**Pandemic Flu: Planning for the ‘What If’**

**BY RICHARD GARDEN, MD, CCHP**

In medicine we must plan for the worst. We exhaustively question, examine and test our patients, being certain to rule out the most sinister of causes for their complaints. Furthermore, we never begin a procedure without having the necessary “what if” equipment at the bedside in case things go bad. In short, we are prepared.

Preparation is incredibly soothing. It not only increases the likelihood of a good outcome, but it also provides a dash of serenity in a world in which nearly anything can happen. Katrina and 9/11 come to mind.

A different type of cataclysmic event may loom on the horizon in the form of pandemic flu. A pandemic is a global outbreak of infectious disease. Flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease causes serious illness, spreads easily person-to-person and can sweep across the country and around the world in very short order.

It is difficult to predict when the next influenza pandemic will occur or how severe it will be. But wherever it starts, everyone around the world will be at risk. Countries might, through measures such as border closures and travel restrictions, delay arrival of the virus, but they cannot stop it.

**Cause for Concern**

Health professionals are concerned that the continued spread of a highly pathogenic avian H5N1 virus across eastern Asia and other countries represents a significant threat to human health. The H5N1 virus has raised concerns about a potential human pandemic because:

- It is especially virulent.
- It is being spread by migratory birds.
- It can be transmitted from birds to mammals and in some limited circumstances to humans.
- Like other influenza viruses, it continues to evolve.

Since 2003, a growing number of human H5N1 cases have been reported in Azerbaijan, Cambodia, China, Egypt, Indonesia, Iraq, Thailand, Turkey and Vietnam. More than half of the people infected with the H5N1 virus have died. Exposure to infected poultry is believed to have caused the infections. There has been no sustained human-to-human transmission of the disease thus far.

However, if H5N1 evolves into a virus capable of human-to-human transmission, then our nation and the world may face widespread illness and death. Should a pandemic occur, our correctional facility staff and inmates are at high risk due to the close quarters and groupings of large numbers of people. Furthermore, risk of transmission is heightened as inmates are frequently moved from one facility to another.

**Considerations for Corrections**

A pandemic not only jeopardizes the health and lives of our staff and inmates, it also may jeopardize our ability to maintain public safety. Effective planning by correctional institutions needs to address both of these issues. Additionally, the pandemic will be dealt with by national, state and local public health agencies.

**Medications**

When preparing the statewide pandemic influenza plan, the Ohio corrections department was able to use many of the typical sources of information for medical movement, triage, disease containment and communications. But one area left us with no significant literature: medication lists.

Many of the usual sources did not apply to corrections. For example, the military treats only generally healthy persons; their deployment lists exclude populations seen in correctional settings, such as patients with diabetes, hepatitis C and HIV. Likewise, lists used by missionary medical providers don’t apply because of the limited availability of many medications in

**Meds in Pandemic Flu Planning: The Missing Puzzle Piece**

**BY SCOTT SAVAGE, DO, CCHP, KIB**

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**Continued on page 18**
Introducing NCCHC’s 2007 Board Chair

One-on-One With George Pramstaller

The Early Days
• Raised in Detroit, Michigan
• BS degree in biology, Wayne State University, 1967
• DO degree, Chicago College of Osteopathic Medicine, 1971

Professional Career
• Following internship and residency, medical practice in various community settings starting in 1973
• Emergency medicine practice in several Michigan hospitals starting in 1999
• Michigan DO, 1992-present: medical services provider, 1992; medical director, northern region, 1996; chief medical officer, 2002 (after several years as acting CMO)

Professional Record
• For 20 years, high involvement in state and national professional associations, including presidencies of the Michigan Association of Osteopathic Physicians & Surgeons and the Michigan Association of Osteopathic Family Physicians
• Outstanding Osteopathic Physician – Life Extension Foundation
• Fellow – American College of Osteopathic Family Physicians
• Honorary professional membership – Michigan Association of Osteopathic Physicians & Surgeons
• American Osteopathic Association Certificate in Health Policy, 1997

The challenge is to develop a delivery system that optimizes the values for legislatures and payors. We must look not only at cost but also at quality of care and outcomes.” He sees elements of community IMOs as viable to replicate in corrections.

Pramstaller has been a key figure in NCCHC’s project to develop a national database for outcomes benchmarks for chronic disease management. The first phases of this project used data from the Michigan and Georgia DOCs.

At the Helm
A member of the American Osteopathic Association for nearly 30 years, Pramstaller was tapped to represent the AOA on the NCCHC board in 1997. He has served with distinction, playing important roles in the executive and other committees. Under his watch as program committee chair, NCCHC educational conferences grew greatly in terms of quality and attendance. “That’s an accomplishment we all can be proud of,” he says.

With that “share the credit” mindset, it’s no surprise that a key goal for Pramstaller as NCCHC board chair is to offer more opportunities for every board member to participate in leadership activities. This will serve to develop individual talents and to strengthen the board as a whole. It’s also vital to ensure that the Commission is well guided into the future, he notes.

World’s Best Grandfather
If Pramstaller doesn’t have a coffee mug that touts his grandfatherly excellence, he should. In his personal life, quality time with his three grandchildren (ages 2, 4 and almost 7) is what he cherishes most. “I spend as much time with them as possible,” he says, and that includes long weekends with no parents around. “It’s a highlight of my life.”

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Outstanding Honorees Earn Accolades in Atlanta

Attendees at the 2006 National Conference on Correctional Health Care enjoyed an opening ceremony in which truly outstanding honorees received NCCHC’s annual awards. Below are brief profiles of each.

Bernard P. Harrison Award of Merit

NCCHC’s highest honor, this award is presented to an individual or group that has demonstrated excellence and service to the correctional health care field, either through an individual project or a history of service.

David Satcher, MD, PhD

Long before it was a given in public health, David Satcher realized that correctional health care is a vital link in the complex chain of factors that influence health and well-being in the community. He took bold steps to ensure that correctional health had a place on the public health agenda, raising its profile among policy makers who needed to hear this message. As director of the Centers for Disease Control and Prevention (1993-1998), he established the agency’s first office dedicated to correctional health. Substance abuse and HIV were the initial focus but this soon expanded to other diseases, leading to corrections-specific studies and guidelines. In confirmation hearings before he became U.S. Surgeon General (1998-2002), Satcher successfully argued that correctional health should be part of public health policy and planning. He addressed the subject in Surgeon General’s reports on topics such as mental health and youth violence, and he proposed a Call to Action on Correctional Health. He also wielded great influence as Assistant Secretary for Health (1998-2001), spearheading the Healthy People 2010 initiative, which sought to eliminate racial and ethnic health disparities as a primary goal.

Having returned to a career in academe—he serves in high-level roles focusing on health disparities as well as mental health at the Morehouse School of Medicine—Satcher remains an important voice concerning health care for the incarcerated. He speaks often on the subject and last year was widely quoted in the media when he said that systemic improvements to prison health care could save the nation $3 billion per year.

Through such dedicated advocacy, he is making great strides toward fulfilling his life’s mission: “to make medicine and public health work for all groups in this nation.”

B. Jaye Anno Award of Excellence in Communication

This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work.

Clinical Practice in Correctional Medicine, Second Edition

Eights years after the first edition, Clinical Practice remains the only multidisciplinary clinical textbook dedicated to correctional health care. But its uniqueness is not why it merits this award.

The new edition was published in January 2006 after a painstaking revision by correctional health expert Michael Puisis, DO. As editor, he assembled an impressive roster of collaborators—11 associate editors and 55 authors—that reads like a “Who’s Who” of correctional and public health. Consequently, the content is of the highest caliber.

This critically acclaimed textbook significantly expands on the first edition. It addresses all major areas of correctional medicine, from intake to hospice care, including clinical management of diseases, ethical concerns, organization of health services delivery, patient-provider relations, legal issues and more. It has new sections on nursing and emergency services, and new chapters on hepatitis C, psychiatric nursing, self-inflicted injury, methadone in corrections, annual health examinations, telemedicine, geriatric care and end-of-life care.

With such comprehensive, high quality coverage, the book is a vital resource for correctional health practitioners of every discipline.

Facility of the Year Award

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

Patrick J. Sullivan Detention Center

Known as the Arapahoe County Detention Facility until 2002, this jail was renamed in honor of its former sheriff. It boasts a 16-year track record of NCCHC accreditation, and high praise from the accreditation surveyors who nominated it for this prestigious award.

The surveyors laud the excellent coordination of services between medical and mental health managers (noteworthy given that the two services report to separate authorities), and the close working arrangements between health and custody staff. To learn more about the jail, see the Facility Profile on page 7.

Program of the Year Award

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

Dialectic Behavioral Therapy Program

Echo Glen Children’s Center

More than 60% of youths in Juvenile Rehabilitation Administration residential care facilities are in the “mental health target population.” Of these MHTP youth, many with the most serious, acute needs are placed at the medium/maximum security Echo Glen in Snoqualmie, WA. They are lucky to be there, because it is one of two JRA facilities with specialized treatment units and enhanced staffing to help these youths correct their dysfunctional behaviors.

Situated amid natural wetlands, the facility was the pilot site for research-based interventions used in the integrated treatment model that the system introduced in 2003. One element of this model, dialectical behavioral therapy, forms the core of MHTP treatment and intervention. This cognitive-behavioral approach aims to teach skills that will enable the youth to cope with and manage their disorders, deal with frustration, recover from past trauma and abuse, and make and keep positive friends.

The strategy is working: Assaults in JRA institutions have decreased by 60%. This innovative program also benefits the community. External studies link DBT and other elements of the integrated treatment model with reduced recidivism and future savings. Echo Glen has become a model for other facilities in the state and elsewhere, creating a ripple effect throughout the country.

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Dental Director Shares Skills With Inmates & Peers

BY MATISSA SAMMONS

If you’ve attended an NCCHC conference in the past few years, there’s a good chance you’ve attended a session led by Allan Noble, DDS, CCHP. Noble’s presentations on correctional dentistry are so popular and well rated that the education committee keeps asking him to return.

When he’s not discussing the finer points of oral health screening, Noble works as director of dentistry for the Maricopa (AZ) County Jail. He is responsible for all dentistry for 10,000 inmates and supervises a staff of two dentists and four assistants operating out of three dental clinics.

