring to the Privacy Rule as being an obstacle to the obviously needed mortality reviews.

This article will attempt to address issues pertinent to mortality reviews in correctional settings within the context of HIPAA. It assumes that readers are familiar with key HIPAA concepts involving covered transactions, covered entities, protected health information, notice, consent, authorization, mandatory and permissive provisions, exceptions and more stringent state laws. There is an abundance of useful information relevant to HIPAA on the Web. An excellent starting point is at www.cms.hhs.gov/hipaa/hipaa2.

Covered Entities

Only "covered entities" are required to follow HIPAA guidelines. Not all correctional facilities (or health care providers) meet the criteria for a covered entity. A health care provider or facility (e.g., hospital, medical clinic within a jail or prison) is a covered entity if as a health care provider the individual clinician or health care organization directly or indirectly engages in at least one standard electronic transaction ("covered transaction"). Such covered transactions include, but are not limited to, health care claim status, health claims or equivalent encounter information, health care payment and remittance advice, referral certification and authorization, enrollment and disenrollment in the health plan, health plan eligibility, including coverage and benefits information, health plan premiums and coordination of benefits.

Not surprisingly, the Privacy Rule (45 CFR Parts 160 and 164) provides definitions of electronic transmission and health care, which are mainly commonsense but have some distinct nuances. For example, while...
The rule strikes a balance to protect the public's health and while allowing the flow of health information is properly protected.

The HHS Office of Civil Rights has assumed that the county jail in Florida is considered to be a covered entity because the nonprofit mental health services provider, which has a contract with the county to provide services to the jail, is a covered entity.

The Privacy Rule
The HHS Office of Civil Rights has provided a summary of the Privacy Rule that states the following:

“A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.”

The basic principle is to define and limit circumstances in which an individual’s protected health information (PHI) may be used or disclosed by covered entities. “Individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral, is considered to be protected. PHI may not be used or disclosed by a covered entity except as the Privacy Rule permits or requires or when the individual (or their personal representative) who is the subject of the PHI provides written authorization.

The Privacy Rule permits a covered entity to use or disclose PHI, without an individual’s authorization, in a number of situations including “for its own treatment, payment, and health care operation activities” (TPO). For purposes of the mortality review being discussed, the Privacy Rule’s definition of health care operations is pertinent. Among the activities included in this definition are the following:

- quality assessment and improvement activities, including case management and quality improvement activities;
- competency assurance activities, including provider or health plan performance evaluation, credentialing and accreditation.

A key principle of the Privacy Rule is “minimum necessary” use and disclosure. Reasonable efforts to use, disclose and request only the minimum amount of PHI needed to accomplish the intended purpose of the disclosure or request are required of the covered entity. The covered entity is required to develop and implement policies and procedures related to this concept. There are also certain exceptions to the minimum necessary requirement.

A covered entity must obtain the individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule. The Privacy Rule provides clear structure for the nature of the written authorization that is required.

Quality Improvement Process
Now back to the sheriff’s dilemma. Assume that the nonprofit mental health agency (Agency X) providing services to the jail has directly contracted with the sheriff’s department in contrast to a different county authority. Agency X should have no significant HIPAA-related problems in accessing relevant health care records of the inmates who committed suicide if the review is part of a quality assurance process, which would fall under the TPO exception. The minimum necessary principle would not deny Agency X access to the complete health care records of these individuals due to the nature of the review required. In these circumstances, the sheriff’s department would have access to the mortality review findings because Agency X is by contract part of the sheriff’s department within the context of HIPAA.

Appropriate custody staff should have participated in the mortality review as part of the quality assurance process if that process at the had been properly established. Quality assurance/improvement processes within correctional facilities should include both health care and custody staffs working together or related to the obvious need for good working relationships between them to facilitate various health care and custody operations. Under this contractual arrangement, any problems in the mortality reviews related to HIPAA would reflect a misunderstanding of the Privacy Rule and would be most likely related to a faulty quality assurance process. Assume that Agency X is another county agency that does not administratively report to the sheriff’s office by contract, but does provide the mental health services to the jail via direct funding from the county commissioners. Does HIPAA create barriers for the sheriff’s investigation of the suicides? The answer will depend on structural and ultimately quality issues concerning the nature of the health care delivery system.

The administrative structure of correctional mental health services is a complex issue due to the diversity of settings and organizational structures. Correctional health care systems’ administrative structures range from the traditional decentralized model to a totally centralized system with variations in between.

Still, some basic principles apply to all correctional health care services delivery models. These include the establishment of an adequate suicide prevention program. National Commission on Correctional Health Care standards for jails and prisons (2003) state “all aspects of the standard are addressed by written policy and defined procedures. The suicide prevention program includes the following: training, identification, referral, evaluation, assessing, monitoring, communication, intervention, notification, reporting, review, and critical incident debriefing.” Detailed discussion of the components is provided in the appendix.

The review component of the suicide prevention program should be part of the system’s quality improvement process. A comprehensive QI program involves a multidisciplinary quality improvement committee of health care providers who meet regularly with correctional administration to design QI monitoring activities and to review the results. In other words, the QI process should include both health care and custody staff.

HIPAA would present no significant obstacles to mortality reviews in a correctional setting if the QI process is established in this fashion regardless of the organizational structure of the correctional health care system in question. HIPAA could certainly present obstacles to an effective mortality review process if the QI process has not been properly designed or implemented. However, the remedy should not be amending HIPAA; rather it should involve establishment of an adequate quality improvement process, which is very compatible with current HIPAA regulations.


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New Orleans Jail Attains the Holy Grail

BY JAIME SHIMKUS

It’s the holy grail of health care: improved quality of patient care at reduced expense. Highly desired yet difficult-to-achieve, this goal is in the sights of jails and prisons everywhere. At the Orleans Parish Criminal Sheriff’s Office, this “grail” is now in their grasp.

