Our Role in Preventing Inmate Abuse

BY SCOTT A. ALLEN, MD, ROBERT L. COHEN, MD, AND WILLIAM J. ROLD, JD, CCHP-A

A n inmate comes to your clinic and tells you that a correctional officer on the third shift has been harassing him and others, and at times has struck inmates in the head with a phone book. What do you do? As you walk through a cellblock on your way to clinic, you see that officers have stripped several inmates to their underwear and placed them in a cell with windows open to the winter air. When you ask one of the officers what’s happening, she tells you she is just “teaching them a lesson.” What do you do?

Officers are preparing to use force in a cell extraction. They ask you to participate in the extraction to “monitor” the use of force. What do you do?

Punitive Setting
Correctional institutions are punitive by design. Health care professionals have a difficult and important role in this punitive, nonmedical setting. Yet, competing loyalties create a conflict between these professionals’ commitment to their patients’ welfare and their institutional roles and responsibilities.

What is the appropriate response when a health professional witnesses or suspects abuse of an inmate-patient by staff? Can a correctional health professional always just “treat the medical problem” and “leave the security issues to the security chain of command”?

Recent allegations of inmate abuse internationally and domestically remind us that health care professionals working in institutional settings can be confronted with situations where they may become aware of inmate-patient abuse, or in some cases become unwittingly complicit in the abuse.

Renewing our familiarity with ethical principles in the care of inmate-patients is essential for all correctional health professionals. This article will address the following issues:

- What is dual loyalty?
- What are the national and international bases for ethical medical practice in correctional settings?
- What is the health professional’s role in use-of-force procedures?
- How should a health professional respond if asked to tolerate, monitor or conceal abuse of an inmate perpetrated by other staff?

The subject of medical ethics is a complicated and nuanced one. This article introduces some basic concepts. Suggestions for further reading are provided at the end of the article.

Dual Loyalty
Dual loyalty is defined as conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state.

This conflict of loyalties is a potent and common moral conflict for health care providers in military and institutional settings, and most health professionals who have worked in correctional institutions are familiar with the challenge of balancing their health professional obligations with the missions of security institutions. Dual loyalty conflicts can arise when the health workers’ professional ethics come into conflict with obligations to the institution even when the activities of the institution are perfectly lawful.

**Codes of Medical Ethics**
Numerous health professional organizations have published codes of medical ethics. Four of the principles that are the basis of most codes of medical ethics have special relevance for our work in corrections and deserve special attention:

- **Nonmaleficence**: Most health care providers are familiar with the Hippocratic adage “First, do no harm.” This principle dictates that, at a minimum, health care providers must avoid actions that may cause harm to their patients.

- **Autonomy and neutrality**: The principle of autonomy in prisons and detention centers dictates that health care workers should have autonomy from nonmedical authorities in making clinical judgments about their patients.

- **Primary loyalty to patients**: Health care workers have a professional obligation to act in their patients’ best interests, particularly in relieving distress and preserving and restoring health. In general, all other interests are subordinate to acting to preserve and protect their patients’ health.

However, this principle is often challenged when it comes into conflict with health care workers’ obligations to nonmedical authorities. This occurs in situations where the institution places competing institutional values above the individual patient’s physical and mental well-being.

- **Trust**: The practice of medicine is

Continued on page 16

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**Three Decades of Progress in Correctional Health Care**
1976 was a momentous year for correctional health care. As you will learn in articles throughout this issue, landmark achievements included the Supreme Court decision in *Estelle v. Gamble*, the first jail accreditation standards, a pilot test of the nation’s first correctional accreditation program, and the first National Conference on Correctional Health Care.

Great progress has been made in the 30 years since, thanks to the efforts of many dedicated people, and the future of correctional health care looks brighter than ever, both for practitioners and for the patients under their care.

On this important anniversary, the 2006 National Conference will highlight events of the past while keeping a steady gaze on the future. With a balance of regular programming and exciting new features, it will provide professional growth, continuing education and plenty of networking for 2,000 attendees.

For more on these subjects, see the letter from Jaye Anno (p.2), an article by Bill Rold (p.7), a special “Spotlight” column by Judy Stanley (p.20) and an overview of this year’s conference (pp.12-13). See you in Atlanta!
30 Years Later, National Conference Remains a ‘Must Do’

BY JAYE ANNO, PHD, CCHP-A

I remember the first National Conference on Correctional Health Care I ever attended. In fact, it was the very first conference in 1976. That conference was very different from the conferences of recent years. To begin with, it was sponsored by the American Medical Association as part of the AMA’s Jail Health Care Project. It lasted only one day, and had only a handful of speakers and no exhibitors.

There were only about 80 participants, many of whom were invited to attend and had their travel expenses reimbursed under the terms of the Jail Project’s grant from the Law Enforcement Assistance Administration (a now-defunct federal agency).

From Modest to Major

Compare those modest beginnings with the conferences of today. Last year, the National Conference on Correctional Health Care, sponsored by the National Commission on Correctional Health Care, attracted nearly 2,000 correctional health professionals. In addition to preconference sessions on Saturday and Sunday, there were 70 educational sessions presented by almost 200 speakers over the next three days.

Additionally, more than 100 exhibitors showed their latest products and services. You could find everything from medication distribution systems to suicide prevention garments to orthotics and prosthetics.

I have attended every Fall conference since that first one in 1976 and I plan to be at the 30th celebration in Atlanta. For me, the Fall conference is a “must do.”

I look forward to seeing old friends and colleagues and to meeting new ones. It is an opportunity for me to learn from other correctional health professionals and to share what I have learned. I also like to see what is new in the products and services that support our field.

As an independent consultant, I no longer have daily contact with my correctional health care colleagues—and I miss that. So, once a year, no matter what else is on my schedule, I set aside time to attend the Fall conference. I hope to see you or meet you in Atlanta.

B. Jaye Anno, PhD, CCHP-A, is a cofounder of the National Commission on Correctional Health Care and now works as an independent consultant. For information about the National Conference, turn to page 12 or visit us online at www.ncchc.org.

Board Member Update

- Sheriff B. J. Roberts has been elected sergeant-at-arms on the executive committee of the National Sheriffs’ Association. The position is the first step in a path that often leads to presidency of the committee. Roberts heads the City of Hampton (VA) Sheriff’s Office. He represents the NSA on the NCCHC board of directors and is vice chair of the accreditation committee.

- David W. Roush, PhD, was one of several juvenile justice experts who presented testimony at the June meeting of the National Prison Rape Elimination Commission in Boston. He spoke on the implications to juvenile justice facilities of the Prison Rape Elimination Act, including staffing and training issues related to sexual assaults on juveniles in confinement. Roush represents the National Juvenile Detention Association on the NCCHC board.

- William J. Rold, JD, CCHP-A, served on the Committee on Ethical Considerations for Revisions to DHHS Regulations for Protection of Prisoners Involved in Research. A project of the National Academy of Sciences’ Institute of Medicine, the committee’s report, Ethical Considerations for Research Involving Prisoners, was published in July. The report will be the subject of an article in the next issue of CorrectCare. Rold represents the American Bar Association on the NCCHC board.

Fill Up Your Book Bag With These New Titles

NCCHC’s latest catalog is loaded with new books. Visit the Publications Section of our Web site for a description of each, as well as our complete catalog and an online order form. Or call 773-880-1460. If you have a suggestion for a book that we don’t carry but should, contact us at editor@ncchc.org.


- Substance Abuse Treatment with Correctional Clients: Practical Implications for Institutional and Community Settings. Edited by Barbara Sims, PhD. Haworth Press (2005). Hardcover, 258+ pages with index, $39.95


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The Seven Habits of Highly Effective Leaders

BY DEAN AUFDERHEIDE, PHD

It All Starts With You
“Don’t you kind of know where you are going, you’ll probably end up somewhere else.” — David Campbell, the Center for Creative Leadership

One day you’re talking and laughing with colleagues about life and how stupid management can be, and the next day, you’re in charge. Everything is different because it is different. You’re in charge of a health care delivery system, or a component of the system, in a jail or prison, or at the regional or central office. Before you became a leader, success was all about growing yourself. When you become the leader, success is all about growing others.

Leadership Defined
“Assessing leadership is like using a micrometer to measure jello.” — Rex Blake, independent consultant

We all seem to recognize leaders when we meet them, but defining leadership is complex and definitions differ in many ways. Perhaps the best definition I have found is that leadership is “the process of influencing an organized group toward accomplishing its goals” (in Leaders and Managers: International Perspectives on Managerial Behavior and Leadership, 1984). So, we start with an understanding that leadership is a process, not a position. A “supervisor” is a position. A leader understands that leadership involves something happening as a result of the interaction between us and those to whom we provide oversight. Being the leader is different from just being the boss.

Myths of Leadership
“Remember the difference between a boss and a leader: A boss says ‘Go!’; a leader says ‘Let’s go!’” — E.M. Kelly

Leaders in correctional health care need to fully comprehend their leadership role in our program settings. First, we must jettison from our thinking the following myths:

• Good leadership is all common sense.
• Leaders are born, not made.
• The only school to learn about leadership is the school of hard knocks.
• You can learn how to be a leader from a book.

Then we must recognize the functional differences between management and leadership in a health care system: Management focuses on control; leadership focuses on change. Management plans, directs and rewards; leadership creates a vision, inspires and empowers. Management focuses on systems and procedures; leadership seeks to create opportunity and synergy.