A Door Opens

A career in corrections was not a starting point for Noble. After graduating from the University of the Pacific Dental School in 1975, he spent 20 years in private practice in a small Arizona town. In 1993, a friend and colleague recruited him into the correctional field on a day everything seemed to be going wrong in his current practice.

Noble did not know what to expect the day he first visited the facility that he would soon join. Yet the only hesitation he had was during the few seconds waiting for one security door to close and the next to open. Indeed, another door did open for him.

Noble recalls being pleasantly surprised to visit a professional and pleasant clinic. He sold his practice shortly thereafter and joined the Arizona Department of Corrections at Winslow Prison, where a nurse who was active with NCCHC introduced him to the organization. Over the next eight years he worked as a lead dentist for three Arizona state prisons.

In 2001, Noble moved to the Phoenix area to be closer to his six children, all of whom were either in college or had recently graduated and were starting their professional lives. That move led to his job with the Maricopa County Jail.

“Go For It!”

Noble doesn’t do a lot of restorative work for patients but rather focuses on issues contributing to major health problems. One of the most prevalent situations he faces on a daily basis comes from methamphetamine users. Almost all drug abuse is damaging to teeth, he notes, but “meth mouth” is one of the most damaging and common problems in corrections and especially in jails.

Despite some of the horrific health conditions he deals with, Noble finds great reward in corrections and enjoys being able to help a population that has no one else to help them. At the same time, he finds it challenging to work with patients who may not appreciate that help. “From a human perspective, it’s touch and go, both professionally and emotionally,” he says. Noble became certified in 2003 in support of and appreciation for the NCCHC Standards and to better himself professionally. In studying for the exam, the Standards helped him gain a great deal of knowledge, he says. This knowledge then enabled him to help the jail prepare for accreditation.

For those considering certification, Noble’s message is clear: “Go for it. The effort you put into it will be amply rewarded by the satisfaction of accomplishing a very worthwhile goal.”

Professional satisfaction, and the desire to help others, is what keeps him coming back as a conference presenter, too.

In his time away from his career, Noble keeps busy as a husband, father and grandfather to 16 grandchildren. He enjoys his time with them, and especially their Sunday tradition of having the whole family sits down together for dinner.

Noble’s message is clear: “Go for it. The effort you put into it will be amply rewarded by the satisfaction of accomplishing a very worthwhile goal.”

Make Advanced Certification Your New Year’s Resolution

That’s just what Joseph E. Paris, PhD, MD, of Marietta, GA, did last year. Not distracted by the glitz and glamour of Las Vegas, he earned advanced certification after sitting for the CCHP-A exam last April at the Updates in Correctional Health Care conference.

You can do it too! All CCHPs are eligible to apply after three years of basic certification. Still not sure? Attend a class presented by NCCHC staff at either of the two conferences listed below to learn more about the program, including eligibility requirements, the application process and how to prepare for the examination.

The CCHP-A exam is offered twice a year. Here are the 2007 exam dates:

• May 6: Orlando, FL, at Updates in Correctional Health Care Application deadline: Feb. 6
• October 14: Nashville, TN, at the National Conference on Correctional Health Care Application deadline: July 14

To learn more, visit our Web site at www.ncchc.org/CCHP or submit this application request form.

CCHP-A Information and Application Request

Name __________________________

Address _______________________

City/State ______________________

Phone _________________________

Fax ___________________________

E-mail _________________________

Initial year of certification ________

CCHP Exam Dates & Locations

• February 10: Florence, AZ, Martinez, CA, Hamden, CT, Chicago, IL, New York, NY, Philadelphia, PA, San Antonio, TX, Tumwater, WA, Walla Walla, WA, Milwaukee, WI, and other sites to be determined
• May 6: Orlando, FL, at the Updates in Correctional Health Care conference
• May 22: Salem, NC, at the North Carolina chapter of ACISHA meeting
• July 15: Las Vegas, NV, at NCCHC’s Correctional Mental Health seminar
• August 18: Brighton, CO, Harrisburg, PA, and other sites to be determined

Additional exam sites are being sought for August 18. If you are interested in hosting an 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, as well as the application booklet, study guide and an online application form.
Certification Program Explodes! (Thanks to 233 New CCHPs)

The Certified Correctional Health Professionals Board of Trustees is pleased to announce the latest group of CCHPs who passed proctored exams at test sites across the country—from Oregon to New York, from San Diego to the Wisconsin Dells—from April through October. The 233 professionals listed on pages 5 and 6 joined more than 1,800 fellow CCHPs as members of this prestigious group. The board welcomes and congratulates them! If you’d like to become certified, please visit www.ncchc.org or e-mail cchp@ncchc.org for information and an application.

Arms T. Adewumi, CCHP
Geo Group Inc., Sun City, CA
Eileen Agbottah, BSN, CCHP
Mercer County Correctional Center
Trenton, NJ
Cheri L. Alcorn, LVN, CCHP
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Cherry Hill, NJ
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Ada County Jail, Boise, ID
Richard W. Ater, MSN, CCHP
King County Jail, Seattle, WA
Glen S. Babich, MD, CCHP
CMS Northeast Correctional Center
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Irene E. Bailey, AA, AS, CCHP
Armor Correctional Health Services
Lake Wales, FL
Lisa Baker, RN, CCHP
DOCL, Racine, WI
Stephen T. Baxley Jr., RN, CCHP
Corrections Corporation of America
Cedar Hill, TN
Susan M. Beardsey, BSN, MBA, CCHP
Federal Bureau of Prisons, Fort Worth, TX
Nikki Behmar, ARNP, CCHP
Snohomish County Corrections
Arlington, WA
Debbie M. Bellinger, ADN, BSN, RN
Snohomish County Corrections, Everett, WA
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Snohomish County Corrections, Edmonds, WA
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Enhanced Selection and Performance Inc.
Port Charlotte, FL
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HRSA/ IHS, Fort Washington, MD
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Teresa Brisbin, LPN, CCHP
Washington County Jail, Dundee, OR
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El Dorado County Juvenile Treatment Center, South Lake Tahoe, CA
Dyni D. Brookshire, RN, CCHP
Jefferson County Jail, Lumbard, GA
Cheryl A. Califugio, MSN, CCHP
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Jani Caldera, LPN, CCHP
La Paz County Jail, Parker, AZ
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Ladysmith, WI
Cyntonia L. Clinic, RN, CCHP
Correctional Medical Service, Canton, MS
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Stoutsvant Translational Facility
Union Grove, WI
Tracey L. Davis, LPN, CCHP
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King George, VA
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Jennifer M. Dittman, LPN, CCHP
PrimeCare Medical Inc., Parker, PA
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Licking County Sheriff's Department
Newark, OH
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Tradee Ettingl, PhD, APRN, LADC, CCHP
Norwich University, Underhill Center, VT
Philip Farabaugh, MD, CCHP
Division of Immigration Health Services
Tacoma, WA
Mark Farssetta, MSW, CCHP
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Frank A. Feeley, PhD, CCHP
State of Washington DOC, Tumwater, WA
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Bowling Green, VA
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NaphCare Inc., Greensboro, NC
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Dadeville, AL
Regina A. Grimes, RN, BSN, CCHP
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Mt. Sterling, OH
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Tami M. Hefer, RN, MSN, FNP-C, CCHP
CorrectHealth, Clarksville, GA
Jason Hershberger, MD, CCHP
The City of New York, New York, NY
Dawn D. Herzog-Gruner, LPN, CCHP
Southern Oaks Correctional,
Edmonds, WA
Clyde Edward Hilliard Jr., MPH, CCHP
Weschester County DOC
New Hempstead, NY
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Kentucky River Regional Jail, Hazard, KY
Peter J. Huling, DDS, CCHP
Ohio Department of Rehabilitation & Correction, Columbus, OH
Monique Hunsinger, MBA, MHS, CCHP
Ace Correctional Health Services
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Shawn L. Hutchins, BSN, CCHP
DBHS, Florence, AZ
Elaine B. Hutto, CCHP
GCCHC Autry State Prison, Pellham, GA
Martha J. Ingram, CCHP
Wexford Health Sources, Monticello, IL
Denise A. Irving, LVN, CCHP
Rappahannock Regional Jail
Fredericksburg, VA
Robert J. Jeminson II, BS, BA, RN, CCHP
Orleans Parish Criminal Sheriff's Office
Avondale, LA
Anita M. Johnson, MA, CCHP
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Brenda J. Jordan-Chote, BSN, CCHP
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Silkstone, MO
Virginia Kelley, RN, CCHP
Alber Wagener Youth Correctional Facility
Jamesburg, NJ
Marti C. Knight, RN, MSN, CCHP
Correctional Medical Services, Trenton, NJ

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Facility of the Year

Teamwork Helps County Jail Provide A-1 Care

BY JAIME SHIMMAUS

A 16-year track record of compliance with NCCHC standards for health services is reason enough to feel proud. But staff at the Patrick J. Sullivan Detention Center in Colorado can also take pride in the fact that their health services department is so exceptional that NCCHC accreditation surveyors nominated it for the Commission’s prestigious Facility of the Year Award.

Surveyors visit a great many correctional facilities and get an inside view of their strengths and weaknesses. What makes this county jail stand apart is an overall high quality of care, excellent coordination between two service areas—medical and mental health—that report to different authorities, and close working relationships between health staff and custody staff.

“We are honored by this award,” says Sheriff J. Grayson Robinson. “We understand the benefits of accreditation and are dedicated to the process. This honor is a direct result of the hard work of the men and women of the sheriff’s office, and those in the health department in particular, to meet and exceed the standards.”

Caseloads, Acuity on the Rise

The Sullivan Detention Center is not unique in terms of many of the challenges it faces: growing populations and patient caseloads, more health problems, tougher health problems.

Patrick J. Sullivan Detention Center

Facility: This county jail is located in a small community about 20 miles southeast of Denver. The facility opened in 1987 as the Arapahoe County Detention Facility; it was renamed in honor of its former sheriff in 2002. Part of the county’s judicial complex, the jail serves as a national model for its direct supervision design, according to administrators.