Over the past five years, while the jail’s inmate population was burgeoning, staff were being added to meet the new demand, and pharmaceutical costs were skyrocketing, the health services department managed to cut its annual budget from nearly $14 million to less than $11 million. At the same time, ambitious—and successful—programs were established to enhance quality improvement, infection control, utilization review, staff training and other areas.

Who’s the broadsheet behind this quest? An internal medicine specialist who, before taking a three-month moonlighting job at the jail, had never worked in corrections. R. Demarce Inglese, MD, was fresh out of the Air Force medical school and had experience primarily as a clinician with some administrative responsibilities.

The sheriff at the time noted his enthusiasm, long hours and initiative in reforming trouble spots such as infection control. When the three months were up, the sheriff asked him to stay on as medical director.

“I told him absolutely not. I had other career plans,” says Inglese, who now is not only medical director but also health services administrator. Finally he agreed, but only with the provision that he’d have carte blanche to rebuild the department as long be delivered in cutting the budget.

Reinventing the Wheel

Looking back at the experience, Inglese says, “I didn’t look at other jails so I had no template. That’s what’s both good and bad about our program. We reinvented the wheel with every program we developed.”

While acknowledging that this approach wasted some time, he did find it helpful to draw on his experience in the Air Force—and his colleagues there. One of his first steps was to replace most of the jail physicians, mainly “moonlighting residents and part-time subspecialists,” with a cadre of new graduates a year behind him at the Air Force.

Why was he willing to follow his career path? Inglese targeted highly motivated doctors with public health and public service interests and offered lucrative terms: a salary competitive with the private sector, and a weekdays-only schedule. Because it operates 24/7, the department uses an emergency medicine group practice to cover evenings and weekends.

Now, Inglese says, “Our patient population has access to young, enthusiastic physicians at the cutting-edge of their field,” noting that many of them also teach at the medical schools at Tulane University and Louisiana State University.

Among the specialties represented by the 12 full-time staff physicians are family practice, various internal medicine subspecialties, ENT, general surgery, OB/GYN and orthopedics.

This staffing plan is key to cost containment, says Inglese. That’s because it enables high quality on-site care, continuity of care, preventive medicine, high formulary compliance, low turnover and many other positive practices.

Dedicated to Quality

The quality improvement mission at OPCSOS’s health services department is so central that it has become a discrete unit with four dedicated staff members. It has several components.

Every inmate grievance triggers a process of investigation and resolution, with corrective action taken as needed. Similarly, all communications from family members and other concerned parties about inmates’ health care are logged and, if it is a complaint, investigated.

The provider peer review program, 5% of all sick call visits are reviewed to assess both quality of care and issues such as resource utilization (e.g., STAT lab tests).

Another main QI task is to track specialty clinics to, for example, measure referral waiting times. In addition, a compliance officer conducts monthly audits of the medical and specialty clinics. These exhaustive audits cover not only “clinical” concerns such as charting, but also virtually every aspect of operations, from general sanitation to narcotics counts.

In each of these QI task areas, detailed periodic reports are used to monitor trends, guide improvement efforts and track progress.

Finally, the department provides an inmate advocate who handles out-of-the-ordinary situations such as, for example, when an inmate needs an orthotic device, or requests special accommodations to donate an organ to a family member.

Quality Pays

Two other ways to foster good quality of care are to control infectious disease aggressively, and to ensure that staff are well-trained. OPCSOS has excellent programs in both areas.

In sum, Inglese says, these measures have helped lower health care costs to $5 per inmate per day, vs. $10 or $12 in the average large jail. Yet the ultimate goal remains foremost: Patients receive superb care.
Labels and Lost Opportunities: Girls in the Justice System

BY JOHN F. CHAPMAN, PhD, CCCP, KIMBERLY SOKOLOFF, LEO ARNONE & ALYSSA BENEDICT, MPH

N the systems of justice and corrections, two agendas—evidence-based practice and gender-responsive strategies—exist on parallel tracks and often contradict each other. Inevitably, systems that try to incorporate both approaches encounter problems. But with arrests of juvenile females increasing (despite no corresponding rise in their criminal behavior), the need for effective gender-responsive practice is more important than ever.

Teaching adolescents about safe relationships, coping skills and appropriate boundaries is helpful but not enough. Knowing the larger psychosocial context of behavior (a context influenced by gender, ethnicity and class) can help better determine which behaviors signal psychopathology and which do not.

Importance of Context

At the heart of contemporary correctional health service is screening and assessment. But diagnoses must be made with caution, and the same is true of the justice system response. Identified symptoms or behaviors must make sense within a context, and this requires consideration of culture, developmental level, context of the behavior and gender.

Historically, the unique factors that underlie female offending have been misunderstood and therefore mislabeled. Further, societal responses have not been gender- or culturally informed. The behaviors that have brought girls into the system have been prematurely criminalized, and the behaviors they exhibit have been prematurely pathologized or even vilified. As a result, girls have been punished more severely than boys and sanctioned to programs designed to address male offending. It’s important to note that among female offenders, delinquency and psychopathology share similar pathways of development. Both are often related to victimization, trauma, mood instability and cognitive deficits. However, views differ on the nature of the offending and of the psychopathology and can be confusing.

Making broad assumptions about girls’ needs may lead to misdiagnosis or missed diagnosis. If unstable relationships, impulsivity and a history of trauma are assumed to be character pathology, then crippling labels may follow. Likewise, if these same factors are assumed to be normal among delinquent girls, treatment interventions may be overlooked.

This clearly speaks to the need for awareness of the individual and her gender-specific realities. However, the movement to embrace a gender-responsive approach elicits questions about assessors’ own biases in identifying needs and pathology.

A Study of Bias

In Connecticut, systemic bias was observed in a pilot study reviewing a small number of counselor intake notes of boys and girls entering detention centers. Three volunteers (two male, one female) rated the adjectives used as having positive, negative or neutral connotations. Agreement among raters was strong.