Habit # 1: To Lead Is to Seed
“Hie that would be a leader must be a bridge.” — Welsh proverb

Seeding is all about effective recruitment; finding good people and then putting the right people in the right places of the health care delivery system. We can’t play all the positions. We need to surround ourselves with good people, for if we are in the right jobs, supporting and advancing those who are, and moving out those who are not.

Habit # 2: Leading Is Weeding
“It’s important that people know what you stand for. It’s equally important that they know what you won’t stand for.” — Mary Widdrop

As leaders, we must have the courage to remove staff from jobs in which they aren’t meeting performance expectations. For example, if the same problem with staff continues to come to our attention, it is our responsibility to ascertain if it is a result of a failure to communicate expectations/requirements, a failure in adequate training, incompetence or purposeful insubordination. If it is incompetence or insubordination, it behooves us to take decisive action to weed out those employees who aren’t meeting their delineated performance expectations.

Habit # 3: Leading Is Feeding
“Only the mediocre are always at their best.” — Jonathan Winters

Too often, we think that our staff development occurs once a year in performance reviews. That’s not even close. It should be a daily event, integrated into every aspect of our oversight responsibilities. Also, the value we place on our human resources can be measured by the emphasis we place on training. We have to coach — guiding, critiquing and helping our staff to improve their performance in every way.

Habit # 4: Leading Is Deeding
“Never tell people how to do things. Tell them what to do, and they will surprise you with their ingenuity.” — George Patton, U.S. Army

Deeding is about giving our staff the authority when we give them responsibility. It’s about inspiring risk-taking and learning by setting the example. We need to encourage our staff to ask, “What if?” and “Why not?” Deeding is about empowering our staff, helping them learn from their mistakes and joining in celebrating their successes.

Habit # 5: To Lead Is to Knead
“Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand.” — Chinese Proverb

Like kneading dough into bread, we must invest time to mentor and, through ongoing performance review, shape the skills of our staff. Kneading is building self-confidence — giving encouragement and recognition. Self-confidence energies and gives our staff the courage to take risks and achieve beyond their perceived limitations. Kneading is the energizing force of a winning team.

Habit # 6: To Lead Is a Creed
“Where there is no vision, the people perish.” — Proverbs 28:18

A creed is a system of beliefs and principles. It’s the communication of the philosophy and core values we want to permeate our programs. It’s about integrity, modeling professional ethics and being impartial in our selection, promotion and disciplinary process. It’s about not just doing things the right way, but doing the right thing. Establishing a creed is about establishing a vision, an idea of what our programs could be, and moving toward achieving that vision.

Habit # 7: To Lead Is to Succeed
“The leader sets the example...not from what the leader says, but from what the leader does.” — Colin Powell

Good leaders get people to believe in them; great leaders get their people to believe in themselves. Leadership means we display an energy, can do attitude about overcoming the many challenges associated with providing health services in correctional settings. It means fighting against negativism and apathy. Leadership to succeed means being able to focus on what is important. When issues arise, we must be able separate the wheat from the chaff, making sure we choose the wheat, not the chaff! Leadership to succeed means linking vision with goals. It is recognizing that, if we aim at nothing, we will hit it every time. In order to lead, we must define our goals. Leadership is about credibility, and credibility is the result of expertise plus trust. We cannot engender loyalty if we don’t have loyalty down. Leadership — it’s everyone’s job!

Dean Aufrderheide, PhD, is the deputy director of mental health for the Florida Department of Corrections.
Seasoned Pro Finds New Challenges in Corrections

BY MATISSA SAMMONS

Education is a passion for Lorry Schoenly, DNSc, RN. This is clear from her own educational achievements as well as her lengthy career in providing professional education to others.

It’s no surprise, then, that Schoenly wasted no time in becoming a certified correctional health professional. She sat for the exam in February 2006, just 11 months after taking her first position in correctional health care, when she joined Correctional Medical Services as director of staff development for its New Jersey region.

She sought certification so quickly, because, she explains, “as an educator, it is important to me that I have a solid grasp of any specialty area I am involved with.” She also appreciates that the credential has helped her to establish her credibility with others in this field.

While Schoenly’s preparation for the exam did provide needed knowledge of correction health care, her professional expertise was already impressive. She has more than 20 years of nursing experience, much of it directly related to staff development and education.

Schoenly earned an MSN degree in 1988 while working as a staff development instructor for Zurbrugg Memorial Hospital, Willingboro, NJ. From there, she advanced to become the director of education and nursing standards for Rancocas Hospital, also in Willingboro, and then the assistant vice president of education and development for both hospitals.

While serving as the director of education with the National Association of Orthopaedic Nurses, Schoenly earned a doctor of nursing science degree in 1997. She has also participated in research activities in project development and management and has contributed to numerous publications.

Challenge and Opportunity

Schoenly was “looking to return to a closer connection with the actual delivery of care” when she came upon the newly created position at CMS. She was intrigued by the potential to help improve care for the 27,000 inmates in the 14 state prisons for which her region is responsible. Her job entails designing and managing orientation, in-service and continuing education programs for nurses, physicians, dentists, managers and ancillary staff.

Schoenly tackles the job with enthusiasm, and views working with inmates as both a challenge and an opportunity. From a health care provider’s perspective, she sees great opportunity to provide treatment for a concentrated period of time, to attend to a largely disadvantaged community and to make a positive impact on public health. She cites communicable diseases as an area where correctional health care can have an especially large impact.

As an educator, however, she says that the great span of services delivered to this needy population is a major challenge. Staff members must have diverse knowledge and experience, and a wide array of skills, from emergency suturing to HIV counseling. They also must stay current on a vast amount of information. “It’s soup to nuts,” Schoenly says.

Answering the Call

Given the demands for professional expertise, becoming certified is “worth every minute of preparation,” Schoenly says. Her experience was particularly beneficial because she formed a study group with other CCHP candidates. Such groups foster mutual encouragement and accountability in learning the standards, she notes. Now she is a vocal advocate of certification for CMS employees.

Despite the difficulties inherent to this field, Schoenly takes inspiration in a statement she learned in her job orientation: “Everyone, not just the privileged or advantaged, deserves quality health care.” A devout woman, she adds that day-to-day work in corrections is not simply a position but a calling, and she finds ample rewards in knowing that she is “contributing to the good of so many.”

Matissa Sammons is the professional services assistant at NCCHC.

CCHP Exam Dates & Locations

- October 5: Newport, OR; hosted by the Oregon chapter of ACHSA
- October 29: Atlanta, GA; during the National Conference on Correctional Health Care
- February 10, 2007: regional sites to include Florence, AZ; Hamden, CT; New York, NY; San Antonio, TX; Tumwater, WA; Milwaukee, WI; and others upon request
- May 6, 2007: Orlando, FL; during the Updates in Correctional Health Care conference

Examination sites are being sought for August 18, 2007. If you are interested in hosting a CCHP exam at your facility or volunteering to proctor an exam, please contact Matissa Sammons at cchp@ncchc.org.

Be sure to visit the CCHP page at www.ncchc.org for the most current list of exam dates and locations. The application booklet, study guide and an online application also are available at the Web site.
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New Member Orientation & Reception
Sunday, Oct. 29, 4 to 5 p.m.
See the box at right for information about this special event to welcome new Academy members.

Exhibition
Sunday-Tuesday, Oct. 29-31
Stop by the Academy's exhibit hall booth (#264) to check out our Web site demo, cast your vote for the board of directors, meet other members and volunteers, sign up to become a mentor or just say “hi”!

Roundtable Discussion Groups
Monday, Oct. 30, 2:15 to 3:30 p.m.
The Academy’s shared interest groups committee invites all conference attendees to participate in its annual roundtable groups. The SIG discussions are small, informal gatherings for the purpose of education, information sharing and idea exchange. They also provide a unique opportunity to meet other conference attendees. Participants form small groups according to interest, discipline and work setting. You need not be a member to join the discussions.

4th Annual Academy Day
Tuesday, Oct. 31
Show your pride in the Academy and your profession by wearing your Academy apparel on Tuesday. Tired of that same old white polo shirt? Look for new styles and colors at the conference bookstore, and don’t forget to ask for your Academy discount!

Annual Membership Meeting
Tuesday, Oct. 31, 5:15 to 6 p.m.
The annual meeting of Academy members will take place at the conference immediately following the day's educational program. The agenda features reports from committee chairs and staff, results of the 2006 election, special recognition of mentors and time for questions.

Atlanta Area Welcome Committee
Academy members from the Atlanta area have been brainstorming to provide conference-goers with an insider’s guide to the city and surrounding area. We know how hard it can be to decide what to do with your free time in an unfamiliar city. And with a packed conference schedule, free time is precious. From restaurant recommendations to spectacular sightseeing to travel tips, the goal of this committee is to help you make the most of your extracurricular activities. Check out their recommendations on the NCCHC conference Web site at www.ncchc.org/education.

Board of Directors Election
The board of directors plays a vital role in establishing the vision and strategic direction for the Academy, and it assures adherence to the Academy’s mission, bylaws, policies, procedures and values. Because of its importance, every member should participate in the process by voting.

Members who attend the National Conference will have the opportunity to vote for the candidates of their choice during exhibit hall breaks Oct. 29-31 at the Academy booth (#264). Members who cannot attend the conference are encouraged to vote online Oct. 2-16.

New Member Orientation
Sunday, Oct. 29, 4 to 5 p.m.
Some 400 conference attendees will join the Academy this year alone. To welcome them, the Board of Directors is hosting a special orientation and reception. Enjoy light refreshments while you meet the organization’s leaders and fellow newcomers and learn more about the Academy and the benefits of membership.