Correctional Population: In 2005 the average daily population was 1,272. The facility houses adult males and females of minimum, medium and maximum custody levels, as well as juveniles adjudicated as adults. These juveniles are placed in a dedicated housing module.

Health Care Staffing & Services: Health and mental health services report to two separate county authorities. The health department runs 24 hours a day and is staffed by 25 FTEs: a health services administrator, 2 charge nurses, 1 infection control nurse, 1 physical exam nurse (all RNs), 1 accreditation nurse (LPN) and two dozen nurses in booking, the infirmary and the housing pods. Two clerks handle appointments, records, etc. Mental health staff consists of 1 manager (MSW), a psychiatrist and a PhD-level psychologist, both part time, and 7 FTE counselors. Physician services are provided under contract with a private agency, Correctional Healthcare Management.

Accreditation: The jail has been continuously accredited since 1989.

Quoteworthy: “NCCHC accreditation allows us to raise the bar of accountability and the care we provide.” —Elaine Meyer, health services administrator

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FALL 2006 • CorrectCare
Academy Gets Seat at the NCCHC Table

Since the Academy of Correctional Health Professionals was formed in 2000, the National Commission on Correctional Health Care has been a staunch supporter of the organization and its mission. In a position now to reciprocate, the Academy has become a supporting organization of the National Commission. NCCHC’s board of directors approved the move at its annual meeting in October.

“This decision reflects the prestige and expertise of Academy members, as well as the organization’s commitment to advancing the profession by becoming an advocate on the board,” says NCCHC board chairman George Pramstaller, DO, CCHP. “It has always been an Academy goal to become a supporting organization, joining the ranks of the American Medical Association, American Nurses Association and American Public Health Association, to name a few. But the Academy had to bide its time for five years before it became eligible for supporting organization status. Once it reached that benchmark, the Academy board unanimously and enthusiastically approved chair Michael Adu-Tutu’s wish to begin the application process. “The Academy looks forward to working with the National Commission and the opportunity to support its mission,” says Adu-Tutu.

A Shoo-In

When it came to finding the right person to represent the Academy on the NCCHC board of directors, it didn’t take long to come up with a candidate.

Jayne Russell, MEd, CCHP-A, has served on the Academy board since its start-up and chaired it in 2003. “I am honored indeed and very proud of the Academy for earning a seat on the board,” she says. “I know the Academy will continue to do great things and I am happy to be a small part of that and continue the work for the Academy.”

Russell has worked in the correctional health care field for 30 years, starting as a counselor and advancing to numerous administrative positions.

No Resting on Her Laurels

While Russell may have looked forward to a break after a position on the Academy Board for five years, she won’t get that chance. Already she has been appointed to a three-year term on the NCCHC board of trustees, a perfect role for one who holds advanced CCHP certification.

“We can think of no better representative of the Academy to hold this esteemed position and look forward to putting her many talents to work for the National Commission,” says Paula Hancoch, NCCHC’s director of professional services.

Academy Election Results

The board of directors comprises 13 members of the Academy: seven directors are selected by the membership through a national elections and six are appointed from the field. Terms of office are for two years.

Participation was tremendous for both the nomination and the election processes. In a closely contested race with six outstanding candidates vying for three open seats, these individuals emerged as the winners: • Calixto F. Calderon, MD, MPH, CCHP • Robert L. Kappler, RN, BSN, CCHP • Leanne J. Long, MA, CCHP

The terms of office on the board are staggered, so there are open seats and an election each year. Look for this and other volunteer opportunities in the coming year.

Scholarship Program Brings Members to Atlanta

The Academy established a scholarship program in 2005 to assist members who have been unable to attend annual conferences. Through members’ generous donations, the first two scholarships were awarded this fall to attend the National Conference on Correctional Health Care. The recipients:

• Martha Applewhite, BSN, MPH, of the Cuyahoga County Juvenile Detention Center in Cleveland, OH
• Patricia McEachrane-Gross, MD, of the Martin Army Community Hospital in Midland, GA

Applewhite described the experience as a privilege and “did her best to take advantage of every minute—from Sunday’s reception to the last session on Wednesday.”

Back at work in Cleveland, Applewhite organized her notes and the PowerPoint presentations to make her own easily accessible reference tool. She also is making a concerted effort to stay in contact with several of the presenters, some of whom invited her to visit their institutions.

McEachrane-Gross took advantage of volunteer opportunities to network with other members and staff, as well as getting an “insider’s look” at the workings of a national health care conference.

Scholarships for Updates Conference

The Academy’s education committee is pleased to announce that two scholarships will be awarded to attend the Updates in Correctional Health Care conference in Orlando, May 5-8, 2007.

Scholarship Award

Each scholarship has a value of $465. Scholarship recipients will receive the following:

• $225 registration fee, paid directly to NCCHC
• $240 travel stipend, paid to the recipient upon check-in at the conference

Scholarship Criteria

• Duration of membership: Applicant has been an Academy member for at least two years.
• First-time attendee: Applicant has not previously attended a national conference sponsored by the Academy of Correctional Health Professionals.
• Professional enhancement: Applicant will benefit significantly from attendance at the Updates conference.

Application Deadline

The application deadline is Monday, Feb. 26. To obtain an application, please visit the Web at www.correctionalhealth.org.
Complement potent PI therapy with TRUVADA

TRUVADA provides patient-friendly dosing, and its components demonstrate tolerability

Trechell: medical biller, cook, successfully maintaining PI therapy (Kaletra) with TRUVADA

Atazanavir and lopinavir/ritonavir have been shown to increase tenofovir concentrations. Patients on lopinavir/ritonavir or atazanavir plus TRUVADA should be monitored for tenofovir DF–associated adverse events. TRUVADA should be discontinued in patients who develop tenofovir DF–associated adverse events. Atazanavir 300 mg should be boosted with ritonavir 100 mg when administered with TRUVADA. Atazanavir without ritonavir should not be coadministered with TRUVADA.

Indication and usage

TRUVADA is indicated in combination with other antiretroviral agents (such as non-nucleoside reverse transcriptase inhibitors or protease inhibitors) for the treatment of HIV-1 infection in adults. Additional important information regarding the use of TRUVADA for the treatment of HIV-1 infection:

- It is not recommended that TRUVADA be used as a component of a triple nucleoside regimen
- TRUVADA should not be coadministered with EMTRIVA, VIREAD, or lamivudine-containing products
- In treatment-experienced patients, the use of TRUVADA should be guided by laboratory testing and treatment history

Important safety information

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs alone or in combination with other antiretrovirals.

TRUVADA is not indicated for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of TRUVADA have not been established in patients coinfected with HBV and HIV. Severe acute exacerbations of hepatitis B have been reported in patients who discontinue EMTRIVA or VIREAD. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who discontinue TRUVADA and are coinfected with HIV and HBV.

Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphatemia), has been reported. Renal impairment occurred most often in patients with underlying systemic or renal disease, or in patients taking concomitant nephrotoxic agents. Some cases have occurred in patients with no identified risk factors

TRUVADA should be avoided with concurrent or recent use of a nephrotoxic agent

Dosing interval adjustment is recommended in all patients with creatinine clearance 30–49 mL/min. TRUVADA should not be administered to patients with creatinine clearance <30 mL/min or patients requiring hemodialysis

Don’t use TRUVADA with EMTRIVA or VIREAD, or drugs containing lamivudine, including Combivir®, Epivir®, Epivir-HBV®, Epzicom™, or Trizivir™

Decreases in bone mineral density have been seen with the use of tenofovir DF

Redistribution/accumulation of body fat has been observed in patients receiving antiretroviral therapy

Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy

Drug interactions have been observed between tenofovir DF and didanosine (ddI)

- Coadministration of TRUVADA and ddI should be undertaken with caution, and the ddI dose should be reduced to 250 mg for patients weighing >60 kg. Data are not available to recommend a dose adjustment of ddI for patients weighing <60 kg. Patients should be monitored closely for ddI-associated adverse events

The most common adverse events observed with the components of TRUVADA include dizziness, diaphoresis, fatigue, headache, abdominal pain, depression, various rash events, and tinnitus. Skin discoloration may also occur
Lactic Acidosis/Severe Hepatomegaly with Steatosis
Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues, alone or in combination, including EMTRIVA and VIREAD. These conditions have been associated with increases in hepatic enzymes and, in some cases, with hepatic fat (steatosis). In most reported cases, patients had underlying risk factors for liver disease; however, some have also been reported in patients with little or no known liver disease. Treatment with EMTRIVA should be discontinued in patients who develop clinical or laboratory findings suggestive of lactic acidosis or severe hepatomegaly with steatosis. The onset of symptoms may be insidious and may range from abdominal pain, increased transaminases, fatigue, and weakness to fulminating hepatic failure with or without encephalopathy and death.

TRUVADA: EMPLOYED IN THE TREATMENT OF CHRONIC HEPATITIS B VIRUS (HBV) INFECTION AND THE SAFETY AND EFFICACY OF TRUVADA HAVE NOT BEEN ESTABLISHED IN PATIENTS WHO HAVE RECEIVED CONCOMITANT EMTRIVA OR VIREAD. HEPATIC FUNCTION SHOULD BE CLOSERLY MONITORED IN PATIENTS RECEIVING CONCOMITANT USE WITH HBV, AND IF APPLICABLE, INITIATION OF ANTI-HEPATITIS B THERAPY MAY BE WARRANTED. (SEE ADVERSE REACTIONS–Postmarketing Experience.)

PATIENTS WITH HBV AND HEPATITIS B VIRUS (HBV) INFECTION
Before initiating antiviral therapy, TRUVADA is not indicated for the treatment of HBV infection and the safety and efficacy of TRUVADA has not been established in patients coinfected with HBV and HIV. Severe acute exacerbations of hepatitis have been reported in patients who are coinfected with HBV and HIV and have received didanosine and emtricitabine. Hepatic function should be closely monitored with both clinical and laboratory evaluations that occur on a scheduled basis. If the liver transaminase activity exceeds five times the upper limit of normal, the patient should be removed from TRUVADA and HBV coinfected subjects should be treated for HBV infection, as appropriate. Initiation of concomitant HBV therapy may be warranted.