Data analysis suggests that the adjectives used to describe girls were significantly more likely to be rated as negative than those describing boys. For boys, common descriptors are “uncomfortable,” “forthcoming,” “irritable.” With girls, the adjectives are more severe: “difficult,” “bellicose,” “overweight,” “promiscuous,” “manipulative.”

While this study has limitations and will be replicated in the future, the robust nature of the results suggests that a gender-responsive approach requires system change that addresses individual biases. How we think about and label girls and boys will impact the course of incarceration, case outcome or services delivered. These findings also have implications for how we assess the mental health needs of girls and determine the services they need. We must apply the lessons learned from the historical response to female offending and must adopt a gender-, culture- and class-informed approach.

This is a complicated task. It is assumed that correctional systems and professions, which have existed for hundreds of years, are well known. Managers do not want to hear that problems exist in how people in their care are treated, or that current practices may actually be harmful.

Nevertheless, true gender-responsive programming calls for an in-depth look at how we apply the unique and specific developmental trajectories of girls and boys, as well as the social definitions we apply to “normal” adolescent behavior of girls and boys. It must account for their differences from intake, directly influencing screening and assessment, treatment matching and service delivery.

Correctional training focuses on the deficits of the offender. Seldom do we examine deficits in programs or biases of staff. Treatment of girls in the justice system is parental at best, and at times indifferent or contrary to principles of effective gender-responsive practice. Instituting a new treatment modality alone is difficult, nevermind asking staff to learn a new language and culture of care all day, every day. The challenge for administrators and clinicians is to open up to review, assessment and improved practice.

Effecting Change

Culture change that lightly touches the heart of real gender reform. Without this, changes made to address girls’ real needs will fade. To change the culture of a facility or program in a meaningful way and assure against eventual stagnation, continuous change must be built into the system. Although continuous change is contrary to old-fashioned correctional management, it is essential for a vibrant and effective operation that is fair, equitable and gender-responsive.

Instituting change will require a commitment to understanding gender-specific issues, recognition that gender issues matter and willingness to examine all aspects of the system under the gender lens. To support this commitment, systems should:

• Promote principles of gender-specific strategies and interventions
• Implement quality assurance strategies, with performance-based measures that include gender-specific standards
• Align with agencies and organizations that embrace gender responsiveness
• Infuse external contracts with gender-specific requirements
• Require staff training in female adolescent development, strengths-based approaches; and the effect of gender bias on practice
• Find coaches and skilled teachers of gender-specific practice and empower them to mentor fellow staff
• Strategies to jump-start change and to continue effective, research-based programming include:
  • Initiate national accreditation programs and promote membership in professional organizations
  • Open programs and facilities to evaluation and assessment through continuous quality improvement
  • Provide relevant, timely, cutting-edge training opportunities, and involve motivated line staff in change strategies

No justice program yet developed will cure criminal behavior or make the pain of victimization go away. It is a responsibility of public servants to continue to look for answers as we change and grow. Part of that growth is the development of a gender-responsive system with demonstrated efficacy for both boys and girls.

John Chapman, PsyD, CCCP, is clinical services coordinator, Kimberly Sokoloff is program manager of girls’ services and Leo Arnone is administrator for juvenile detention for the State of Connecticut Judicial Branch, Court Support Services, Wethersfield. Alyssa Benedict, MPH, is executive director of CURE Associates (Creating Opportunities through Research and Education), Manchester, CT.

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Preceptor Program Turns Students Into Colleagues

BY JANET FRASER HALE, PhD, APRN, BC; LYNNE FOSTER DAVIDSON, MSN, PA, FNP; ROSALIE BERRY, MSN, APRN, BC

What if the concept of a teaching hospital, well-established in the free world, were adapted to a prison setting? Wouldn’t it be great if medical and nursing students could receive training at a state prison system, building their skills and experience and at the same time strengthening prison health care delivery and staffing? For the past eight years, that vision has developed into reality at the Massachusetts Department of Corrections.

With the Massachusetts Correctional Institution at Concord (MCI-C) leading the way, the DOC, the University of Massachusetts Worcester, UMass Correctional Health and other partners created a preceptor program that is bringing the concept of “teaching prison” to fruition. Since others may wish to reap the same benefits, this article will describe the logistics, challenges and rewards of our clinical rotation program.

Getting Started

We found that it is important to plan and prepare for student presence in your health service unit. Without buy-in from the HSU as a whole, it is difficult to provide a positive learning experience. Ideally, all staff support and can articulate the vision of the teaching prison. HSU leaders must be committed to successful student learning, and must encourage the staff to help provide an optimal environment for this to happen. This means HSU staff must be flexible, open to new opportunities and willing to take risks, recognizing the potential of each student placement.

A caution: The HSU must resist the temptation to use students to supplement staff, which would be unfair to both student and staff. It is prudent to orient staff to student roles and expectations. They should be encouraged to treat students as colleagues in learning.

Once everyone is on board, contact the health professions programs at educational institutions within a 30- to 60-minute drive. HSU leaders or an employee who is a graduate of the program can describe the rich learning opportunities available.

If the institutions agree to pursue the relationship, a contract is drawn up (most educational programs have a template for such agreements) and signed by senior administrators. For all parties to benefit, the relationship must be clearly defined. A release clause will enable either party to terminate the contract at any time or to remove a student should irreconcilable issues arise.

Assign one HSU representative as the point of contact (POC) with the educational institutions to streamline communication and scheduling of students. In our case, most schools are on the semester basis, so most students are at the prisons one or two days a week for 15 to 18 weeks. Most also take courses along with their clinical work.

At the outset, note the course length, number of clinical hours, days per week, number of students, other demands on students and the required student evaluation tools. It is vital to know the schools’ learning objectives and expected outcomes for the students so that you know what the student is expected to be able to do each week as well as cumulatively when the rotation ends.

The POC arranges for students’ DOC orientation and ensures appropriate credentialing of preceptors and students. The POC matches the student with the appropriate preceptor, ensures that there is “space” for the student near the preceptor, and arranges for sufficient on-site staff to enable the preceptor to devote time to the student and still fulfill regular responsibilities.