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30 Years After Estelle v. Gamble: A Legal Retrospective

BY WILLIAM J. ROLD, JD, CCHP-A

“It is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.” — Spicer v. Williamson

As we focus on Estelle v. Gamble, 30 years after the U.S. Supreme Court held that prisoners had a constitutional right to health care, it is important to ask where we got there. To do so, we return to rural North Carolina in 1926.

The Wounding of Peter Camel
Duplicity County Sheriff Williamson’s deputy wounded Peter Camel when he returned Mr. Camel’s fire while arresting him for armed robbery 80 years ago. The local doctor told the sheriff that Mr. Camel’s injuries required hospitalization and surgery beyond his skills. The sheriff took Mr. Camel to Dr. Spicer, a surgeon in the next county. According to the decision, Sheriff Williamson said to Dr. Spicer about Mr. Camel: “How do you expect me to pay; and (3) the public (i.e., Commissioners as a third party).”

Fifty years later, these decisions on liability for the services thus rendered by a physician under the employ of the common law duties of sheriffs is important to remember how we "the public be protected, as a matter of constitutional law, the patient’s right to request treatment; (2) consequences of correctional officials to honor these rights has judgment. The failure of correctional officials to provide medical care under the Constitution. The antecedents of the law’s prohibitions on cruel and unusual punishment can, by reason of the deprivation of the right to a professional medical care professional orders treatment that would not have been ordered if it was not for the errors in medical care made by medical personnel, using equipment designed for medical use, in conditions conducive to medical functions, and for reasons that are purely medical.”

While the constitutional standard does not require that an express intent to inflict pain be shown (Wong v. McCloud), it would ask an inquiry into the defendant’s state of mind for a “subjective” showing of “deliberate indifference.” It is not enough that the defendant should have known or understood the danger to the inmate. The defendant must know of and disregard a substantial risk (Farmer v. Brennan). Such knowledge, however, can be inferred from the surrounding facts where the failure to respond to a clear risk is reckless.

‘Serious Medical Needs’
The Constitution requires that correctional officials provide medical care only for “serious medical needs.” Generally, a medical need is serious if it “has been diagnosed by a physician as mandating treatment or ... is so obvious that even a layperson would easily recognize the necessity for a doctor’s attention.” Conditions are also considered serious if they “cause pain, discomfort, or threat to good health.” (DeShoe v. Underwood). A condition need not be life-threatening to be deemed serious, and many treatment plans that are labeled “elective” nevertheless are deemed serious within the context of Estelle v. Gamble. In general, courts consider three factors in determining whether correctional officials are being deliberately indifferent to serious medical needs: (1) a diagnosis of the condition; (2) consequences to the patient if treatment does not occur; and (3) likelihood of a favorable outcome. Within this mix, the court also looks at the anticipated length of the patient’s incarceration. It is one thing to decline provision of dentures or an artificial limb to an inmate with a three-day jail sentence. It is quite another to withhold such adjuncts to a patient serving 20 years to life.

The Impact of Managed Care
Estelle was decided before the advent of modern notions of HMOs, managed care and “contracting out” for medical services. The impact of these developments would reach the Supreme Court in 1998. Again, North Carolina was center stage. Quincy West was an inmate whose Achilles tendon was repaired by Dr. Atkins, an orthopedic surgeon under contract with the state department of corrections. Mr. West submitted a law suit claiming that Dr. Atkins’ care was so deficient as to constitute deliberate indifference was dismissed by the
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QI Process Keeps Clinical Performance at Its Peak

BY DANIEL BERMAN, RN, PsyD, MSHA, MSN

W e’ve come a long way since the days when prison health care was an afterthought, if it was even provided at all. Sparked by litigation and legislation at the highest levels, along with intense advocacy efforts, positive change has come in fits and starts.

Today, prisons and other correctional facilities are expected to deliver a community standard of care, guided by national standards such as those of the National Commission. And increasingly they are expected to use continuous quality improvement methods in all aspects of health care. (See standard P-A-06 in NCCHC’s Standards for Health Services in Prisons.)

This article describes how to plan and implement a quality improvement program for clinical care in a prison setting.

Step by Step

Several steps must be taken to establish a clinical quality improvement process. The first step is to form a committee dedicated to this project. The team members should include...

- The staff person or department that will lead the process (often this is the department responsible for the overall quality improvement effort)
- Chief medical officer
- Chief psychiatrist
- Chief dentist
- Medical director
- Psychiatric director
- Dental director
- Clinician in charge of infection control

...as well as representatives from...

- Senior management
- Nursing department
- Social work and discharge planning
- Health records department
- Prison administration
- Prison security

The next step is to identify quality indicators in the patient record that can be measured and tracked. In determining these indicators, the team must explore several categories of clinical values, including functional health status, clinical outcomes, costs, and patient and clinical satisfaction.

- **Functional health status** includes physical, mental, social and health risks. One useful tool for measuring functional status is the SF 36, a standardized psychometric questionnaire that measures patients’ perceptions of their wellness and their ability to perform activities of daily living.

- **Clinical outcomes** refers to documented progress or regression in defined domains.

- **Costs** are the direct fiscal expenditures for delivering care.

- **Patient and clinical satisfaction** addresses perceptions associated with delivering or receiving care.

While exploring which indicators to incorporate, the team must consider the use of documented clinical criteria such as those provided in standards from NCCHC, the American Medical Association, the American Dental Association, the American Psychiatric Association, the American Psychological Association and the American Society of Addiction Medicine, to name a few.

The selected indicators also should focus on clinician compliance in using the criteria or other sources of indicators. Let’s say the QI team wants to measure the efficacy of the use of antidepressants. A checklist with established benchmarks should be developed to enable the clinician to check “yes” or “no” for the signs of patient progress or regression on certain symptoms or abilities.

It is important to have a checklist versus a narrative because, for facilities with electronic health records, a computer cannot search narrative comments. And if a human is doing the chart abstraction, it avoids problems of interpretation: The clinician has either checked the box or not.

In the area of clinician compliance it is easy to check for items like:

- Date of the initial history and physical
- Use of certain blood tests
- Use of certain medications

This is necessary to measure compliance with recommended forms and medication protocols.

Once the quality outcome indicators are selected, the team must set goals for the organization to reach. First, however, it is important to get baseline data for a specified period (e.g., one year) before a specified start date.

The goals should state the progress to be achieved—that is, where the team would like the clinical measures...
to be—in one year. Each goal should be broken into smaller goals to achieve quarterly throughout the year. For instance, if the goal is to complete 100% of patients’ medical histories and physicals within a certain time frame and the present rate of compliance is 60%, goals can be set to improve by 10% per quarter.

Before implementing the program, the clinical QI team must seek buy-in—or at least acceptance—from all involved. Individually, team members bring the goals and indicators to their own departments for discussion and eventual buy-in. Quite often these discussions will result in requests for minor modifications that are sent back to the committee for consideration. Flexibility on these points will bolster acceptance of the program.

Implementation
Once the clinical performance data is extracted and analyzed, results for each department should be shared with that department. When results are less than satisfactory, the department head should develop a corrective action plan with measurable management actions. These plans should be presented to the quality improvement team for approval, and then to senior management for final approval.

Subsequently, the department head should make quarterly reports to the quality improvement committee. The report should include:
- Definition of the quality indicator to be measured
- A summary of the data for that quarter showing point by point whether the goals were reached
- The deviation from the goal in percentages
- Barriers in reaching the goal(s)
- New and revised management action steps to be taken over the next quarter

A discussion of barriers is essential because the committee can identify organizational or technical systems issues that get in the way. Then the members can take these issues back to their departments for discussion and brainstorming of solutions.

One major barrier to the success of any QI initiative is a lack of support from senior management and the correctional administration staff. As we all know, security is primary, so we must incorporate any security barriers into the discussion of new or innovative management action steps. That, in part, is why members of senior management and correctional administration serve on the team.

Also, once the quality initiative is implemented, representatives of senior management and correctional administration must participate in the review of data and progress toward meeting goals.

A Word on EMR
The clinical QI process described above can be implemented whether or not a correctional facility uses an electronic medical record system. However, it is vastly better with an EMR.

One concern that senior correctional health care managers often raise about such systems is the cost. EMR systems are, without a doubt, expensive. But the added value they bring to the quality improvement process outweighs the cost.

First, anything automated is much more efficient than human labor. It is also more accurate: When using human chart abstractors, the results can be tainted because data is in the eye of the beholder. An EMR, in contrast, simplifies and standardizes complex data extraction, tracking and analysis.

Also, when presenting results to a payer, regulating agency or an accrediting body, the project will be viewed as having greater reliability and validity.

This latter point is extremely important in today’s correctional health care market, in which many government agencies hire contract management firms to provide health services. One major benefit of this type of quality improvement initiative is to prove the value of correctional health care expenditures. With solid reporting in hand, buyers and contractors can easily see the payoff for the money spent.

Daniel Berman, RN, PsyD, MSHA, MSN, is an independent consultant who specializes in health care quality, performance improvement and clinical outcomes. Based in Jensen Beach, FL, he also teaches nursing and health care management courses at A.T. Still University and Walden University. To contact him, e-mail dberman1@adelphia.net.
A CDC report published in July will help correctional health officials in the struggle to keep tuberculosis at bay in their facilities, where the disease is particularly problematic.

Two years in the making, “Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC” updates 1996 guidelines issued by the Advisory Council for the Elimination of Tuberculosis. ACET also contributed to the new report as part of an ad hoc Tuberculosis in Corrections Working Group made up of representatives from NCCHC, the Academy of Correctional Health Professionals and other organizations.