RENAL IMPAIRMENT
Emtricitabine and tenofovir are principally eliminated by the kidney. During long-term administration of TRUVADA, a reduction in GFR has been observed in patients with chronic kidney disease (CKD) (creatinine clearance < 60 mL/min). The NRTIs, emtricitabine and tenofovir, are primarily eliminated by the kidney and therefore patients with renal impairment should be closely monitored for TRUVADA-associated adverse events. TRUVADA should be used with caution in patients with moderate renal impairment (GFR 30–59 mL/min/1.73 m²), and should be avoided in patients with severe renal impairment (GFR ≤ 30 mL/min/1.73 m²). Clinical experience with these drugs in dialysis patients is limited. Close monitoring of patients is recommended in order to detect any adverse drug reactions and to modify the dosing of the drug in these patients.

Didanosine should be discontinued in patients who develop didanosine-associate adverse events.

Other
TRUVADA is a fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate. TRUVADA should not be coadministered with EMTRIVA or VIREAD, or drugs containing lamivudine, including COMBIVIR, EPIVIR, EFV, D4T, EFV/HV, and EFFEM.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Emtricitabine: In male fertility studies, no drug-related increases in tumor incidence were found in mice at doses up to 200 mg/kg/day (approximately 3 times the human systemic exposure at the therapeutic dose of 200 mg/day) or in rats at doses up to 600 mg/kg/day 0.1 times the human systemic exposure of the therapeutic dose. Emtricitabine did not affect fertility in rats at doses up to 750 mg/kg/day (1.8 times the human systemic exposure at the therapeutic dose).

Tenofovir disoproxil fumarate: Tenofovir disoproxil fumarate was mutagenic in the in vitro mouse lymphoma assay and negative in an in vitro bacterial mutagenicity assay (Test Assay). In an in vivo mouse micronucleus test, 1000 mg/kg/day (approximately 140 times the mouse and female mice at approximately 60-fold higher exposures (AUC) in humans given the therapeutic dose) did not effect the frequency of micronucleated lymphocytes in mice. In rats given the oral dose of 3.75 mg/kg/day the frequency of micronucleated lymphocytes was increased at 30-fold higher AUC at therapeutic dose of 200 mg/kg/day. Tenofovir disoproxil fumarate was teratogenic in female rats at the oral dose levels of 100 mg/kg/day (approximately 19 times the human systemic exposure at the therapeutic dose). In mice and rats, the fetal weight, length, and body weight of the offspring of rats exposed daily from birth (in utero) through sexual maturity were reduced at therapeutic dose of 50 mg/kg/day. In mice, the offspring of rats exposed at therapeutic dose of 50 mg/kg/day reared to sexual maturity at a higher frequency than controls. Tenofovir disoproxil fumarate was teratogenic in the in vitro mouse lymphoma assay and negative in an in vitro bacterial mutagenicity assay (Test Assay). In an in vivo mouse micronucleus test, 1000 mg/kg/day (approximately 190 times the mouse and female mice at approximately 60-fold higher exposures (AUC) in humans given the therapeutic dose) did not effect the frequency of micronucleated lymphocytes in mice. In rats given the oral dose of 7.5 mg/kg/day (approximately 20 times the human systemic exposure at the therapeutic dose) did not effect the frequency of micronucleated lymphocytes in mice. EMBRACE Study: The incidence of fetal variations and malformations was not increased in fetal assessment performed at 15 weeks of gestation in women exposed to tenofovir and emtricitabine in combination for at least 90 days during pregnancy (AUC approximately 50–100 times and 50–100 times higher than in pregnancy versus 28 weeks in control, respectively). A dose-related increase in the incidence of fetal variations and malformations was observed in the EMBRACE Study in women exposed to 250 mg/day of emtricitabine and 300 mg/day of tenofovir disoproxil fumarate for at least 90 days during pregnancy (AUC approximately 50–100 times and 50–100 times higher than in pregnancy versus 28 weeks in control, respectively). In the EMBRACE Study, the incidence of congenital hand or foot defects was increased in women exposed to both emtricitabine and tenofovir disoproxil fumarate (AUC approximately 50–100 times and 50–100 times higher than in pregnancy versus 28 weeks in control, respectively). In the EMBRACE Study, the incidence of cleft lip and/or palate defects was also increased in women exposed to both emtricitabine and tenofovir disoproxil fumarate (AUC approximately 50–100 times and 50–100 times higher than in pregnancy versus 28 weeks in control, respectively). In the EMBRACE Study, the incidence of major congenital anomalies was not increased in women exposed to both emtricitabine and tenofovir disoproxil fumarate (AUC approximately 50–100 times and 50–100 times higher than in pregnancy versus 28 weeks in control, respectively).

Bone Effects
In a 144-week study of treatment-naive patients, decreases in bone mineral density (BMD) were seen at the lumbar spine and hip in both arms of the study. At Week 144, there was a significantly greater mean percentage decrease from baseline in BMD at the lumbar spine (–3.1% vs. –1.3%) and femoral neck (–2.5% vs. –0.9%) in patients receiving stavudine, lamivudine + efavirenz, compared with patients receiving stavudine, lamivudine + emtricitabine. Changes in BMD at the hip were not statistically different between the two arms in both groups, in patients who were treatment naïve and in patients who had received prior antiretroviral therapy. The majority of the reduction in BMD occurred in the first 24–48 weeks of the study and this reduction was maintained at Week 144. Twenty-eight percent of VIREAD treated patients (vs. 21% of the comparator patients) had at least 5% of BMD (at the spine or ≥ 5% at the hip) < T-score of –2.0 at Week 144. Decreases in bone mineral density (BMD) in patients with HIV who are receiving concomitant nephrotoxic agents should be carefully monitored for underlying systemic or renal disease, or in patients taking nephrotoxic agents, to monitor for the development or worsening of bone disease. The effects of VIREAD on bone mineral density and cortical or cancellous bone have not been established in any age group.

Lactic Acidosis/Severe Hepatomegaly with Steatosis
Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues, alone or in combination, including EMTRIVA and VIREAD. These conditions have been associated with increases in hepatic enzymes and, in some cases, with hepatic fat (steatosis). In most reported cases, patients had underlying risk factors for liver disease; however, some have also been reported in patients with little or no known liver disease. Treatment with EMTRIVA should be discontinued in patients who develop clinical or laboratory findings suggestive of lactic acidosis or severe hepatomegaly with steatosis. The onset of symptoms may be insidious and may range from abdominal pain, increased transaminases, fatigue, and weakness to fulminating hepatic failure with or without encephalopathy and death.

Clinical studies of EMTRIVA or VIREAD did not include sufficient numbers of patients with impaired renal function and over to determine whether the drug has different effects in younger subjects. In general, dose reduction for the elderly population is usually not required (see DOSAGE AND ADMINISTRATION). However, in patients with impaired renal function (GFR ≤ 30 mL/min), particular caution should be exercised when initiating therapy (see DOSAGE AND ADMINISTRATION). Changes in renal function have been observed in patients receiving EMTRIVA or VIREAD. Changes in renal function have been observed in patients receiving EMTRIVA or VIREAD (see ADVERSE REACTIONS). The majority of these cases occurred in patients with underlying risk factors for renal dysfunction, such as severe underlying systemic or renal disease, or in patients taking nephrotoxic agents. The association with the use of VIREAD (see ADVERSE REACTIONS–Postmarketing Experience). The majority of these cases occurred in patients with underlying risk factors for renal dysfunction, such as severe underlying systemic or renal disease, or in patients taking nephrotoxic agents. Estimation of GFR should be performed in all patients receiving EMTRIVA or VIREAD for whom the potential for serious adverse reactions in nursing infants. mothers and children, renal function should be monitored in women who are pregnant during treatment.
Methadone Safety Alert

The Food and Drug Administration is alerting health care professionals who use methadone to treat patients for pain that it has received reports of death and life-threatening effects such as cardiac arrhythmias and slowed or stopped breathing in patients taking the drug. Methadone may build up in the body to a toxic level if it is taken too often, if the amount taken is too high or if it is taken with certain other medicines or supplements. Physicians prescribing methadone should be familiar with methadone’s toxicities and unique pharmacologic properties. The FDA has posted suggested procedures to follow when prescribing the drug at www.fda.gov/ceder/drug/infrac/ methadone.

“It is well-known that methadone can be problematic, which is why treatment guidelines are patient specific and why physicians who prescribe methadone usually have special training,” comments Judith A. Stanley, MS, OCCHP, director of accreditation for NCCHC.

Principles for Drug Abuse Treatment

With drug use rife among individuals who find themselves in the criminal justice system, the National Institute on Drug Abuse has issued research-based treatment recommendations to help reduce rates of drug abuse and crime and to save taxpayer dollars. Based on review of the scientific literature on drug abuse treatment and criminal behavior, Principles of Drug Abuse Treatment for Criminal Justice Populations distills research findings into 13 essential principles.

For example, drug addiction is a brain disease that affects behavior, recovery requires effective individualized treatment that may include medication, and continuity of care is essential for drug abusers re-entering the community after a period of incarceration. NIDA is an agency of the National Institutes of Health. The free publication is available at www.drugabuse.gov/podata_cj, or e-mail bmarquis@nida.nih.gov.

Preventing Postsurgical Infections

To prevent surgical site infections, some physicians give patients broad spectrum antibiotics over 24 hours before the surgery. But a single dose seems to be just as effective, according to a study in the November issue of Archives of Surgery. A before-after study of over 12,000 patients in a private hospital in Brazil found the same rate of infection, about 2%, in both groups of patients. None of the patients had infections before the surgery. The one-dose prophylaxis also saved money. In a commentary in HealthDayNews, one expert said that institutions may elect to exclude certain high-risk procedures from the protocol. Find the article at http://archsurg.ama-assn.org/cgi/content/abstract/141/11/11.

Promising Treatment for HCV

Hepatitis C patients who have not responded to other therapies may benefit from combination treatment with ribavirin and Interferon, a highly potent form of Interferon reported at the October meeting of the American Association for the Study of Liver Diseases. According to an Oct. 30 report in HealthDayNews, a team at the Saint Louis University School of Medicine found that this combo therapy was nearly twice as effective at controlling hepatitis C’s effects on the liver than standard treatments. The study included more than 500 patients, 77% of whom had advanced fibrosis.

Off the chart.