A major challenge at first was having students complete the DOC’s required 40-hour safety and security training before beginning rotations. However, word-of-mouth about the rotation was so positive that students soon were not only willing but even asking to complete the training during school breaks so they could start on schedule. Planning is now done weeks or months beforehand.

The Preceptor

An preceptor is one who takes on an intensive but short-term teaching and supervision role; who for a fixed period teaches, counsels, inspires, serves as a role model, supports the growth and development, and helps to socialize a novice into the new role. In terms of qualifications and attributes, preceptors must:

• Value student/staff contributions as a catalyst to high quality care
• Have adequate time to precept
• Exhibit good interpersonal skills
• Be comfortable with their clinical skills

Correctional Mentoring Is Win-Win-Win

Clinical rotations in corrections provide excellent learning opportunities. For advanced practice nursing students, medical students and some medical residencies, opportunities include frequent comprehensive physical exams, health promotion and disease detection, chronic disease management, infectious disease case management, sick call/episodic visits, urgent care/walk-ins, behavior management and first aid/emergency care. In some facilities, inpatient care, oncoology, dialysis and assisted living are available. Learning opportunities for RN and LPN students include RN sick call (evaluating patient problems, taking a short history, and physical examination and treatment via nursing protocol), medication administration, pre-segregation assessment, daily segregation rounds, phlebotomy/ECG techniques and patient education. From a psychosocial perspective, corrections offers a rich and unique environment for students in the mental health and social work disciplines.

The benefit of placing students in correctional settings goes well beyond meeting their educational and experiential needs. Preceptors and other staff gain satisfaction from seeing students’ skills, competence and confidence develop. Despite the demands it places on them, the providers at MCI-C are eager to function as preceptors.

Importantly, this program provides a feeder system for recruiting high-quality, corrections-savvy professionals into a correctional career. To date, MCI-C has precepted 14 students, 12 of whom have become DOC employees. In addition, the presence of students has a positive influence on patient care delivery. Students tend to keep health staff up-to-date on developments in research and education. Further, many educational programs require that students “give back,” providing the facility with patient education materials, an educational program or some other benefit.

Finally, providing health care at or above the community standard benefits the public health when inmates reenter their communities.
Preceptors will do well to foster a professional relationship with the student. Get to know him or her early, ask about past clinical experiences, learning needs and concerns about a clinical placement. Explain your expectations and the ground rules. Ask what types of patients and procedures cause the most anxiety, and be present and supportive until their competence and confidence increase. Familiarity with the student's program of study and objectives for the clinical placement is essential.

Preceptors will differ in how they perform their role, but for one nurse practitioner at MCI-C, a tried-and-true approach is to have the student “shadow” her for a day or two, closely observing her interactions to gain a sense of the process, timing and special approaches to patients that are unique to a correctional health care setting. She then observes the student perform six episodic encounters (sick call) and three comprehensive physical exams to assess skills, knowledge, comfort level, strengths and weaknesses, and the level of trust for allowing the student to work independently. She gives students space to see patients independently, and co-signs all documentation after discussion and review for each patient. Different approaches toward oversight are worth noting. Directing provides specific instructions and closely supervises performance; it is useful when the student is hesitant or unable to complete a task. Coaching is useful when the student is unsure but willing to try to complete the task. Supporting works best when the student can complete the task but lacks sufficient confidence. Delegating works when the student can and will perform the task relatively independently.

For example: A student struggling with basic patient care tasks should not work with a preceptor with a delegating style. This student would succeed better with a coaching or supportive preceptor. A student who demonstrates mastery of clinical skills or strong initiative in satisfying his or her learning needs might object to a directing/coaching person but would thrive in a delegating environment.

It is very important to reward student contributions with frequent praise and constructive feedback. If the preceptor has problems with a student or is not sure the student is progressing on schedule, the assigned faculty member should be contacted. No surprises should surface at the end of the rotation.
AGING PRISONERS (continued from page 1)


necessary to date, but this living arrangement has greatly improved routine chronic care by consolidating visits, says Marshall. Also, inmate assistants are provided for those with mobility or other limitations.

For those with more serious needs, the Zephyrhills facility’s mental health building has a dorm that serves as a sheltered care environment for the aged and infirm. The “J Unit,” as it is called, is an open dorm designed for 100 beds in four pods. In the works is a fellowship program that will bring a geriatric specialist from Nova Southeastern University College of Osteopathic Medicine to practice within the unit.

The Wakulla Correctional Institution has an eight-bed unit in the infirmary to provide end-of-life palliative care to inmates, regardless of age. A geriatric coordinator or a life expectancy is generally less than six months.

These steps to serve the growing geriatric population in Florida’s prisons are just the beginning of what’s being developed long-term, says Marshall, and many other projects and programs are being considered.

Housing for the elderly isn’t universally welcomed by the inmates placed there, some of whom have worked hard to get assigned to preferred facilities, such as those near family.

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Study Calls for New Tactics to Reduce Women’s HIV Risk

One might reasonably surmise that incarcerated women who receive treatment and counseling for low levels of drug use, their illiterate counterparts who have not received such treatment. Conducted by a team of researchers from the College of Criminal Justice at the University of Huntsville, TX, the study and its findings were described in the latest issue of the Journal of Correctional Health Care. (See box below for title and authors for this and the other six articles in this issue of the Journal.)

The upshot: “Increasing numbers of female offenders entering prison with histories of high-risk activities suggest that correctional health care administrators rethink current means to assess, manage and deliver treatment programs to female inmates.”

Studying the Issue

Two converging trends make this a serious issue: Significant growth in the rates of women being incarcerated (mostly for drug offenses) and of women entering prison who have histories of illegal drug-taking behavior. About one in every four women admitted to correctional facilities in 1998-1999. The questionnaire assessed prevalence of licit and illicit substance use, criminal history, physical and mental health, high-risk sexual behaviors and demographics.