The report explains the rationale for aggressive TB control efforts in correctional settings, and then describes the measures to be taken, with detailed sections on “fundamental activities.” These include:

1. Screening: finding persons with TB disease and latent TB infection (LTBI). Early identification should be accomplished upon entry and through periodic follow-up screening.

2. Containment: preventing transmission of TB and treating patients with TB disease and LTBI. This includes use of airborne precautions (e.g., airborne infection isolation, environmental controls and respiratory protection) and comprehensive discharge planning.

3. Assessment: periodic monitoring and evaluating of efforts at screening and containment.

4. Collaboration: close collaboration between correctional facilities and public health departments in TB control, with clear roles of shared responsibility.

The report also notes that continuing education of inmates and correctional facility staff is needed to maximize cooperation and participation.

What’s New

Fifteen important changes from the 1996 recommendations are enumerated. These changes include:

• Inclusion of jail staff in the target audience.
• The need to base screening procedures on assessment of risk for TB.
• The need for all inmates with suspected TB to be placed in airborne infection isolation immediately.
• Updated testing recommendations include the new QuantiFERON-TB Gold (QFT-G) diagnostic test.
• Expanded discussion of environmental controls.
• Information on respiratory protection and program implementation.
• Updated treatment recommendations for TB and LTBI based on the latest expert statements.
• Case management of inmates with TB disease and LTBI.
• Early discharge planning in coordination with local public health staff.
• U.S. Immigration and Customs Enforcement detainees.
• Correctional/public health collaboration in discharge planning, contact investigation and training programs.
• Program evaluation, e.g., assessment of risk, performance measurement, information infrastructure.

The report was published July 7 in Morbidity and Mortality Weekly Report and offers continuing education credit through a self-study exam. Find it online at www.cdc.gov/mmwr; click on Reports and Recommendations and scroll down to Vol. 55, No. RR-9.

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National Conference on Correctional Health Care
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From humble beginnings in 1976, the National Conference has grown into the premier educational event of the year. Please join us and 2,000 of your colleagues in Atlanta for this year’s 30th anniversary celebration. Whether you’re a 30-year attendee or a first-timer, you will be enriched by all that the 2006 conference has to offer.

Why You Should Attend
• Discover the latest tools, techniques and solutions from top professionals
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• Choose from over 100 content-rich educational sessions
• Deepen your knowledge by taking part in preconference workshops
• Gain insights from celebrated dignitaries during keynote presentations
• Network with colleagues, from top decision makers to line staff
• View new products and services in the Exhibit Hall
• Visit the Bookstore for publications plus CCHP and Academy items
• Explore Atlanta through one of the many cultural tours and activities available

Program Highlights

Featured Speakers
Befitting the importance of a 30-year anniversary, NCCHC has invited two eminent public health professionals to speak at the opening session. See the column at right to learn about these individuals.

Advanced Education

Nearly 40% of conference attendees have worked in this field for 10 or more years! With this in mind, we are offering a significant number of advanced level sessions to meet the educational needs of these seasoned professionals.

Leadership Series

Attendee feedback guided the creation of a new track to help managers, both new and experienced, hone their skills and become effective leaders in our unique and challenging field. Open to all, these sessions offer...
• Interactive and high-level educational experiences
• Outstanding faculty with extensive correctional health care expertise
• Practical information to help make you more effective and efficient
• Diverse topics, from budgeting and finances to staffing and utilization

Meet and Mingle

A valuable part of the conference is the chance to mingle with colleagues. Be sure to take advantage of these networking events:
• Exhibit Hall Opening Reception: Sunday, 5 to 7 p.m.
• Special Interest Group Discussions: Monday, 2:15 to 3:30 p.m.
• Educational Poster Display Reception: Monday, 4:45 to 6:30 p.m.
• Monster Mash Halloween Party: Tuesday, 8 to 10:30 p.m.

Exhibit Hall Par Excellence

Behind the scenes, countless suppliers of goods and services make the work you do possible. Come meet with these invaluable partners in the exhibition hall. Representatives from more than 100 companies will be on hand to discuss how their products and services can assist you. See the back page for a list of exhibitors and corporate sponsors.

Conference Objectives
• Demonstrate increased awareness of common correctional health care issues, including quality of care, access to care and cost containment
• Identify major health care, research and policy issues facing incarcerated individuals, including infectious diseases, mental illness, substance abuse and special needs (e.g., women’s issues, juvenile health, geriatrics, disability)
• Demonstrate increased understanding of skills necessary to better manage common medical, dental and psychological problems found in correctional settings
• Describe legal, ethical and administrative issues and ways to prevent potential problems that arise in correctional settings

Continuing Education Credits

The maximum CE hours indicated below include preconference seminars.

• CCHPs: Certified Correctional Health Professionals may earn up to 32 hours of Category 1 credit for recertification
• Nurses: NCCHC is an approved provider of continuing education by the Illinois Nurses Association, an accredited approver by the American Nurses Credentialing Center. This activity was approved for 38.4 contact hours
• Physicians: NCCHC is accredited by the American Medical Association to provide continuing medical education. Physicians may earn up to 32 hours of Category 1 credit
• Psychologists: NCCHC is approved by the American Psychological Association to offer continuing education for psychologists. This activity has been approved for up to 32 hours of credit
• Social Workers: NCCHC is approved by the National Association of Social Workers to offer continuing education. This educational activity has been approved for up to 32 hours of credit.
Spotlight on the CDC

Exclusive Tour of CDC Campus and Research Facilities
Tuesday, 9-11:30 am & 1:30-4 pm

The Centers for Disease Control and Prevention is a principal U.S. agency for protecting the health and safety of Americans and for providing essential human services, especially for those least able to help themselves.

Since it was founded in 1946 to help control malaria, the CDC has remained at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities and environmental health threats. Today, the agency is globally recognized for conducting research and investigations and for its action-oriented approach.

The CDC has arranged tours of its main campus and research facilities specially for NCCHC conference attendees. Including transportation, each excursion will be about two and a half hours. You must be a U.S. citizen to take the tour; photo ID required.

Space is limited to 25 people per tour. Visit our Web site to register.

The CDC Presents...
Be sure to check out these timely sessions presented by eminent faculty from the CDC.

• Latest Information on Pandemic Flu Preparedness and Response; session 148, Tuesday, 1:30-2:30 pm
• New CDC Guidelines on TB Management; session 167, Tuesday, 4-5 pm

What to Do, Where to Go in Hot ‘Lanta

Atlanta irresistibly combines the charm of the Old South with the energy of a modern metropolis. Filled with a wealth of arts, attractions and activities, the city offers something for everyone. Even so, it can be hard to decide how to spend your free time when you’re in an unfamiliar place. To help you make the most of your visit, the Academy has created a “welcome committee” of Atlanta locals to lend their advice. Below is a sampling of their suggestions. Check out the full guide online at www.ncchc.org/education.

Committee Picks

Buckhead is a neighborhood noted not only for exquisite homes on rolling, wooded lands, but also for the ultimate in shopping, with fabulous boutiques, spas, art galleries, two elegant malls and a host of fine dining restaurants. It also is also home to the Georgia Governor’s Mansion and the Atlanta History Center.

The Inside CNN Studio Tour provides a behind-the-scenes view of TV news-making action at the headquarters of CNN and Headline News. The tour includes the Control Room Theater, a look at CNN Español, the workings of the special effects studio and the main newsroom.

The Jimmy Carter Library and Museum features photos and memorabilia from his presidency (1977-1981), a replica of the Oval Office, an exhibit of significant events during Carter’s life and political career, and his Nobel Peace Prize. An outdoor exhibit honors Georgia’s two Nobel Peace laureates, Carter and Martin Luther King, Jr. The Carter-King Peace Walk links the Carter Center with the MLK Jr. Historic Site along 1.5 miles of the Freedom Park Trail.

Stone Mountain Park is a fun destination where you can experience 3,200 acres of entertainment and recreation. Visit Crossroads to see what life may have been like in an 1870s Southern town. Enjoy the 4-D theater, Great Barn, Treehouse Challenge, riverboat, Sky Lift to the top of the world’s largest piece of exposed granite, Scenic Railroad, Antebellum Plantation and the world’s largest Lasershow Spectacular.

Zoo Atlanta, just minutes from downtown in historic Grant Park, features more than 200 species of animals from the African plains and Asian forests. With 22 gorillas, the Ford African Rain Forest houses one of the largest captive gorilla populations in North America. Unusual creatures include Bornean Sumatran orangutans, Asian small-clawed otters, Sumatran tigers and giant pandas from China—including a cub born at the zoo on Sept. 6.

Local Weather

Atlanta often enjoys Indian summer in October, and temperate weather that reaches the 80s can linger as late as mid-November. That said, wintry temps in the 40s are not unheard of. The average high is 73º; the average low is 53º.

Conference Site

All educational activities will be at the downtown Hyatt Regency, 265 Peachtree St., NE; 404-577-1234. A contemporary yet elegant property with deluxe amenities and services, the hotel feature a revolving penthouse restaurant with great views of the city. If you haven’t yet made your reservation, the rooms are going fast. Visit the NCCHC Web site for other lodging options.

Registration Information

Pre-registration will be accepted through Oct. 13. Written confirmation will be mailed within three weeks. Badges and other meeting materials will be distributed at the conference when you check in. After Oct. 13, please register on site at the conference, on the lower level near the Grand Hall. Find complete registration information and policies at www.ncchc.org.