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Pay Now or Pay Later: Why the Goal Is Control With Diabetes

A n epidemic is sweeping the United States. Diabetes affects over 20 million people, almost a third of whom do not know that they have the disease. People with this disease often find out only when an organ has already sustained damage.

The impact extends beyond health. From 1997 to 2002, the annual cost for this disease in medical expenditures and lost productivity rose 35% and the average per capita cost for treatment rose more than 30%.

At any given time, nearly 80,000 people with diabetes are incarcerated. Most of those have type 2 diabetes, which for years was erroneously thought to be a less serious form of the disease. Although any immediate health problem has associated costs for practitioner visits, medications and adjunct therapy, the price tag is even higher for unrecognized and uncontrolled diabetes.

Controlling Complications
Numerous studies, the most familiar being the Diabetes Control and Complications Trial, offer convincing evidence that good control of diabetes, as shown by a lower hemoglobin A1C level, can prevent or reduce the complications (and their related costs) of the disease.

What are those complications? It’s well-documented that people with diabetes are two to four times more likely to have a heart attack or stroke. They are 10 times more likely to have an amputation; in fact, comprehensive foot care programs can reduce amputation rates by as much as 85%, according to the American Diabetes Association. Diabetes also is the leading cause of new cases of blindness and of kidney failure in the United States.

The ADA Position Statement on Diabetes Management in Correctional Institutions reflects these findings and provides a framework of preventive and therapeutic interventions that can save health care dollars and achieve better inmate health.

The statement addresses such issues as initial and ongoing screening for diabetes, frequency of testing for complications, diabetes management plans, and preventive and educational measures.

ADA clinical practice recommendations also form the basis of the National Commission on Corrective Health Care’s clinical guidelines on diabetes, which are tailored to care in correctional settings.

Although the details of these position statements and guidelines may seem formidable at first glance, good diabetes care primarily requires two things: good understanding of diabetes and knowledge about current therapies, and an organized, methodical approach to management of the inmate’s diabetes care.

One of the most challenging aspects of care is being on top of who gets what test when. For me, an invaluable tool is a spreadsheet of all inmates with diabetes. It notes the required testing and the last results, making it easy to see at a glance who has elevated A1C levels or other out-of-range test results. Another plus of organizing the data this way is that it prevents unnecessary repeats of costly lab work as well as the dreaded FTC (fell through the cracks) syndrome.

Easy as A-B-C
Especially in a correctional facility, the goal is control. All inmates with diabetes should have a management plan that monitors and optimizes their glycemic control. The management plan should focus on three key components, labeled as the ABCs of diabetes management:

A — The A1C test, which measures the average blood glucose level over the past 60 to 90 days, is the gold standard for how well a person’s diabetes is managed overall. Although the goal should be individualized, the management plan should strive for the near-normal A1C goal of less than 7%.

B — Good glycemic control is achieved through therapies of diet, exercise and medication (if needed). Regular finger-stick blood glucose tests are necessary because they measure the daily effects of the therapies and give providers the information needed to make adjustments. Daily blood glucose tests tell us how to fine-tune the therapy; A1C tests tell us the overall success of those adjustments.

C — Cholesterol and triglyceride control are especially important for people with diabetes because of the increased incidence of coronary artery and other blood vessel disease. Often, lipid control follows normalization of blood glucose levels.

I also focus on two other components:

D — Diet, more correctly referred to as medical nutrition therapy, focuses on a healthy way of eating. MNT, by the way, information needed to make adjustments. Daily blood glucose tests tell us how to fine-tune the therapy; A1C tests tell us the overall success of those adjustments.

E — Education. For 25 years I have taught thousands of patients and professionals about diabetes management, and I have learned a valuable lesson: The sooner you teach diabetes and its management, the better the outcomes.

Knowledgeable health professionals provide better care for patients. And knowledgeable patients make better choices, communicate more effectively with the providers and self-manage their disease better. Diabetes self-management training (DSM-T) is now a standard of care in the free world, and it can improve the care and cooperation of inmates.

Staff education for both the health care staff and correctional officers should be ongoing to ensure that they have the information and skills to effectively manage inmates with diabetes.

The Bottom Line
Diabetes management really comes down to this: Pay me now or pay me later. You can invest in staff and inmates and make the necessary steps to follow the standards of care, and make the effort to organize and optimize the medical management of inmates with diabetes, resulting in better outcomes. If you don’t, you most likely will find yourself continually throwing money away for the medical problems that plague those with poor diabetes control.

Better glycemic control reduces the complications of diabetes. Fewer complications reduce the health care dollars spent. In the words of Dr. Robert A. Rizza, in an address at the 2006 annual scientific sessions of the ADA, “It costs less to properly treat diabetes than it does to treat the complications that you get if you don’t properly treat diabetes. It’s a wise investment no matter how you look at it.”

Rebecca B. Jones, RN, BSN, CDE, is a nurse consultant in Wetumpka, AL. To contact her, send an e-mail to thrive survive@gmail.com.

The position statements and clinical guidelines cited above may be accessed online. For the ADA documents, visit www.diabetes.org. The NCCHC guidelines are posted at www.ncchc.org. Additional resources are available from the American Association of Diabetes Educators, www.aadet.org.
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HIV Testing In the News

CDC Recommends Routine Testing

The Centers for Disease Control and Prevention recommends that voluntary HIV testing of all patients aged 13 to 64 be a routine part of clinical care in all health care settings in the public and private sectors, including correctional facilities. The guideline was published Sept. 22 in the CDC’s MMWR Recommendations and Reports (Vol. 55, No. RR-14).

Previous CDC guidelines issued in 1993 recommended routine counseling and testing for people at high risk for HIV, for all pregnant women, and in acute care settings where HIV prevalence is 1% or more.

A major impetus for the new recommendations was success with universal screening of pregnant women, which has resulted in a drastic drop in the number of infants born with HIV. The CDC also notes that 25% of the 1-million-plus people with HIV in this country do not know they have the infection.

Major revisions from previous guidelines include the following:
• Screening is recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
• Persons at high risk for HIV should be screened at least annually.
• Separate written consent should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.

• Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings.
• For pregnant women, HIV screening should be part of the routine panel of prenatal screening tests.
• In areas with high rates of HIV infection among pregnant women, repeat screening is recommended in the third trimester of pregnancy.

The guideline and related information are posted at www.cdc.gov/hiv/optics/testing/healthcare. The CDC will issue implementation guidance for the recommendations in 2007.

HIV Testing Laws Compendium

The National HIV/AIDS Clinicians’ Consultation Center has updated its State HIV Testing Laws Compendium. It describes each state’s policies, rules and regulations on HIV testing and provides state-by-state comparisons. The compendium is online at www.ucsf.edu/hivcntr/PDFs/WEB2006State%20Laws.pdf.

New Test to Detect HIV

The Federal Drug Administration has approved the first diagnostic test to detect the RNA of HIV-1, the main virus that causes AIDS. The APTIMA HIV-1 RNA Qualitative Assay “has important implications ... because it could be a potential alternative” to the Western blot test typically used to confirm HIV-1 infection when screening tests for HIV-1 antibodies are positive, according to an FDA news release. The new assay also can be used “in clinical laboratories and public health facilities to detect early HIV-1 infection, before the appearance of antibodies.” Learn more at www.fda.gov/bbs/topics/news/2006/new01479.html.

HIV in Prisons

The numbers of HIV-positive state and federal prisoners fell for the fifth consecutive year, as did AIDS-related prisoner deaths, according to a report by the Justice Department’s Bureau of Justice Statistics.

In 2004, 23,046 prisoners were HIV positive prisoners vs. 25,807 in 1999. Despite the overall decline, 24 states and the federal prison system saw increases. The largest increase of new cases (138) was in Florida, the largest decline (500) in New York.

The number of confirmed AIDS cases in state and federal prisons rose in 2004, from 5,944 to 6,027. With a 50 confirmed AIDS cases per 10,000 inmates, the AIDS rate in prisons was more than three times higher than in the U.S. population (15 per 10,000 persons).

However, AIDS-related deaths fell from 282 to 203 in 2004. Further, 6% of state inmate deaths were attributable to AIDS, down from 34% in 1995. These declines reflect the use of protease inhibitors and combination antiretroviral therapies in prisons, the report notes.
Ethical Rules Must Govern Research With Prisoners: IOM

BY JAIME SHIMMINS

The use of prisoners as human subjects in biomedical and behavioral research should adhere to an ethical framework that entails more oversight, safeguards and protections for the prisoners, according to a recent report from the Institute of Medicine.

While research can prove beneficial to individual prisoners and prison populations as a whole, the safeguards are needed to ensure that it does not jeopardize participants’ health, well-being and human rights, the report notes.

**Ethical Considerations for Research Involving Prisoners**

Ethical Considerations for Research Involving Prisoners is the result of a study commissioned by the Department of Health and Human Services’ Office for Human Research Protections.

“The Department of Health recognizes the seriousness of the report and we have received assurances that there will be careful consideration of our recommendations,” says Lawrence O. Gostin, JD, LLD, who led the IOM committee that conducted the study and issued the report. Gostin is an associate dean at the Georgetown University Law Center, Washington, DC.

The OHRP is now reviewing those recommendations, says public affairs specialist Patricia El-Hinnawy. “Some are actions that our office could take, some would have to be handled by the Secretary of Health and Human Services and others would require action by Congress.”

After the agency develops action plans for each recommendation, it will invite public input before they are implemented, she adds.

**Evaluating the Status Quo**

The need for the study was determined by an OHRP advisory subcommittee charged with evaluating the provisions (known as Subpart C) that relate to prisoners in the federal regulations for the protection of human research subjects. Those regulations were written 30 years ago, and with revelations of abusive and dangerous research over the years, DHHS decided to revisit them.

“We concluded that Subpart C was inadequate,” says Nancy Dubler, LLC, who co-chaired the OHRP advisory subcommittee and also served as special advisor to the IOM committee that conducted the study. Dubler directs the division of bioethics, department of epidemiology and social medicine, at Montefiore Medical Center in New York City.

This led to the report’s “broad recommendations about the changes that need to be made to accommodate the tremendous demographic distance between we were when Subpart C was written and where we are now,” Dubler says.