The data analysis compared women who had received drug treatment in the past and those who had not. Overall, the likelihood of drug and sexual risk activity was two to three times greater among women who had received drug treatment, prior treatment a particularly strong predictor of risky drug-related behaviors. The results showed that these women were more likely to have...

• shared a dirty needle or other injection drug equipment in the six months before incarceration
• had unprotected sex with multiple partners
• exchanged sex for drugs, money or gifts
• had sex with an intravenous drug user or a crack cocaine smoker

Perhaps counterintuitively, the women who reported greatest perceptions of their risk of HIV infection were those with a history of drug treatment and those who reported taking part in high-risk activities. In other words, women who engaged in risk-taking behavior understood that their activities placed them at high risk for HIV.

The researchers also analyzed the data in terms of demographic variables such as age, race and education and present significant findings in the Journal article.

Window of Opportunity

What to make of these study results? Clearly, say the researchers, drug treatment alone may not be effective in reducing incarcerated women’s HIV risk behaviors. The results showed that the reduction of drug-related behaviors is less well understood, however, is the effect of such treatment on risk perception and risky behaviors among women inmates. To shed some light on this, the Texas researchers examined self-reported interview data from 1,198 female prisoners newly admitted to Texas Department of Criminal Justice facilities during 10 months spanning 1998-1999. The questionnaires assessed prevalence of licit and illicit substance use, criminal history, physical and mental health, high-risk sexual behaviors and demographics.

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The researchers also analyzed the data in terms of demographic variables such as age, race and education and present significant findings in the Journal article.

Window of Opportunity

What to make of these study results? Clearly, say the researchers, drug treatment alone may not be effective in reducing incarcerated females to reduce risk behaviors that can result in HIV. In fact, high-risk status—and awareness of that status—may actually “promote an ‘I don’t care’ fatalistic attitude,” they note.

Incarceration is an opportunity time to reach these high-risk women at a “teachable moment,” when they are likely to be receptive to messages and education about self-improvement and behavioral change. Thus, the study findings point to important implications for correctional health policy and programming, the researchers say. Bolstered by conclusions presented in previous studies, they offer several recommendations:

• HIV/AIDS education and prevention programs must be available to women in correctional facilities, for this may be the only venue in which a population immersed in risky drug and sexual behaviors can be reached.
• Since the majority of women inmates have histories of illicit drug use, these programs must include drug treatment, complete with intensive training in risk-reduction skills and a focus on increasing self-protective behaviors. Treatment that aims merely to reduce drug use may not be adequate for reducing HIV risk behaviors. Thus, the study findings point to important implications for correctional health policy and programming, the researchers say. Bolstered by conclusions presented in previous studies, they offer several recommendations:

• HIV/AIDS education and prevention programs must be available to women in correctional facilities, for this may be the only venue in which a population immersed in risky drug and sexual behaviors can be reached.
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National Conference on Correctional Health Care
Hyatt Regency New Orleans • November 13–17

Join NCCHC and the Academy of Correctional Health Professionals in fabulous New Orleans for the premier educational event in correctional health care. Seasoned professionals in this field know this is the “must-attend” meeting of the year, where they can gather with 2,000 of their colleagues for a gumbo stew of educational sessions, discussion groups, networking activities, an outstanding exhibition and much more. This meeting will present the top-quality elements you’ve come to expect, along with plenty of N’awlins’ style lagniappe, or “something extra.” Laissez les bons temps rouler (Let the good times roll!)

Program Highlights

Captivating Keynoter
Carl C. Bell, MD, CCHP, will address attendees at the opening ceremony on Monday morning. An eminent and highly accomplished psychiatrist who is a roughing and visionary speaker, Bell will outline the benefits of correctional health care to the public health sector. He also will highlight model programs that demonstrate how correctional health professionals can accomplish a public health mission. Bell is president and CEO of Community Mental Health Council & Foundation, Inc., in Chicago. He also is the director of public and community psychiatry and a clinical professor of psychiatry and public health at the University of Illinois. He is a founding member and past board chair of NCCHC. Over the past 30 years Bell has published more than 200 articles on mental health. His new book, The Sanity of Survival: Reflections on Community Health and Wellness, is due out soon from Third World Press.

Before Bell’s presentation, the ceremony will kick off at 8 a.m. with an impressive color guard ceremony, welcoming remarks from NCCHC and Academy leaders and other dignitaries, and the annual presentation of the highest awards in correctional health care.

Premier Programming

With more than 100 sessions by some of the most respected names in correctional health care, this multi-track program will enable you to create a curriculum that meets your needs and interests. Presentations cover the entire spectrum of care, as well as administrative, legal and ethical issues, in prisons, jails and juvenile facilities. Since nearly two-thirds of attendees have extensive experience in this field and are regulars at NCCHC meetings, we now offer many advanced-level presentations. Whatever your level of expertise, you’ll gain new ideas and information to improve health services in your facility.

Share a Little, Learn a Lot

All attendees are encouraged to participate in the Shared Interest Groups taking place Monday afternoon from 2:15 to 3:30. Sponsored by the Academy of Correctional Health Professionals, SIGs are small, focused discussion groups for the purpose of education, information sharing and idea exchange among professionals. Participants join together according to interest, discipline and work setting. In some cases, noted correctional experts moderate the discussion.

Wine and Cheese Reception

Help us kick off the educational poster presentations during a wine and cheese reception on Monday evening from 4:45 to 6. At this networking event you can meet with the presenters to discuss their posters. Open to viewing through the end of the conference, the posters address topics that run the gamut, from program innovations to research findings to treatment recommendations and more.

Tuesday Celebration

You can find bons temps—French for “good times”—every day of the week in the Crescent City. But Tuesday evening will be extra special. Round up your conference buddies old and new, then head to the annual gala for great music, mingling and dancing, complemented by a delectable array of hors d’oeuvres and drink. Always a high spot at the National Conference, the event will take place from 7 p.m. to 10 p.m.