• Academy Member: $315
• Nonmember: $390
• One Day: $185 (Mon, Tue, Wed)
• Guest: $55 (access to all exhibit hall events)
• Preconference Seminars: full-day $170; half-day $95

Conference Sponsors

National Commission on Correctional Health Care
Academy of Correctional Health Professionals

For complete information or to register, contact NCCHC: 773-880-1460 info@ncchc.org www.ncchc.org

Monster Mash

Tuesday, 8 to 10:30 pm
It’s Halloween and this monster mash will be a graveyard smash. So join us—if you dare—for an evening of tricks and treats at the Hyatt Regency. A DJ will spin hair-raising tunes while you dance, mingle or simply relax and talk with friends. Light refreshments and a cash bar will be available. Costumes are encouraged.

SCP Annual Meeting

The Society of Correctional Physicians’ day-long educational meeting will address the concept that correctional practitioners don’t treat individual patients only; rather, the population is the patient. Cosponsored by Emory University School of Medicine, the program is intended for physicians and psychiatrists who work in correctional health care or interact with corrections systems through community agencies. The program also is open to physician assistants, nurses, nurse practitioners and other professionals. For details or to register, call 800-229-7380, visit www.corrdocs.org or e-mail scp@corrdocs.org.

2006 Annual Conference

Public Health and Correctional Medicine
Responding to Community Concerns
Sunday, October 29, 2006 at the Hyatt Regency Atlanta Georgia
A new medical director, a neighboring county’s medical cases and a space of suspicious sores on jail inmates all led up to a crash course in how to fight a “superbug.” In February 2004, media in South Florida were highlighting the problems of MRSA, a nasty superbug, in the Palm Beach County jail. As the health care manager for the five Broward Sheriff’s Office detention facilities just south of Palm Beach County, I took particular interest in the articles and the problem.

Then a call came from the director of detention. “What is MRSA and do we have it in our facilities?” As nurses do so well, I smugly answered, “It is methicillin-resistant Staphylococcus aureus, and at any given time we have two to four cases in our facilities.” The director asked for information in layman’s terms and wanted to know if it was a problem for us. I told him about the situation to our north and we decided that we had to watch the matter carefully and be appropriately proactive.

To start, we sent a MRSA training bulletin to our detention staff to be read at roll calls, at all facilities, on all shifts, for three straight days. The training bulletin used information and color pictures taken from the Centers for Disease Control and Prevention Web site. This bulletin also was sent to our medical services administrators, nursing directors, detention commanders, the infection control nurse and the detention health care manager. We also notified the Broward County Health Department and reviewed our newly developed MRSA protocols with one of its physicians.

The following week, we updated health department officials on our daily operations, reviewed the MRSA protocols once more and gave them a tour of the North Broward Detention Facility where we had set up the MRSA isolation unit. They examined the unit, the infirmary and the food services area. They looked at the laundry facility and washing procedures, taking note of the wash and rinse water temperatures, the detergents used and the drying times.

After going over everything with a fine-tooth comb, the officials determined that BSO’s medical team was meeting—even exceeding—CDC guidelines for treating and handling the MRSA outbreak.

Our next move was to develop protocols to address everything from inmate housing and visitation to decontamination and release. We also had to keep the lawyers, judges and others in the legal community informed and safe.

### Rapid Response

We moved quickly to keep the superbug at bay. We met with the facility captain and explained that we needed to isolate the suspected MRSA inmates and decontaminate their housing areas. We moved those first six inmates into our infirmary while awaiting the results of their cultures.

Next, we called an emergency meeting with all practitioners, health services administrators, nursing directors, detention commanders, the infection control nurse and the detention health care manager. We also notified the Broward County Health Department and reviewed our newly developed MRSA protocols with one of its physicians.

The following week, we updated health department officials on our daily operations, reviewed the MRSA protocols once more and gave them a tour of the North Broward Detention Facility where we had set up the MRSA isolation unit. They examined the unit, the infirmary and the food services area. They looked at the laundry facility and washing procedures, taking note of the wash and rinse water temperatures, the detergents used and the drying times.

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### Comprehensive Protocols

Here is what we did:

- **Housing:** We identified inmates with suspected wounds and, with the assistance of the classification supervisor, set up two housing units for suspected MRSA cases: one for men, another for women. Ultimately, we formed four units: males pending and confirmed and females pending and confirmed.
- **Decontamination:** We established procedures for decontamination of the inmate housing areas, holding cells, transport vehicles and just about any area where a potentially infected inmate might be taken. All isolated inmates were allowed to go out for recreation and the areas they used were cleaned afterward.
- **Transportation:** With five detention facilities throughout the county, we had to watch the matter carefully and be appropriately proactive.
- **Laundry:** Any laundry from units where suspected MRSA inmates were housed was put first in “wash-away bags” and then in a highly visible red bag before being removed. Laundry supervisors were notified of the MRSA issue and all protocols were explained. Again, we reviewed the process to make sure the right chemicals, water temperatures and drying times were in place.
- **Uniforms and linen:** We decided to provide a daily linen and uniform exchange for all pending and confirmed MRSA patients. (Having a washer and dryer in the housing unit for personal laundry would be best, if practical, and personal laundry should be washed daily.)
- **Food service:** All pending and confirmed MRSA patients are served using disposable, styrofoam trays. In addition, all inmates who work in the kitchen had to be medically cleared, and each worker was rechecked every week. We also had the food vendor staff keep an eye on the inmate workers for signs of MRSA.
- **Medical treatment:** See protocols above for suspected and positive cases. For positive cases, we initially did weekly cultures of both wound and nares, but discontinued that because the treatment protocols effectively eradicated the MRSA.
- **Movement:** Inmates who were identified as possible MRSA cases were taken directly to the newly formed medical isolation unit, without stopping at the intake area.
- **Legal/courts:** When the MRSA outbreak was first identified, we explained the situation to the judges, public defenders and personnel from the state attorney’s office, as well as BSO’s legal staff. They greatly appreciated the notice.

Initially, inmates with pending wash hands often.

### MRSA Management Protocols

**Culture Pending**

- Move inmate to MRSA-pending housing unit
- C&S (culture and sensitivity) of wound
- Call physician for medication orders
  - Bactrim DS 1 tab p.o. BID x 10 days (if no sulfan allergy)
  - Doxycycline 100 mg 1 tab p.o. BID x 10 days
  - Tums 2 tabs p.o. BID x 10 days
  - Rantidine 150 mg 1 tab p.o. BID PRN x 10 days
- Daily shower with antimicrobial cleanser
- Daily uniform and linen exchange
- Cleaning supplies to cell daily
- May receive mail, use telephones and receive visitors
- Court attendance by policy

**Culture Positive**

- Protocols are the same as above.
MRSA

Living With MRSA

Our compliance unit helped us track and examine the MRSA cases. It notified arresting officers of possible exposure to MRSA-positive inmates and it mapped locations where MRSA cases might have originated. Health department guidelines dictated that any MRSA case identified within seven days of intake should be classified as a community-acquired infection. With this data, the compliance unit could track the number of MRSA cases based on where they originated: the community, a hospital or the BSO jail system. The pin-mapping results suggested that the cases were widespread in the community, but there were no discernible trends or geographic areas of severe concern.

After several months of tracking and treating MRSA in our detention facilities we knew the infection was not going to go away. On average, we continue to have 15 to 20 positive cases and another 15 to 20 pending cases at any given time. However, infected inmates make up only about 0.003% of an average daily population of approximately 5,200.

Looking back, the MRSA outbreak presented the BSO Sheriff’s Office with an exciting opportunity. I learned new techniques and procedures. We strengthened existing partnerships and formed new ones. We challenged our staff and saw them rise to the occasion. We were committed from the start to keep the outbreak from getting out of control and we accomplished something of which we can all be proud.

Carol L. Shepard, BSN, CCHP, is the health care manager for the Broward Sheriff’s Office, Ft. Lauderdale, FL.

I.D.E.A.S. for Handling MRSA in a Correctional Setting

A. Aggregate. Bring everyone together to develop a united approach.

- Local health department
- Neighboring county jails
- Legal system
- Transportation
- Food service
- Detention staff
- Medical staff

B. Systematically monitor.

- Track daily all movement, releases, lab results and treatment
- Monitor protocols
- Evaluate process
- Document progress

What Is Staph?

Staphylococcus aureus are bacteria usually located on the skin or in the nose of a healthy person. If staph are present but there is no illness, the person is a carrier. Staph can cause skin infections, deep-tissue infections and severe, life-threatening blood infections. Most staph infections are minor and demonstrate as pimples and boils.

What Is MRSA?

Methicillin-resistant Staphylococcus aureus is most common in hospitals, where infection usually develops in patients who are very sick or have open wounds. Outside of hospitals, MRSA cases have been associated with recent antibiotic use, sharing contaminated items, having active skin diseases and living in crowded settings. MRSA infections are usually just skin infections but may cause serious illness. Symptoms include a red and inflamed area around a wound, pimple, boil or abscess. Serious symptoms may include fever, chills, lethargy and headaches. Treatment can be difficult, and includes antibiotics and, if necessary, draining or cleaning of the sore.

Infection Protection

- Wash hands often with soap and water.
- Avoid close physical contact with others that have a known infection.
- Wipe gym equipment with a towel.
- Keep cuts and abrasions clean and covered with a bandage until healed.
- Wash clothes, bedding and towels that come into contact with wound.
- Don’t share personal items, such as razors and toothbrushes.