**Study Focus**

The goal of the IOM study, according to the report, is to “ensure rigorous responsible research that improves...

Continued on page 16
The well-being of prisoners while taking great care to protect their health, well-being, and human rights. The committee focused on four tasks:

1. Consider whether the ethical bases for research with prisoners differ from those for research with nonprisoners.
2. Develop an ethical framework for the conduct of research with prisoners.
3. Identify considerations or safeguards necessary to ensure that such research is conducted ethically.
4. Identify issues and needs for future consideration and study.

Although the original regulations noted the “vulnerability” of correctional populations, the IOM report cites many changes since then that indicate a need for even stronger protections. Among these changes are the modifications to the document that has quadrupled in the past three decades, overcrowding in the facilities where inmates are housed and large numbers of disengaged populations under correctional supervision, including persons with mental illness and communicable diseases. With regard to health care, the report says that “access ... has not kept pace with the rising tide of pris- oners.” A key concern, then, is that consent to take part in research “is not simply a desperate attempt to obtain treatment.” The study also found that most research projects involving prisoners today do not receive federal money and thus are not covered by Subpart C. Many of these studies lack any institutional review board oversight.

“...There is no ethically defensible reason to exclude certain prisoners from, if not all, human subject protections afforded by federal regulation,” the report states.

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**CONTRAINDICATIONS:** There are no contraindications to the use of TWINRIX or any component of the vaccine, including yeast and neomycin, to a contraindication (see DESCRIPTION in full prescribing information). This product does not confer immunity against infection or immunity to TWINRIX or monovalent Hepatitis A or Hepatitis B vaccines.

**WARNING:** There have been reports of anaphylactic/anaphylactoid reactions following routine clinical use of TWINRIX. (See CONTRAINDICATIONS). The site topopera in the upper arm and that of the large dose of TWINRIX should be used for those patients who have previously reacted to TWINRIX and may have a history of hypersensitivity to egg products. To avoid a large reaction, the TWINRIX containing the vaccine should be used.

**PRECAUTIONS:** General: As with all vaccines, delay administration, if possible, in persons with a moderate or severe acute illness. Minor illnesses such as mild colds, fever, or a minor skin abrasion should not delay administration of TWINRIX. In patients with a low-grade fever are not contraindications.

Multiple Sclerosis: Results from 2 clinical studies indicate that there is no associa- tion between hepatitis B vaccination and the development of multiple sclerosis, and that vaccination with hepatitis B vaccine does not appear to increase the short-term risk of relapse.

TWINRIX is contraindicated in patients who have a previous history of anaphylactic/anaphylactoid reactions to TWINRIX and, in persons with a history of egg anaphylaxis (except to egg products), to egg products should be considered a contraindication to TWINRIX administration.

**ADVERSE REACTIONS:** Adverse reactions seen with TWINRIX were similar to those observed after vaccination with the monovalent components. The frequency of solicited adverse events did not increase with successive doses of TWINRIX. Most events reported were con- sidered by the subjects as mild and well-tolerated and did not last more than 48 hours. Among 2,399 subjects in 14 clinical trials, the following adverse events were reported to occur within 30 days following vaccination with the frequency shown below:

**Incidence 1% to 10% of Injections: Local Reactions at Injection Site: Induration. Respiratory System: Upper respiratory tract infections.**


**Nervous System: Myalgia, paresthesia, vertigo, somnolence, insomnia, irritability, psychoses. Special Senses: Blurred vision, photophobia, ophthalmia.**

**As with any vaccine, it is possible that expanded routine clinical use of the vaccine will uncover rare adverse events.**

**Incidence <1% of Injections, Seen in Clinical Trials With HAVRIX and/or ENGERIX-B: Body as a Whole: Swelling. **

**Cardiovascular System: Hypotension. Gastrointestinal: Constipation, diarrhea.**

**Neuropathic and Psychiatric: Dizziness, depression, anxiety.**

**Frequent laboratory abnormalities include:**

**Increased: AST, ALT, LDH, GGT.**

**Decreased: WBC, lymphocytes.**

**As a separate sterile syringe and use risk/benefit analysis; research environment must maintain adequate protections.**

**Mumps.R.C.**

**Mumps, Measles, Rubella, Varicella Vaccine Sensitivity:**

**Informed Consent:**

**Enforceable Consent:**

**Immunosuppressive Therapy:**

**Healthcare Workers:** It is not known whether TWINRIX is excreted in human milk. Because many drugs are excreted in human milk, use caution when administering TWINRIX to a nursing woman.

**Pediatric Use:** Safety and effectiveness in pediatric patients below the age of 18 years have not been established.**

**GUARANTEED USE:** Clinical studies of TWINRIX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects.

**Table 1: Rate of Adverse Events Reported After Administration of TWINRIX, ENGERIX-B and HAVRIX**

<table>
<thead>
<tr>
<th>Event</th>
<th>TWINRIX</th>
<th>ENGERIX-B</th>
<th>HAVRIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Local</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Skin</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Special Senses</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**ADVERSE REACTIONS:** In clinical trials involving the administration of 6,643 doses to 2,299 individuals and during routine clinical use of the vaccine outside the United States, 11 adverse events have been reported. Of these, 4773 vaccinees were participating in a US comparative trial, 389 subjects received at least 1 dose of TWINRIX and 384 received at least 1 dose of HAVRIX. In a separate trial of 4022 subjects, 1265 received at least 1 dose of ENGERIX-B. Reporting of adverse events associated with PEPFAR’s global vaccination campaign does not follow the same criteria as those used in other trials, for example, the adverse events reported after administration of TWINRIX, compared with adverse events reported after the administration of ENGERIX-B or HAVRIX, are shown in the table above.

**Five Objectives**

The committee’s recommendations fall within five major objectives.

1. Expand the definition of “pris- oner” — This would cover the nearly 5 million people on parole or proba- tion in the community. The rationale is that, like those residing behind bars, the liberty of these individuals is restricted and they thus experience greater vulnerability.

2. Establish consistent eth- ical protection — Current DHHS regulations apply only to research funded by three federal agencies. Under the proposed framework, all human research involving prisoners would be subject to the same ethical guidelines as mandated by Congress. To shed light on prisoner involve- ment in research, a national database of research would be established and accessible to the public.

3. Shift from a category-based to a risk-benefit approach to review of proposals involving prisoners — This approach would use risk/benefit analysis; research would be ethically permissible only if it offers prisoners potential benefits that outweigh the risks. This approach differs from the current biomedical research and lower-risk social/behavioral and epidemiological studies, with stricter limitations on the early phases of biomedical research and socioeconomic exceptions may apply.

4. Update the ethical framework to include collaborative responsibility All relevant parties (prisoners, correctional officers, medical staff, etc.) should have input into the design, planning and implementation of research. This will foster openness and prevent conditions that might favor exploitation. The research envi- ronment must maintain adequate standards of care. This recommendation also calls for government agen- cies and correctional institutions to delineate crit- ical areas of correctional research.

5. Enhance systematic oversight of research involving prisoners — This entails strengthening systems of self-regulation and oversight by applying them consistently. One element is to monitor research throughout the study, preferably by an independent “prison research subject advocate” who is not employed by the correctional facility.

**Implications**

The report’s recommendations have clear implications for policy makers and researchers, but they also affect correctional institutions, Dubler says. “Research should only be done in facilities that have demonstration of health service so that prisoners have a real choice, which is necessary for informed consent” to participate. Dubler also would like researchers to heed recommendations to conduct studies aimed at improving the lot of prisoners. “This report urges and structures protections for pris- oners…But that leaves open where there are soci- etal obligations to investigate what prisons do to people.”
Healthy Behaviors of Older Inmates Linked to Self-Confidence

Studies estimate that 85% of older inmates have at least two major illnesses. Providing health care for inmates age 50 and older—the fastest-growing age cohort—is challenging prisons across the nation, write Susan J. Loeb, PhD, RN, and Darrell Steffensmeier, PhD, in the latest issue of the Journal of Correctional Health Care.

With a long-term goal of developing ways to improve the health of older male prisoners, the authors investigated the relationships between health status, beliefs about self-efficacy and health-promoting behaviors in a sample of 51 inmates aged 50 to 80 at a Pennsylvania state prison for males.

The study sought to answer four key research questions:
1. How do incarcerated older men describe their health?
2. How confident are older male inmates in their ability to manage their health?
3. To what degree do older male inmates participate in health-promoting behaviors?
4. What is the relationship of self-efficacy for health management to health-promoting behaviors and health status?

The theoretical framework of the study came from Bandura’s social cognitive theory. According to Loeb and Steffensmeier, this theory describes a model in which “behavior, cognitive and other personal factors, and environmental events all operate as interacting determinants of each other.” Self-efficacy, a key concept in the theory, is defined as “confidence in one’s ability to mobilize them to initiate, sustain, and mobilize them to manage their health now and on release from prison, about six in 10 inmates described their health as good; 22% described it as fair. Two in five inmates said their health had worsened since incarceration, while one-third said their health had not changed.

The study measured the inmates’ health-promoting behaviors by asking about their participation in immunizations, screenings, exercise, substance abuse programs and other health programs. The 24 items on this measure were tallied to arrive at a score with a possible range from 24 to 96, with higher scores indicating greater involvement in the behaviors. The average score was 73.2.

Inmates also were queried on their likelihood of watching for various health-related physical changes. The range of possible scores was 14 to 56, and the average actual score was 49.

Statistical analysis of the relationships determined that inmates with greater self-efficacy for managing their health—both in prison and on release—tended to rate their health to be better, to engage in more health-promoting behaviors and to report improved health since incarceration. Greater self-efficacy was not, however, significantly related to the number of health conditions reported.

These relationships held after statistically controlling for the effects of age and race.

Positive Prospects

Loeb and Steffensmeier view these findings as quite positive and conclude that “if health-promotion opportunities are available to older inmates, they possess the motivation and wherewithal to use and benefit from them.” They also point to implications for policy that could have far-reaching beneficial effects: “Strides made in promoting older inmates’ health will likely contribute to more humane health care and a more efficient inmate health system that lessens the burdens and costs of providing health care to this population both during incarceration and upon release. Better health would likely contribute to greater productivity as well as enhanced prospects for successful reintegration into society.”