Experience the Many Charms of the Crescent City

The National Conference is so valuable to our attendees it hardly matters where we hold the meeting—but let’s face it: New Orleans is about as good as it gets. The Hyatt Regency, our headquarters hotel, is in a perfect locale downtown, adjacent to the Superdome and New Orleans Shopping Center, and a short walk to the world-renowned French Quarter and Mississippi River.

The French Quarter is a treasure trove of shopping, dining and entertainment. In Jackson Square, a centuries-old gathering spot where the Quarter meets the river, the Cabildo, Presbytere and other Louisiana State Museum buildings provide a fascinating blend of history, legend and present day.

Hop on a streetcar to visit Jefferson Parish, home to historic attractions, verdant parks, great shopping and famous cuisine, or the Audubon Zoo. Relax on a riverboat tour and soak up the aura of a bygone era.

When the sun comes down, the curtain goes up on an unforgettable show. New Orleans at night! Bourbon Street, in the heart of the Quarter, is home to incomparable jazz clubs and nightlife, with a carnival of barker’s, cabarets and endless eateries. Don’t stay out too late, though. Educational sessions start early!

If you prefer some expert guidance for exploring New Orleans, Big Easy Tours offers a wide variety of tours, including city walks, plantation visits and swamp cruises. To learn more, call toll-free at (877) 407-4299, or visit the Web at www.bigeasytours.us.

Parade float (courtesy of the New Orleans CVB)

Registration Information

Academy Member: $285. Academy members save $75 off the regular fee!

Nonmember: $360. If you are not an Academy member but wish to join, simply sign up using the conference registration form.

One Day: $185. Select the day you wish to attend: Monday, Tuesday or Wednesday. The fee entitles you to participate in all events that day.

Guest: $45. This special registration enables guests to attend all exhibit hall events, including the top presentation on Sunday and lunch on Monday. It does not provide access to educational sessions.

Preconference Seminars: Full day seminars, $170; half day seminars, $95.

Presented by the National Commission on Correctional Health Care and the Academy of Correctional Health Professionals

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.
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The Most Important Standard: Receiving Screening

BY JUDITH A. STANLEY, MS, COHP-A

For the correctional facility concerned about efficient health services management, essential standard Receiving Screening (E-02) might well be the most important of all standards in the NCCHC manuals. From the first jail version in 1977...

“Receiving screening is performed on all inmates upon admission to the facility before being placed in the general population or housing area, with the findings recorded on a printed screening form approved by the responsible physician.”

“Receiving screening is performed on all inmates immediately upon arrival at the intake facility” with the intent of “immediate” can be met with appropriate modifications. For example, when 20 individuals come in at one time, a two-tiered process may be useful. A trained officer screens each inmate for need of immediate medical attention and asks about any urgent health needs. Those needing immediate attention undergo the full screening process with health staff. All other newly received inmates are watched in the intake area, with signs explaining how to access health services, until the health staff gets to each and completes the full screening.

If no health staff are on site, an on-call professional can be telephoned for guidance on steps to take to meet the inmate’s health needs, including further evaluation in a community emergency room.

Quick, Effective Screening
Receiving screening can be accomplished quickly and effectively as soon as an inmate enters the facility. For NCCHC’s purposes, screening is a brief but comprehensive process that for the trained screener normally will take about 10 minutes or less.

Meeting Identified Needs
The purpose of identification of health needs is to meet those needs as dictated by the arriving inmate’s clinical condition. In fact, this standard is not fully met until the needs are met. To put it simply, appropriate clinical intervention must occur in a timely fashion in keeping with current standards of care on site.

Ideally, receiving screening is done by health staff, and the more experienced the screener, the more effective the process. However, the reality is that many correctional facilities, especially medium to small jails and juvenile facilities, health staff are not on site “24/7.” Even in facilities where a nurse is present, it may not be possible for the nurse to do the screening. NCCHC’s standards do allow for trained correctional staff to do the receiving screening in facilities with an average daily population of less than 500.

The understanding and positive working relationship between custody and health staff concerning their roles when an inmate is admitted are factors that affect timely, appropriate interventions. Health staff need orientation that enables them to appreciate security concerns, while custody staff require training to understand that meeting the identified health needs of inmates being admitted is as much a legal mandate for correctional authorities as for health professionals.

One common problem is the inmate who states his need for a meal and ends up in an acute low-blood-sugar reaction, the depressed inmate who does not receive her antidepressant for a week after admission and cuts herself, the hypertensive inmate who ends up in the ER because his usual medication was not on the formulary, the inmate in DTs because no watch was instituted when he arrived in an inebriated state—all are the result of poor policies and procedures or lack of follow-through.

Once problems are identified, failure to intervene in a timely fashion can have dire consequences.

Consider, for example, the suffering of an adolescent with impacted wisdom teeth who gets no pain medication, the staff exposure to contagious disease when the inmate with active TB is admitted to general population or the significant legal action a facility may face when an inmate dies because her brain-injury-related seizure was not identified.

Getting It Right
To meet the intent of the screening for those with identified health needs, facilities must have clear policies and procedures developed by the responsible physician, health authority and legal authority and must ensure that they are followed. When health staff are not available on site to assess the significance of the findings, on-call procedures can dictate that the screening officer contact a health professional by telephone as the next step.

Nurses who provide screening or who are the health staff consulted by screening personnel should understand when they need to contact the midlevel practitioner or physician and not exceed their scope of practice in determining dispositions. The same clinical decision making that occurs in free world settings should be in place in correctional settings.

It is the nature and extent of the medical or mental health condition that dictates the response, not the legal status of the inmate.

The understanding and positive working relationship between custody and health staff concerning their roles when an inmate is admitted are factors that affect timely, appropriate interventions. Health staff need orientation that enables them to appreciate security concerns, while custody staff require training to understand that meeting the identified health needs of inmates being admitted is as much a legal mandate for correctional authorities as for health professionals.