I.D.E.A.S. for Handling MRSA in a Correctional Setting

A. Identify and isolate.

- Instruct health care providers and detention staff on what to look for. Following culture, isolate patients with suspicious wounds. Medically isolate confirmed cases and culture suspected cases of MRSA. Develop protocols for laundry, medical treatment, dietary needs, wound care and lab orders.

B. Decontaminate.

- Immediately clean with appropriate agent:
  - Cell the inmate came out of
  - Common areas in housing unit
  - Transportation vehicles
  - Holding cells used on way to medical isolation unit
  - Laundry

C. Educate.

- Target everybody:
  - Inmates
  - Health care providers
  - Detention staff
  - Arresting law enforcement officers
  - Courts
  - Legal system (public defender’s office, state attorney’s office, etc.)
  - Media (via press release)
  - Public (post information at front door; master control, visiting areas)

D. Document.

- Track daily all movement, releases, lab results and treatment
- Monitor protocols
- Evaluate process
- Document progress

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DUAL LOYALTIES (continued from page 1)

based on trust. Health care workers must strive to honor their patients' trust. This principle is fundamental in the ethics of preserving confidentiality and obtaining informed consent in correctional settings.

National & International Guidelines
Numerous guidelines articulate basic medical ethics, but those that address the health care worker in prisons and detention facilities deserve our special consideration. Four are described in brief here. See page 17 for Internet links to these documents.

World Medical Association Declaration of Tokyo: Also adopted by the American Medical Association, the Declaration of Tokyo provides clear and explicit guidelines to physicians in preventing torture and cruel, inhuman or degrading treatment of prisoners and detainees. Physicians are prohibited from facilitating torture, and from “diminishing the ability of the victim to resist such treatment,” and they must not be present when torture is practiced. The principles go on to assert that physicians must preserve the confidentiality of medical information, and may not use their knowledge or skills to facilitate interrogation, whether legal or illegal. They also must have complete autonomy over the clinical care of their patients. The declaration also addresses physician conduct in the event of a hunger strike, which is beyond the scope of this introductory article.

United Nations’ Principles: This statement—the full name of which is the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment—articulates six principles similar to those of the World Medical Association. To summarize: Health personnel have a duty to provide prisoners and detainees “with protection of their physical and mental health” with a standard of care comparable to individuals not imprisoned or detained. Health professionals must not engage “actively or passively” in torture or cruel, inhuman or degrading treatments or punishments. Health professionals must not be involved in any professional relationship with prisoners or detainees other than evaluating, protecting or improving their physical or mental health.

Health professionals must not apply their skills in a manner that may adversely affect the physical or mental health of prisoners or detainees, and they must not certify their fitness for the infliction of punishments that may adversely affect their health and do not accord with relevant laws.

American Psychiatric Association and American Medical Association positions: Ethical principles promulgated by the APA state that no psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, and advising authorities on the use of specific techniques of interrogation with particular detainees.

Participation in interrogation also is addressed in a new AMA policy, which states that physicians “must not conduct, directly participate in, or monitor an interrogation with an intent to intervene, because this undermines the physician’s role as healer.”

NCCHC Standards
The National Commission on Correctional Health Care has consistently affirmed the components of a policy against torture and other cruel, inhuman or degrading treatment of inmates. NCCHC also recognizes the principle of autonomy.

The Standards for Health Services for adult facilities preclude health staff participation in nonelectronically ordered restraint and seclusion, except to monitor health status (I-01), and in the collection of forensic information (I-03). They require the patient’s informed consent for “all examinations, treatments, and procedures” (I-05), recognize the patient’s right to refuse treatment (I-06) and protect inmates as subjects in human research (I-07). Other standards insist on medical autonomy in clinical decision making (A-02), maintenance of health information confidentiality (H-02) and patient privacy (A-09).

The standards also require documentation of patients’ health status at each encounter—articulate special attention to the medical and mental health of inmates under close confinement (E-09). Other standards address adequate nutrition (F-02) and a safe and healthy environment, including personal hygiene, hot water, heat, lighting and noise containment (B-02). These standards approach but do not address directly the dilemma of a health professional who (1) is asked to participate, even indirectly, in abusive control or coercion of an inmate, or (2) witnesses inmate abuse or its medical or mental health consequences.

The NCCHC board of directors is considering draft language relating to the roles and responsibilities of correctional health professionals confronted with abuse, torture or other cruel, inhuman and degrading treatment of inmates. NCCHC also is considering draft language relating to health professional participation in any aspect of interrogation.

Role in Use of Force
Is it appropriate for health professionals to monitor use of force? The idea is tempting, as it appears to be consistent with patient safety. On further examination, however, health professionals are not qualified to monitor use of force for appropriateness and safety, and such a role is inconsistent with medical autonomy and neutrality.

In fact, the presence of health professionals during the application of force has been shown to “ratchet up” force, as security staff feel less need to exercise self-restraint, feeling they can “keep going” until health staff intervene. On the other hand, given the risk of injury during use-of-force procedures, health care staff do have a duty to respond to any injuries sus-
Avoiding Complicity

So what are health professionals to do if they become aware of possible abuse against an inmate-patient? How should they respond if they are told by custodial staff to “stay out of security matters” and “stick to medicine”? Consistent with the professional ethics described above, health professionals have an affirmative duty to report all allegations of alleged torture and cruel, inhuman or degrading treatment up the chain of command. In most correctional settings, such reporting is encouraged and supported by the institution. However, in some settings, reporting of allegations against staff can be perceived as disloyal.

While confronting witnessed or suspected abuse can present one of the greatest challenges to correctional health professionals, they have a primary commitment to preserve the health and safety of their patients. Confronting abuse is consistent with that role.

While “leaving security issues to security staff” sounds reasonable, health professionals practicing in correctional settings need to understand the legitimacy their profession imparts to the institution as a whole. Even without participating in abuse, medical professionals may become socialized to environments that are permissive of abuse.

Health care professionals who fail to confront acts of abuse inadvertently sustain those environments by the implicit acceptance of these acts, through their silence and through their failure to use their medical authority in defense of their patients’ well-being.

Another form of complicity occurs when health care professionals use their confidential knowledge and clinical expertise to assist in interrogation. Health professionals should not be present in the interrogation room, ask or suggest questions, or advise authorities on the use of specific techniques of interrogation with particular detainees.

Closing Thoughts

This article provides a brief overview of the role of health professionals in confronting abuse in correctional settings. Obviously, as with any real-world ethical conundrum, the issue is complex and nuanced.

The National Commission recognizes the growing need for correctional health professionals to become familiar with the subject. To that end, the NCCHC policy and standards committee is drafting a position statement to address the roles and responsibilities of health professionals in reacting and responding to abuse, torture and cruel, inhuman and degrading treatment of inmates.

Medical Ethics: Declarations, Principles, Statements & Guidelines

World Medical Association — Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment www.wma.net/e/policy/c18.htm

United Nations — Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment www.unhchr.ch/html/menu3/b/h_comp40.htm


American Medical Association — Physician Participation in Interrogation (ethical guideline) www.ama-assn.org/ama/pub/category/16446.html

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Readiness for Disease Reporting

Infectious disease surveillance and reporting by correctional institutions is a highly desirable public health goal. However, the overall readiness of correctional health care systems to participate in a national reporting program was "less favorable" than anticipated in a recent study by Abt Associates. The study was funded by the National Institute of Justice. Issued in June, the report's title is a whopper: Technical Capability Assessment of Correctional Health Care Data Management Information Systems and Overall Readiness to Participate in the Development of a Disease Reporting System.

State and federal prison systems and large jails were surveyed on three factors of capability and readiness: internal recording of test results; external reporting of results to state health agencies; and technical resources, such as hardware, software, training and data entry. The authors cite recommendations in NCCHC's 2002 report to Congress, The Health Status of Soon-to-Be-Released Inmates, as a direct impetus for the project. The report includes statistical findings and recommendations. It is available at www.ncjrs.gov/pdfiles1/nij/grants/215095.pdf.

SAMHSA's Latest TIP: Detox Protocols

Detoxification and substance abuse treatment are covered in the latest Treatment Improvement Protocol from the Substance Abuse and Mental Health Services Administration. Although detention facilities are not mentioned specifically, TIP 45 does address detoxification in nontraditional settings. It provides medical information related to specific substances, and explains considerations for patients with mental disorders or other co-occurring illness. The booklet is posted at www.hap.samhsa.gov/products, or call 800-729-6686.

New Antiretroviral Therapy Guidelines

New developments in antiretroviral therapy for HIV-infected adults are reflected in the latest treatment guidelines from the International AIDS Society-USA. A 16-member volunteer panel reviewed data published or presented in the last two years to guide the revision. Recommendations center on four key issues: when to start antiretroviral therapy, what to start, when to change and what to change. The guidelines were published in the August 16 Journal of the American Medical Association, and are available at www.iasusa.org.

In the News

West v. Atkins was of considerably greater moment than the Achilles tendon job that prompted the case or the quality of Dr. Atkins' care: If corrections could avoid Estelle liability simply by "contracting out," the body of law developed since Estelle was gravely at risk. The Supreme Court ruled that Dr. Atkins could be sued under the Eighth Amendment. Two important principles emerge from West and its progeny. First, private contractors to state and local governments who provide services to prisoners are "state actors" for purposes of the Eighth Amendment. Second, the governments that hire them also remain liable for failing to provide constitutionally adequate care.