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must meet with them to ensure they are aware of and prepared for the medical and public safety issues that may arise.

- Contact the homeland security representative in your agency. This person may want to include pandemic planning in the overall disaster preparation.
- Local medical services may not have the surge capacity to accommodate inmates when overwhelmed with community patients. Consider establishing an on-site isolation ward for those infected. An on-site morgue also may be necessary. Discuss this with the local EMS planners and the medical examiner’s office.
- Health care staff serve as resident experts and should anticipate providing correctional administration with updates and technical information to facilitate public safety. They also may serve as a communication conduit between community services and corrections.

- If outbreaks occur simultaneously across the country, your state department of corrections may not be able to obtain assistance from other states.
- We may have as much as a three-month warning of impending pandemic—or no warning at all.
- Depending on where the pandemic strikes first, vaccine may not be available for up to eight months after onset. Also, correctional facilities may not be given top priority if vaccine supplies are limited.
- Once formulated, the vaccine may not be available for widespread use for another five months.
- The initial wave of infections will be followed by a second wave three to nine months afterward. Each wave is estimated to last about 30 days.
- Movement of clinically ill inmates should be minimized; they should not be transferred to a facility where illness has not struck.
- It is unlikely that limited resources will be allocated to corrections while mainstream needs go unmet. So plan ahead!

Throughout human history pandemics have struck with varying degrees of catastrophe. Little question exists that another will occur; it simply is a question of when. Knowing that such an event is unavoidable and that our profession cares for a particularly vulnerable population demands that health professionals be prepared for the event. Proper planning will improve our management, provide the satisfaction and peace of mind of being ready for the task, and go a long way toward preventing the unthinkable.

Richard Garden, MD, CCHP, is the clinical director for the Utah Department of Corrections, Draper.

and treat uncommon or unusually severe conditions that are not reflected here. For example, medication used as an adjuvant in cancer chemotherapy are not listed because of the highly individualized nature of treatment. It is critical to develop lists of medications for specific patients who have these types of conditions and to ensure that adequate supplies are maintained for them.

Also, medicines found on typical crash carts are not listed because many facilities depend on local ambulance services to provide this care. Facilities large enough to have resuscitation teams will need to consider how they want to maintain them.

Medications on this list were not selected on a cost-effective basis for routine use and should not be considered as routine stock. When available, both oral and injectable forms will be useful.

Admittedly, difficult and subjective trade-offs were made. If Tylenol is on the list, is it necessary to have Motrin, as well? Given the two broad spectrum and admittedly expensive antibiotics listed, should azithromycin also be included? Is there enough incognto of intoxicated to warrant having activated charcoal on the list?

Facing Realities

In the end, the objective is to use a small number of versatile medicines for several reasons. First, the physical reality is that because of increased demand and loss of personnel, the medical services organization will be on the verge of chaos. It is not enough to have a nice list of medications. The medications must be obtained, stored, processed, accounted for and distributed. The shorter the list, the more likely facilities will be able to actually deliver medications to the patient in times of extreme stress.

Second, the political reality is that it will be easier for correctional administrators to add medications to the list than to explain to the myriad groups of citizens, patients and governmental oversight committees why they are not including them.

Finally, the financial reality is that if the list is too extensive, the correctional system may be forced to do nothing at all rather than try to pick and choose options.

As well as choosing what medicines to add or substitute, each organization must determine medication stocking levels. Many variables come into consideration; budget is obvious, but even storage arrangements, inmate populations, time to resupply and availability of staff during a crisis must be considered. Importantly, if more than seven days of crisis is anticipated, HIV-related antiviral medications must be on this list, and discussion with a hepatologist about hepatitis C treatment medications should be considered, as well.

Of course, it is expected that most, if not all, medications prescribed to patients will be given until it is impossible or dangerous to do so as determined by the organization director. This list is only a small part of a larger plan for dealing with catastrophic pandemic influenza outbreak. The medications listed below should be the highest priority to stock in case of such an event.

**Antivirals**
- Acyclovir (Zovirax)
- Tamiflu (Oseltamivir)

**Analgesics**
- Acetaminophen (Tylenol)
- Ibuprofen (Motrin)
- APAP/codeine (Tylenol #3)

**Anti-infectives**
- Ceftriaxone (Rocephin)
- Ciprofloxacin (Cipro)
- TMP/SMX (Bactrim DS)
- Antiviral medications as determined by the CDC

**Endocrine**
- Regular insulin
- Long-acting insulin (NPH)
- Metformin (Glucophage)
- Prednisone
- Methylprednisolone (Solumedrol)
- Dextrose 50% injectable

**Gastrointestinal**
- Sublingual nitroglycerin
- Propanolol (Inderal)
- Furosemide (Lasix)
- Warfarin (Coumadin)
- Hepalin
- Aspirin
- Antiarhythmics medications as required by specific patients

**Respiratory**
- Albuterol for nebulization
- Albuterol meter-dose inhaler
- Diphenhydramine (Benadryl)

**Gastrointestinal**
- Promethazine (Phenergan)
- Activated charcoal
- Loperamide (Imodium)
- Bisulfate salicylate (Pepto-Bismol)

**Mental health**
- Ziprasdione (Geodon)
- Fluoxetine (Prozac)
- Diphenhydramine (Benadryl)
- Lorazepam (Ativan)

**Neurological**
- Phenotoin (Dilantin)
- Valproic acid (Depakote)
- Gabapentin (Neurontin)
- Tegetrol (Carbamazapine)
- Naloxone (Narcan)

**Ophthalmological**
- Glicazin (Ciprofloxin Ophthalmic)
- Prednisolone acetate (Pred Forte)

**Other**
- Saline and intravenous supplies
- Bandages, suture kits, wound care supplies
- Glucose testing supplies, equipment
- Chemotherapy-related medications as required by specific patients
- Life-sustaining medications as required by specific patients

Scott Savage, DO, CCHP, KB, was assistant medical director for the Ohio Department of Rehabilitation and Correction when he wrote this. A Fellow of the American College of Emergency Medicine, he has extensive military training in disaster medicine and planning.
Problematic Medication Practices: The Top 10

By Judith A. Stanley, MS, CCHP-A

This is the first of a two-part article. Part two will appear in the next issue of CorrectCare (Vol. 21, Issue 1).

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Problematic Practices

1. Delay in continuing prescribed drugs at admission or transfer

This is probably the most common (and potentially lethal) medication error, especially in jails but also with prison transfers and short-term moves. Good medical practice, and compliance with the standard, requires that there be no interruption of time-sustaining medications or those needed to maintain therapeutic blood levels for serious health conditions.

Reasons for this problem are many: experience with questionable inmate self-reporting, the need to maintain control of drugs coming into the facility, inability to stock or access certain drugs. Timeliness of health staff review of incoming inmates’ health needs and different opinions as to which drugs are essential.

2. Running out of prescribed medication

Interruptions in medication lead to drops in therapeutic drug levels and reduced drug efficacy. There are myriad system-related causes for depleted drug stocks. If a facility is short-staffed, proactive initiatives may be set aside to grapple with the day’s emergencies. Or efforts to get inmates to take responsibility for self-care can backfire when unexpected events interrupt a “fail-proof” delivery system.

3. Altering the drug form for security reasons

In the desire to control hoarding or selling, or perhaps as a result of one had outcome, the facility may turn to diluting, crushing or otherwise making it impossible for anyone besides the intended inmate to get the drug. Not all medications can be treated in this manner; in fact, the efficacy of time-release or specially coated drugs can be destroyed.

4. Changing medications or doses without discussing with inmate

Perfectly good clinical decisions become problematic when the patient does not know what is happening. Yes, it is time-consuming to call the inmate to the clinic just to tell him that lab results indicate the dosage needs to be increased. But if you don’t, you risk dealing with an irate inmate who thinks the medication nurse is “picking on me.” For an inmate with paranoia, a change in color of a regular pill is a threat.

5. Frequent medication changes by different prescribers

Medications require time to have an effect; some must be stopped for a period before a different formula is tried. Thus, it is clinical common sense not to change medications too frequently. When several part-time physicians, each with different backgrounds and professional biases, provide care, there is the tendency for medications to be changed more often than good practice would dictate.

6. Medication changes to stay on formulary

While the standards require use of a formulary, the caveat is that the clinician may order off formulary when it is clinically indicated for a given patient. Procedures for off-formulary ordering can be so complex that it takes multiple approvals and an inordinate amount of time, which unnecessarily delays treatment. Pressure to keep drug expenditures within projected limits can be strong when correctional health budgets are tight and getting tighter.

7. Inadequate pain medication

Inmates do suffer from terminal illnesses and painful chronic conditions, and they can experience acute and debilitating pain. Even in the best

Continued on page 20

A fter yesterday’s root canal, you call your dentist’s office to complain that the over-the-counter pain reliever he recommended is not working. His dental assistant tells you that your dentist never gives anything stronger for root canal work and ends the conversation with “Take two!”

For years you have heard voices that interfered with your ability to function on a daily basis. Last year, after many years of trying different psychotropic medications, side effects and all, a new drug has stopped the voices. But your new psychiatrist isn’t comfortable with this drug and decides to switch back to your last one. She did not tell you this; you found out when you picked up the refill from the pharmacy.

Your diabetes finally responded to a schedule and dose of a specific insulin after years of trial and error. You have learned when and how to eat, and can anticipate a need for additional insulin. Your boss just transferred you to the night shift. Since this will upset the balance between eating times and blood sugar levels, you ask to thenightshift. Since this will upset the balance between eating times and blood sugar levels, you ask to remain on the day shift. His reply: “Take it—or leave.”

Unacceptable? Indeed. Fortunately, as a member of the free world, you are free to change dentists or psychiatrists and to explore legal options for medical accommodations.

But inmates have almost no control over the health care they receive, and getting needed medications can be a central concern. Whether it is a long-standing order for chronic care meds or a time-limited prescription to treat an acute illness, a hassle-free system that delivers the right drug to the right person at the right time and in the right manner can make the difference between acceptable and intolerable conditions of confinement. When this system fails, inmates’ choices are limited and remedies difficult to obtain.