One common problem is the inmate who is on medications and for whom the change in medication may have significant negative results. NCCHC does not dictate how this is to be done, but a process must be exist to ensure that inmates continue medication as medically necessary in a timely fashion.

The responsible physician may implement a policy that allows medications accompanying the inmate to be administered until the physician sees the inmate. This would require safeguards such as accepting only medications in original pharmacy containers, individually labeled, with a telephone check to the prescribing physician or dispensing pharmacy.

Another option is to disallow the use of medication not provided by the facility, with arrangements to obtain any necessary medications by at least verbal order of the facility physician. Protocol may require that the physician alone may prescribe the medication, but this means that the physician must be on site during admission process or come in after hours as needed.

Continued on page 21
Juvenile Standards Compliance

Q: Our juvenile facility will be surveyed for the first time later this year. We are prepared for the 1999 Standards for Health Services in Juvenile Detention and Confinement Facilities. Now that the 2004 edition has been published, will we be held to the changes when we are surveyed?

A: No. NCCHC accreditation surveys will use the 1999 version through December 2004. However, moving as quickly as possible to full compliance with the new standards is encouraged. You may find that implementation of some of the new version's changes would be helpful. You should discuss these options with NCCHC accreditation staff, who will be glad to provide guidance.

Accreditation: For Facilities Only

Q: Is there a list of accredited correctional health care companies that I can reference?

A: NCCHC does not accredit companies, states, agencies, contractors or systems “in the abstract.” Rather, NCCHC accredits individual correctional facilities for compliance with the relevant Standards for Health Services. It does not matter how many players (private contractors, state employees, etc.) are in a facility’s health care system: The accreditation is awarded to the facility itself for compliance with the requirements of the standards (100% of the applicable essential standards must be met and at least 85% of the applicable important standards).

CQI Program Studies

Q: Our question is about P-A-06 Continuous Quality Improvement Program and two of its compliance indicators: 3d, “performs at least one process quality improvement study a year” and 3e, “performs at least one outcome quality improvement study a year.” Please explain what is meant by the term “study” and what evidence is required to meet this indicator.

A: “A study” is a process of reviewing an identified problem to assess potential causes. Subsequent corrective action is documented and evaluated. You might see if the intervention was effective in addressing the problem. Process studies focus on implementation of policies and procedures (usually involving more than one category of staff) and look at the effectiveness of those processes. For example, examining the effectiveness of your chronic care procedure might involve looking at how you identify chronic care patients, how you schedule them for clinics, whether any security escort problems cause delays, how documentation is kept, etc. An outcome study on the same subject might focus on whether the chronic care inmate’s symptoms are actually decreasing or at least are not worsening as a result of the care.

The evidence would be documentation of the studies themselves, either the actual study documents and summary of the results, or a detailed discussion of the same in the CQI meeting minutes. In the Standards, Appendix B, Continuous Quality Improvement, provides further details. Also, the preconference seminars on quality improvement offered at the National Conference on Correctional Health Care (Nov. 13-17) may be helpful to you. You can learn more about the conference online at www.ncchc.org.

RECEIVING SCREENING (continued from page 20)

Whether the screening is done by health or trained correctional staff, periodic reviews of outcomes and refresher training should be in place. Review and debriefing with staff involved when a problem develops should be routine. When something is missed and bad outcomes happen, it is critical that the review process be one not of fault finding, but rather of identifying where things went wrong and what corrective action is needed. This is where the link to an active continuous quality improvement program is beneficial.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation. To contact her, call (773) 880-1460 or e-mail judithstanley@ncchc.org.
National Conference on Correctional Health Care
New Orleans, Louisiana • November 13-17

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 some $7 billion 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 the National Conference in Correctional Health Care, which attracts highly qualified attendees with buying authority. In fact, in attendee evaluations of the 2003 National Conference, 77% indicated that they visit the exhibit hall to learn about new products and services. In addition to the extensive commercial exhibit, this well-attended meeting offers over 100 educational and numerous networking opportunities.

Exhibitor Benefits
• Breaks, lunch and networking opportunities in the exhibit hall, with 10 hours of exclusive exhibit time
• Company listing and product description in the Final Program, and a listing in CORRECTCARE (deadlines apply)
• Pre- and final registration lists with attendee addresses
• Preconference and on-site promotion
• Discount advertising in CORRECTCARE
• Virtual Exhibit Hall listing at NCCHC Web site

Sponsorship Opportunities
Premier Educational Programming: Sponsorship of educational programs on hot topics enables companies to support the correctional market and gain great exposure. Educational Poster Reception: Sponsor the 1 1/2 hour poster reception and share in the success of this highly popular annual event, which attracts over 500 attendees.

Tuesday Evening Event: This can’t-miss event is your opportunity to treat attendees to live music, food, drinks and dancing in a setting that’s ideal for networking.

Conference Portfolio: The portfolios contain essential conference material distributed to all attendees. The sponsor’s logo is displayed on the back cover.

Proceedings Manual: The manual provides attendees with a lasting record of each concurrent session, including speaker abstracts and handouts. The sponsor’s logo is displayed on the back cover.

The Internet Lounge: Exhibit hall visitors love to check their e-mail at these computer stations, which display the sponsor’s name, logo and link on-screen.

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!

Registration Information
Three booth sizes are offered: 10 x 10, 10 x 20, 20 x 20. Rental fees vary by booth size and location. The fee for each booth covers one full and two exhibit-only registrations. Additional representatives receive a discounted rate. To obtain a prospectus, visit the Supplier Opportunities page at www.ncchc.org, or call (773) 880-1460.

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Classified Advertising: Ads appear under the following categories: Employment, Meetings, Marketplace. The text-only ads cost $1.25 per word. Box your ad with a solid border for an additional $50. Text for classified ads should be submitted in electronic form (e.g., via e-mail).

For More Information
To learn more about advertising and other marketing opportunities, call Lauren Bauer, meetings and sales representative, at (773) 880-1460, ext. 298, or e-mail laurenbauer@ncchc.org.