Conclusion

"No serious student of American correctional history can deny that litigation has provided the impetus for reform of medical practice in prisons and jails" (Nathan, 1985). As resources become increasingly scarce and government officials are constantly faced with doing more with less, it can be taken as some comfort that the courts remain steadfast as a last resort for a safety net for prisoner patients and for their providers.
Triage Model Improves Mental Health Care in San Diego

When a jail inmate in general population requests psychiatric care, that request must trigger a diagnostic evaluation. But does the evaluation always have to be done by a psychiatrist? That question was posed by a charge nurse at the San Diego County Sheriff’s Department in October 2003. She proposed that some of those inmates could be triaged for evaluation by a licensed clinical social worker in special mental health clinics and may not need further evaluation or treatment by a psychiatrist. If this could be done effectively without compromising needed care, it would free up valuable psychiatrist time to focus on more acute cases and would reduce waiting times to see a psychiatrist.

That suggestion quickly led to a pilot study—and subsequent expansion—of a mental health clinician (MHC) model of care, as it is called in the San Diego County jail system. The model and the study are described in the latest issue of the Journal of Correctional Health Care (see table of contents below).

Four Premises

1. There is a population in jail that seeks psychiatric help for certain symptoms—anxiety, depression, sleep disturbance and substance abuse concerns—but doesn’t require psychiatric evaluation, treatment and/or medication.
2. This population can be identified and triaged by a medical registered nurse and assessed by a mental health clinician, and a significant number of these patients will not need further evaluation for psychotropic medications by a psychiatrist.
3. The population that does not need to be seen by a psychiatrist can be treated with holistic approaches. The jail system has developed written directives for addressing anxiety, cognitive behavioral issues, sleep disturbance and drug withdrawal issues.
4. For patients who need referral to a psychiatrist for further diagnostic evaluation, the time required for that evaluation will decrease significantly. This will enable the psychiatrist to evaluate and treat more patients who more clearly need evaluation for psychotropic medications.

As implemented in the pilot, the nurse who conducted the triage screenings had experience with psychiatric patients. The nurse referred to the mental health clinician those patients who requested psychiatric services for any combination of symptoms noted above and were not on psychotropic medication. As implemented in the pilot, the mental health clinician received 40 hours of training over 10 weeks from the medical director, who is a psychiatrist and neurologist. The medical director also performed the MHC evaluations.

The Findings

The formal study of the model looked at utilization, referrals and outcomes at the jail where the pilot took place and three other jail sites that later adopted the model.

From November 2003 through November 2004, 572 patients were seen in 125 MHC assessment clinics. Of these patients, 52% required only an initial evaluation by the mental health clinician. After holistic treatment, their symptoms improved to the extent that they did not need a follow-up visit.

Follow-up with the MHC clinician was needed for 14% of the patients, usually for depressive symptoms. In general, these symptoms improved over time without medication.

Overall, 31% of the MHC clinic patients required a referral to a psychiatrist. The psychiatrist prescribed psychotropic medication for 98% of these patients; the other 2% refused medication. Among these referred patients, the initial psychiatric evaluation time fell from 45 minutes, on average, to 15 to 25 minutes. The waiting time for a new inmate-patient to see a psychiatrist also decreased, from two or three weeks to one week or less.

Mission Accomplished

“The mental health clinician model of evaluation and care has met the goals set by the San Diego County Sheriff’s Department,” the study authors write.
30 Years . . . and Still Making a Difference

BY JUDITH A. STANLEY, MS, CCHP-A

In 1776, the Declaration of Independence was adopted by the 13 British colonies in North America. This declaration is one of the most significant documents upon which our nation is founded. In a sense, our U.S. Constitution became the “procedure” for implementing the “policies” articulated in the declaration. Two hundred years later, in 1976, the first Standards for Health Services in Jails were developed as part of the American Medical Association’s Jail Project, with funding from the Department of Justice’s Law Enforcement Assistance Administration.

These standards are the foundation for correctional health care, accepted by the courts and the field as the benchmark for constitutional, professional practice that meets national community guidelines for health care in all its variations. In essence, they are the policies for correctional health care.

Other parallels emerge between the events of 1776 and 1976. Like the health care viewed as optimal in the 1970s (dialysis), we often find that they are no better and no worse than the standards covered in the standards, at least implicitly. That’s because the standards are founded on principles.

He identified inadequate health services in jails as a problem, and he set out to do something about it. His research made it clear that...

• Correctional health care needed to be defined and organized in such a way that health staff could understand what they should be doing—and why—in an environment inhospitable to treatment and healing.

• Correctional administrators needed to understand their roles and responsibilities in providing health services in accord with inmates’ constitutional rights.

• A neutral, professional guide was needed to help the two components of the system to coordinate services.

By 1983 the AMA project had evolved into the National Commission on Correctional Health Care, an independent, not-for-profit organization governed by a board of 22 directors, each representing a national organization involved with health care, corrections, or the law.

Today the board represents 38 supporting organizations, and the Standards for Health Services exist in separate versions for jails, prisons and juvenile facilities. NCCHC’s professional and educational initiatives have grown, but the purpose of the standards and accreditation remains the core of our mission: “to improve the quality of health care provided in jails, prisons and juvenile facilities.”

Past Informs Present

Why the history lesson? Without a grounding in why the standards exist and what purpose accreditation was meant to serve, users may become enmeshed in a cycle of trying to be perfect for the sake of a certificate. Or they may become overly critical and see only what is wrong.

To reinforce the purpose of the standards, I offer four practical points for those seeking to obtain and maintain accreditation:

• Accreditation is not an end in itself, but a beginning for better practice. The goal is to improve the quality of health services, not to achieve a perfect “score.”

• Being cited for noncompliance is not a problem; not taking corrective action is.

• Spend your time and energy to correct, not to defend.

• Focus on essentials, meet the important standards as applicable and weigh the value of recommendations before you change anything.

It is also worthwhile to understand the perspectives of those who survey, interpret and explain the standards:

• The accreditation survey is a sharing of expertise among colleagues, not a “white glove” inspection.

• Almost always, a standard’s compliance guidelines are the way to achieve compliance. But there will be rare alternatives that succeed in meeting the standard’s intent.

• A facility may be in compliance technically but fail to be accredited because the outcome—timely and professional care to meet inmates’ health needs in keeping with community practice—is lacking.

Finally, let’s consider the perspectives of those who revise, advise, critique and approve the standards:

• Meeting the standards cannot solve every problem. There are no substitutes for solid management and oversight of professional practice.

• Use of the Standards can, however, raise red flags when something is awry.

• Healthy tension exists between optimal practice (the cutting edge) and what is required (the community standard of basic, solid health care). As the Standards have evolved, some care viewed as optimal in the 1970s later was defined as essential. But as new issues arise (DNA testing, HIV testing and treatment, transplants, dialysis), we often find that they are covered in the standards, at least implicitly. That’s because the standards are founded on principles.

• There’s a delicate balance between asking too much and asking too little. Changing times may call for explicit guidelines for new issues, and some practices become so common that they don’t need to be monitored. But standards can be neither too loose nor too tight. They also must be as applicable to the 60-bed county jail as to the 7,000-bed prison, as relevant to the urban facility in a statewide system as to the stand-alone structure in a rural setting. Our focus on the intent of each standard is how we maintain an ethical and practical balance.

Ahead of the Curve

Increasingly, the public health system understands correctional health care’s place in the continuum of public health care. As the community system grows to know the challenges and achievements of the correctional system, they may be amazed to find us their equals in some areas and at the cutting edge in others—including widespread use of standards and a time-tested accreditation program.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation. Reach her at judithstanley@ncchc.org.
Role in Disciplinary Actions

At least once a year, an inmate gives one of the nurses at that time and security staff wants nursing to write a disciplinary report. Usually we write information reports and security does the disciplinary report to avoid any conflict. We want a solid answer as to whether or not medical should be involved in disciplinary actions.

Condom Distribution in Prisons

I am a nurse and also a student in a health care policy course. I am trying to learn about condom distribution in state prisons. Our system does not give condoms to prisoners. Where might I find information on this topic?

To learn the policies of a given prison system, you should contact the system directly. Most state departments of corrections have Web sites with contact information. For general information or research findings, an Internet search will yield helpful results. Search for “condom use in prison” at the National Library of Medicine’s PubMed database (www.pubmed.gov) or Google Scholar (http://scholar.google.com). Other useful sites are the CDC (www.cdc.gov) and the National Criminal Justice Reference Service (www.ncjrs.gov).

University of Massachusetts Medical School

PRACTICE OPPORTUNITIES

The University of Massachusetts Medical School is actively recruiting for faculty physicians to serve in the UMass Correctional Health (UMCH) program. UMCH has a long-term contract to deliver health care services to inmates in the Massachusetts Department of Correction prisons. The system includes 10,000 inmates at 18 sites in central and southern Massachusetts. We are committed to providing high quality care with an eye toward outcomes evaluation, continuous quality improvement and development of a correctional health academic center of excellence.

We are recruiting for full-time, part-time and per diem physicians. Interested candidates should be board certified in internal medicine, family medicine, emergency medicine or surgery. Candidates with an MPH degree or fellowship training in primary care are particularly desirable.

Board certified physicians are hired as faculty physicians within the University. Salaries are competitive with excellent benefits. Additionally, as faculty within the medical school, physicians have an opportunity to teach, to participate in faculty development and to engage in research and quality improvement projects. The University has a national reputation in primary care and has been rated by U.S. News and World Report in the top 10 medical schools for primary care for several years running.

We have an immediate opportunity for a medical director for the women’s prison in Framingham. Physicians with an interest in women’s health are encouraged to apply.