To obtain NCCHC’s Marketing and Resource Guide, which contains an insertion order form, visit the Web at www.ncchc.org and go to the Supplier Opportunities section.

Notes
1. Ad sizes encompass live area, no bleeds.
2. Color ads cost $250 per color additional per page or fraction.
3. Frequency discounts are based on total number of insertions within the next four issues. Ads need not run consecutively.
4. Recognized advertising agencies receive a 15% discount on gross billing for display ad space and color if paid within 30 days of invoice date.
5. Special opportunities are available for conference exhibitors; please see the Marketing and Resource Guide or contact NCCHC for information.
6. Electronic files (Quark, Pagemaker or PDF) preferred; include font files. We also accept camera-ready copy and film (120 line, right reading, emulsion side down). Proofs must accompany all ads.
7. Cancellations must be received in writing before the insertion order deadline.
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Mental Health Titles
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• Treating Adult and Juvenile Offenders With Special Needs is loaded with practical information that addresses what works in treatment; release planning and aftercare concerns; and the logistics of prison systems and community settings. This groundbreaking book emphasizes offenders’ biological, psychological and social needs, and promotes the development of rehabilitative models based on firm scientific information. Edited by Jose B. Ashford, Bruce D. Sales, and William H. Reid. 2001, 518 pages, hardcover, $49.95.

• Acting Out: Maladaptive Behavior in Confinement examines inmates who sabotage their rehabilitation by repeated displays of violence, disruptiveness or other self-defeating behavior. The authors used disciplinary records and mental health exams of chronic offenders to analyze the common threads that precipitate “acting out,” and describe a model intervention for disrupting the cycle of maladaptive behaviors. By Hans Toch, Kenneth Adams, J. Douglas Grant and Elaine Lord. 2002, 446 pages, softcover, $29.95.

Meetings

Correctional Satellite Videoconference:
Early Identification of HIV & Newer Treatment Strategies. Coordinated by Allina Medical College, this program takes place Oct. 19 from 12:30 p.m. to 3:30 p.m. EST, and offers 3.0 CEU nursing credits. For information or to sign up, visit the Web at www.amc.edu/patient/hiv/hivconf, send an e-mail to ybarraj@mail.amc.edu, or call (518) 262-5674.

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The National Commission on Correctional Health Care and the Academy of Correctional Health Professionals thank our sponsoring organizations for their support and dedication to the correctional field. Through generous educational grants and sponsorships, the following companies are helping to make the 2004 National Conference on Correctional Health Care an exceptional event.

- **Abbott Laboratories** is an organization devoted to the discovery, development and management of pharmaceuticals products. Abbott provided an educational grant toward the funding of Tuesday’s breakfasts for medical directors and for mental health directors. Wednesday’s educational luncheon and an educational session in the mental health track.

- **Correctional Medical Services** is one of the leading providers of managed health care services. CMS provided a grant toward the funding of the conference lunyars.

- **Eli Lilly and Co.** creates and delivers innovative medicines that enable people to live longer, healthier, more active lives. Eli Lilly provided an educational grant toward the funding of the Monday evening poster reception.

- **Gilead Sciences** is a biopharmaceutical company that develops and commercializes therapeutics to advance the care of patients suffering from life-threatening diseases. Gilead provided an unrestricted educational grant toward the funding of Tuesday’s educational breakfast and a session in the infectious disease track.

- **GlaxoSmithKline** is a research-based pharmaceutical company dedicated to correcting health care and supporting programs to improve patient care. Glaxo provided an unrestricted educational grant toward the funding of the free Saturday afternoon seminar “Infectious Diseases in Corrections: An Integrated Approach,” as well as Tuesday’s educational luncheon and a session in the infectious disease track.

- **Pfizer Inc.** is a company committed to the discovery, development and manufacturing of innovative therapeutic products. Pfizer provided an unrestricted educational grant toward the funding of two educational sessions, one in the infectious disease track and one in the mental health track, and is the sole sponsor of the Conference Proceedings Manual.

- **Prison Health Services** is the founder of the private managed correctional health care field. Since 1978, PHS has delivered value-driven health care to hundreds of jails, prisons and juvenile facilities across the country. PHS provided a grant toward the funding of Monday’s first exhibit hall break.

- **Roche Laboratories Inc.** is an organization dedicated to creating, producing and marketing innovative solutions of high quality for unmet medical needs. Roche provided an unrestricted educational grant toward the funding of an educational session in the infectious disease track.

Exhibit Hall Hours
Sunday 5pm–7pm Opening reception
Monday 9am–1pm Exhibits open
9:30am–10:30am Break and raffle
11:45am–12:45pm Lunch and raffle
Tuesday 9am–12pm Exhibits open
9:15am–9:45am Break and raffle
11am–12pm Break and raffle

Moore Medical Corp.  504  
NaphCare Inc.  317  
National Commission on Correctional Health Care  110/112  
National Institutes of Health  524  
National Library of Medicine  421  
National Network of STD/HIV Prevention Training Centers  624  
Opus Unit Dose  207  
Pfizer Inc.  519  
PharmaCarr  401  
PMP Inc.  113  
PrimeCare Medical Inc  214  
Prison Health Services Inc.  709  
QuickMed Inc.  410  
Retractable Technologies  216  
Roche Laboratories Inc.  505  
Rx Advantage Inc.  626  
Sage Publications  501  
Sanitary Solutions  425  
Secure Pharmacy Plus  711  
Sequest Technologies  215/217  
Serapis  500  
Smallwood Prison Dental Services Inc.  728  
Society of Correctional Physicians  100  
Solvay Pharmaceuticals Inc.  205  
Syscon Justice Systems Ltd.  528  
Terumo Medical Corp.  400  
Tiburon Inc.  418  
U.S. Medical Group Inc.  104  
ViroLogic Inc.  619  
Wexford Health Source  526  
Zerowet  625

(List current as of Sept. 30.)