The University of Massachusetts is an Equal Opportunity Employer. For more information on these opportunities, please contact:

Warren J. Ferguson, MD
Vice Chair, Department of Family Medicine and Community Health
University of Massachusetts Medical School
55 Lake Ave North, Worcester, MA 01655
Tel: 508-793-6327 Fax: 508-793-6329
Email (preferred): ruslows@umassmed.edu
Join the Celebration
The 30th anniversary of the National Conference promises to be something special. Widely renowned as the premier annual meeting in correctional health care, this year’s event features standout programs and activities that will attract the movers and shakers in this field. This is your opportunity to meet with nearly 2,000 professionals who influence or make decisions about correctional health care products and services. And they spend significant time browsing the conference exhibits to learn about the latest medical supplies and pharmaceuticals, information technology, contract services, staffing services and more. If you exhibit at only one meeting in 2006, this has to be it!

At NCCHC’s 2005 National Conference, attendees' postconference evaluations revealed the following:
• 95% visited the Exhibit Hall at least twice
• 94% found the exhibit hall worthwhile
• 81% visited to learn about new products and services
• 43% visited to meet with current suppliers
• 43% are authorized to make purchases

Exhibitor Benefits
NCCHC is committed to creating a sales environment conducive for you as well as meeting attendees.
• Breaks, lunch and networking in the exhibit hall, with 9 hours of exclusive exhibit time
• Opportunity to participate in the popular raffle drawings
• Company listing and promotional writeup in the Final Program, and a listing in CORRECTCARE (deadlines apply)
• Pre- and final registration lists with attendee addresses
• Special advertising opportunities for CORRECTCARE, the conference program and the conference Web site
• Virtual Exhibit Hall listing at the NCCHC Web site
• Lead retrieval scanner system available
• Priority booth selection for 2007 National Conference

Who Should Exhibit?
Associations; computer/software; contract management; dental supplies/equipment; diagnostic equipment; educational materials/training; EHR/health records; infection control; medical devices/equipment/supplies; pharmaceuticals and pharmacy services; publications; recruitment/staffing services; universities; uniforms/scrubs

Sponsorship Opportunities
Exhibitors can enhance their exposure by sponsoring services, sessions and events that support the conference.

Premier Educational Programming: Sponsorship of educational programs on hot topics enables companies to support the correctional market and gain great exposure.

Proceedings Manual on CD: Now distributed in popular CD format, the manual provides a lasting record of each concurrent session, including abstracts and handouts. The sponsor credit will be highly visible on the CD.

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

Other Opportunities: Registration bags, lanyards, cups, badges, banners: all are good ways to gain visibility. Have other ideas for sponsorship? We’d love to hear them!

Registration Information
Exhibition hours are Sunday through Tuesday. Prices for 10' x 10' booths start at $1,350; double-size and premium spaces are available. Prices include one full and two exhibit-only registrations. Other representatives may register at a discount. For a prospectus with details and a reservation discount. For a prospectus with details and a reservation

Exhibit Breaks: Scheduled breaks enable attendees to meet with exhibitors and network with colleagues while enjoying morning coffee and afternoon snacks.

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Published by the National Commission on Correctional Health Care, this quarterly newspaper provides timely news, articles and commentary on subjects of relevance to professionals in the field of correctional health care.

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

Editorial Submissions: We may, at our discretion, publish submitted articles. Manuscripts must be original, unpublished elsewhere and submitted in electronic format. For guidelines, contact the editor at jmashimkus@ncchc.org or 773-880-1460. We also invite letters of support or criticism or correction of facts, which will be printed as space allows.

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

To obtain NCCHC’s 2007 Marketing and Resource Guide, which contains an insertion order form, visit the Web at www.ncchc.org and go to the Supplier Opportunities section.
ODOC Seeks Physicians

The Oregon Department of Corrections (ODOC) is seeking physicians for full-time employment. ODOC, with a strong national reputation of excellence and innovation, provides a dynamic work environment, effective support and referral practices, and professional security.

Forty-hour work weeks are the general rule; call involves phone triage and rare in-person visits. No office to run, no insurance forms. Oregon, which provides malpractice coverage. Physicians in ODOC are employed directly by the State of Oregon, which provides malpractice coverage. Physicians in ODOC are employed directly by the State of Oregon, which provides malpractice coverage.

ODOC is seeking physicians for full time employment. ODOC, with a strong national reputation of excellence and innovation, provides a dynamic work environment, effective support and referral practices, and professional security.

Effective support and referral practices, a reputation of excellence and innovation, and a competitive insurance benefits and a secure position make this opportunity well worth your consideration.

Contact: Oregon Department of Corrections, Health Services – Annette Skillman, 2500 Westgate, Pendleton, OR 97801; phone 541-278-7121; fax 541-278-7191; Annette.C.Skillman@doc.state.or.us.

Meetings

HIV Management Satellite Videoconference. “Managing Addiction in the HIV-infected Patient” (part of the Management of HIV/AIDS in the Correctional & Community Setting series) takes place Oct. 18, 12:30 to 2:30 p.m. ET. The free program is sponsored by Albany Medical College. CME and nursing credits are available. Visit www.ame.edu/HIVConference, or e-mail ybarraj@mail.ame.edu for info.

Public Health Meeting. The American Public Health Association’s annual meeting will take place Nov. 4-8 at the Boston Convention Center. The theme is “Public Health and Human Rights.” Visit www.apha.org/meetings, or send an e-mail to dianc.lentini@apha.org.

Job Opportunities in Correctional Settings

• Using the MMPI-2 in Criminal Justice and Correctional Settings.

New Titles in the NCCHC Catalog

• Health Issues Among Incarcerated Women. This comprehensive book features 20 essays that address the challenges of health care delivery that meets the unique needs of the growing population of female inmates. Edited by Ronald Braithwaite, Kimberly Jacob Arriola and Cassandra Newkirk. Rutgers University Press (2006). Softcover, 376+ pages, $29.95

• Using the MMPI-2 in Criminal Justice and Correctional Settings. This is the first work that instructs correctional psychologists in the unique applications and interpretations of the MMPI-2, the most widely used and thoroughly researched personality assessment instrument in correctional settings. The book addresses differences in administration, scoring and evaluation; describes the special issues that must be taken into account; and presents case study analyses. By Edwin I. Megargee, PhD, CCHP. University of Minnesota Press (2006). Softcover, 480 pages, $50

Postgraduate Education Opportunities

This comprehensive book features 20 essays that address the challenges of health care delivery that meets the unique needs of the growing population of female inmates. Edited by Ronald Braithwaite, Kimberly Jacob Arriola and Cassandra Newkirk. Rutgers University Press (2006). Softcover, 376+ pages, $29.95

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National Conference on Correctional Health Care
Exhibitor Lineup

Meet the Exhibitors

The National Conference experience would not be complete without spending some quality time in our first-rate exhibit hall. After all, where else will you learn about all of the innovative products and services designed to help your department be the best it can be? Be sure to thank the exhibitors for supporting the cause. Can’t come to the meeting? Check out these companies’ listings and links at our Virtual Exhibit Hall, online at www.ncchc.org.

3 Cheers for Our Corporate Sponsors

The National Commission on Correctional Health Care and the Academy of Correctional Health Professionals thank our corporate sponsors for their support and dedication to the correctional field. Through generous educational grants and sponsorships, the companies listed below have helped to make the 2006 National Conference an event to remember.

Abbott Laboratories provided an educational grant toward the funding of the educational breakfast on Monday and a session in the infectious disease track.

Boehringer Ingelheim provided an educational grant in support of the infectious disease track.

Bristol-Myers Squibb provided an educational grant in support of the infectious disease track and the mental health track.

Correctional Medical Services provided a grant toward the funding of the conference badge holders.

Gilead Sciences provided an unrestricted educational grant toward the funding of the educational breakfast on Monday and a session in the infectious disease track.

GlaxoSmithKline provided an educational grant toward the funding of the preconference seminar “Managing Infectious Disease: An Expert Panel” (Saturday afternoon, free to all), Tuesday’s educational luncheon, two sessions in the infectious disease track and one session in the mental health track. GSK also funded the conference proceedings on CD-ROM.

Janssen Pharmaceuticals provided an educational grant toward the funding of an educational session in the mental health track.

Medco provided an educational grant toward the funding of an educational session in the mental health track.

Prison Health Services provided a grant toward the funding of the conference keynote.

Roehe Laboratories provided an unrestricted educational grant toward the funding of an educational session in the infectious disease track.

RaffleMania!

Besides networking and nosing, the exhibit hall is the place for nabbing grand prizes. Raffle drawings will be held during both exhibit hall breaks on Tuesday. If luck is on your side, you may be one of the dozens of attendees who win a fabulous prize. What can you expect? From NCCHC and the Academy, conference registrations, airline or hotel vouchers, annual membership, apparel, books and more. In addition, many exhibitors provide generous gifts such as medical equipment, travel bags, golf clubs, goodie baskets, cold hard cash and more.

Spin and Win

You will receive one raffle ticket along with your name badge at registration check-in. Do not lose this ticket: It is the only way to take part in the drawing! Fill out the ticket (legibly please) and drop it in the drum in the exhibit hall lounge. During the drawings listen for your name. If it is called, come to the podium and spin the Winner’s Wheel. Then cross your fingers and wait for Lady Luck to choose your prize!

Exhibit Hall Hours

Sunday 5 pm–7 pm Opening reception

Monday 9 am–1 pm Exhibits open

9:30 am–10:30 am Break

11:45 am–1 pm Luncheon

Tuesday 9 am–12 pm Exhibits open

9 am–9:45 am Break and raffle

11 am–12 pm Break and raffle

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