Laying the Groundwork

Like the NCCHC Standards for Health Services in general, essential standard D-02 Medication Services intends that practices be “commensurate with current community practice.” The standard lays out the basic requirements for correctional medication services: They must be “clinically appropriate and provided in a timely, safe, and sufficient manner.”

Using as a guide this and the other standards that relate to medications can help facilities avoid the top 10 problematic practices that we see with correctional medications. The practices listed here are cited most

www.neche.org FALL 2006 • CorrectCare 19
New Resources Aid Chronic Care Management

NCCHC’s clinical guidelines for chronic conditions seen commonly in jails and prisons are invaluable resources for correctional health care practitioners. But a piece was missing, says NCCHC’s vice president, R. Scott Chavez, PhD, CCHP-A.

That piece—three forms for clinicians to use in daily practice—are now available online. “When used with the clinical guidelines, these forms make for a complete monitoring program,” says Chavez. The forms were approved by the Commission’s clinical guidelines subcommittee in October.

The first form compiles initial baseline medical data and should be used when seeing a patient for the first time. It contains a checklist for all of the chronic diseases identified at the initial visit and collects comprehensive information for each, along with health history and other data. It also addresses assessment of degree of control, patient education and plans for tests or other clinician orders.

The second is a chronic disease clinic follow-up form for patients with a single or multiple chronic diseases. It lists medications used, summarizes test results essential to assess the degree of control and addresses patient adherence.

The third document is a nursing chronic disease flow sheet, designed to be used for a nursing visit that occurs between a clinician’s chronic disease visits. It allows vital signs, relevant nursing history and objective data to be viewed over time to assess clinical trends.

The three forms, instructions for their use and definitions of control for each disease are posted as PDF files at the Resources section of the NCCHC Web site, www.ncchc.org.

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8. Lack of informed consent regarding use of psychotropic medication

Written consent for the use of psychotropic medication (except in emergencies) is standard practice supported by legal requirements. It is good clinical practice, as well, given the significant side effects possible with many of these drugs. General laxity when it comes to consent issues can be pervasive in correctional settings, especially when it comes to treatment for mental illnesses.

9. Inflexible drug distribution schedules

In the paramilitary correctional environment, schedule deviations are problematic. Exceptions may be required when a patient cannot take a certain medication on an empty stomach, or must wait a set interval between meals and meals or doses. Altering distribution procedures is often complex when security classifications make movement limited.

10. Lack of, or limited access to, opioid dependence treatment options

In the community, it is common and acceptable practice to use methadone or buprenorphine to aid withdrawal from opioid dependency. Although less common, it is also accepted practice to use these substances for maintenance therapy.

However, very few jails offer therapeutic methadone-based withdrawal, and new detainees who participate in a community methadone program seldom can continue that treatment behind bars. “Cold turkey” is no longer an acceptable approach to withdrawal, and protocols that don’t use opioid agonistic agents are not as therapeutic as other alternatives.

Share Your Solutions

Part 2 of this article will appear in the next CORRECTCare. Besides discussing the standards’ expectations and requirements, it will outline solutions, many of them from facilities that have struggled with these issues as they worked toward accreditation.

Do you have a contribution to offer to the dialog? Please forward your thoughts so that we may include them in the sequel article.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation. E-mail her at judithstanley@ncchc.org.
Inmate Workers
In what capacity in a long-term-care facility (prison setting) are inmate workers allowed to assist the nurses? Specifically, can they assist in lifting and in transferring inmates?

A

Standard P-C-06
Inmate Workers states that inmates are not to provide direct patient care (Compliance Indicator 3). If they are simply supplying the physical energy necessary to lift and transfer patients (e.g., floor to gurney, gurney to bed) and the nurse is right there supervising and directing, such assistance would be in compliance with the standards.

As for routine transfers such as bed to wheelchair, these are considered assistance with activities of daily living (ADLs). Some national correctional health care contractors have extensive initial orientation for new RNs. Unfortunately, some new nurses don’t receive orientation and find themselves alone and unprepared for a paramilitary setting in which security and safety—not health care—is the main focus. They can be prey to many problems, not only from inmate behavior but also from unfamiliarity with their environment and dependence on correctional staff cooperation to do their jobs effectively.

Knowledge about correctional health care is highly valuable for a nurse seeking to navigate these waters. NCCHC receives many calls from experienced RNs who are new to corrections and unsure enough to realize they need help. If the facility is accredited by NCCHC, the nurse is at great advantage in working under a mentor who is knowledgeable about the Commission and its standards. The Academy of Correctional Health Professionals, a supporting organization of NCCHC, has as members correctional nurses who will mentor or share advice. Nurses new to corrections also would benefit from attending NCCHC conferences and participating in its certification program to better understand this complex field, develop professional networks and build confidence.

Nurse Training Requirements
I am looking for specific training requirements for RNs who want to work in prisons and jails. Do the NCCHC Standards have any information about this?

A

NCCHC does not specify preemployment training requirements, nor do correctional facilities generally. However, RNs interested in working in this challenging field should be current in their state licensure, keep up with renewal requirements and be sure their assigned duties are in keeping with their qualifications. CPR and first aid certifications are a must.

Important standard G-O-09 Orientation for Health Staff stipulates that new health staff employees must receive basic orientation on the first day of on-site duty and in-depth orientation within the first 90 days.
Exhibitor Opportunity

Updates in Correctional Health Care
Orlando, Florida • May 5-8

Your Time to Shine
Updates in Correctional Health Care attracts the movers and shakers in this market, and they want to know about your company. The conference exhibition is your time to make a great impression. Don’t miss this opportunity to make connections, stand out from your competitors and significantly increase your company’s presence among these influential professionals.

Exhibitor Benefits
What makes Updates 2007 special for exhibitors?
• 1,000 high-quality attendees: These professionals are looking for solutions to the challenges they face.
• An exciting destination: Orlando is an attendee favorite.
• A top-notch educational program: Share in the success of a proven winner.
• Exclusive exhibit hall hours: Develop valuable prospects and reconnect with current customers through one-on-one networking during three days of scheduled activities and breaks (Sunday evening through Tuesday at noon).
• Long-term benefits: Your company will receive a 6-month pre-and post-show marketing (deadline applies)
• Complimentary electronic attendee registration list for pre- and post-show marketing
• Opportunity to add a marketing giveaway to the conference program
• Exclusive opportunity to participate in raffle drawings
• Ability to raise visibility by sponsoring NCCHC activities
• Special advertising discounts for corrections, health departments and other agencies
• Priority booth selection for the 2007 National Conference on Correctional Health Care in Nashville

Who Should Exhibit?

Sponsorship Opportunities
Pump up your presence and maximize marketing dollars through these outstanding sponsorship opportunities.

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

Proceedings Manual: Distributed in popular CD format, the manual provides a lasting record of each concurrent session, including abstracts, handouts and PowerPoint. The sponsor will be acknowledged on the CD cover.

The Internet Cafe: Enjoy a high-tech presence by sponsoring the exhibit hall computer stations, where attendees flock to check e-mail and browse the Web.

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

Other Opportunities: Registration bags, lanyards, cups, badges, banners—all are good ways to gain visibility.

Registration Information
Prices for 10’ x 10’ booths start at $1,100; double-size and premium spaces are available. Prices include one full and two exhibit-only registrations. Other company representatives may register at a discount. For a prospectus with details and a registration form, visit www.ncchc.org or e-mail info@ncchc.org or call 773-880-1460.

Advertisements: Our Readers Are Looking for You!

The leading newspaper dedicated to correctional health care, CorrectCare features timely news, articles and commentary on the subjects our readers care about: clinical care, health services administration, law, ethics, professional development and more. The quarterly paper is free of charge to members of the Academy of Correctional Health Professionals, as well as thousands of key professionals working in the nation’s prisons, jails, juvenile facilities, departments of corrections, health departments and other agencies. The paper also is available online at www.ncchc.org. New in 2007, printed inserts! We also offer special packages for companies that advertise in CorrectCare and exhibit at NCCHC conferences, and opportunities to advertise on the NCCHC Web site. Contact us for details.

Production Schedule

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<th>Insertion Order Due</th>
<th>Ad Copy/Art Due</th>
<th>Distribution</th>
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<td>January 8</td>
<td>January 22</td>
<td>March</td>
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<td>April 9</td>
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<td>June 18</td>
<td>July 2</td>
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Advertising Rates

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Classified Advertising: Ads appear under the following categories: Employment, Meetings, Marketplace. Cost is $1.50 per word for these text-only ads (no logos or graphics). Box your ad with a solid border for an additional $100. Text for classified ads should be submitted in electronic form (e.g., via e-mail).

For More Information
To learn more about advertising and other marketing opportunities, call Lauren Bauer, 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.

About CorrectCare™
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.

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

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 jaimeshimkus@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.

Notes
1. Ad sizes encompass live area, no bleeds.
2. Color ads cost $250 per color additional per page or fraction.
3. Frequency discounts are based on total number of insertions within the next four issues. Ads need not run consecutively.
4. Recognized advertising agencies receive a 15% discount on gross billings for display ad space and color if paid within 30 days of invoice date.
5. Electronic files preferred (Quark, PageMaker or PDF); include font files. Word processing files (e.g., Word, WordPerfect) are not accepted. Camera-ready copy and film (120 line, right reading, emulsion side down) are accepted. Proofs must accompany all ads.
6. Ad materials for black & white display ads must be provided in black & white.
7. Cancellations must be received in writing before the insertion order deadline.
8. NCCHC reserves the right to change rates at any time. NCCHC reserves the right to charge a fee to make copy and design changes.
9. Acceptance of advertising does not imply endorsement by NCCHC.

22 FALL 2006 • CorrectCare www.ncchc.org
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 statewide coverage. Physicians in ODOC are employed directly by the State of Oregon, which provides malpractice coverage. No office to run, no insurance forms or billing. ODOC is recruiting physicians for rural Eastern Oregon. Rural practitioners in the state have a dry, high-desert climate. Immediate area, including wintersports, recreation is available and plentiful in the area.

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Health Issues Among Incarcerated Women. This comprehensive book features 20 essays that address the challenges of health care delivery that meets the unique physical and mental 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, 490 pages, $50


• National Conference on Correctional Health Care Proceedings on CD-ROM. The proceedings contains program abstracts, outlines and handouts from the 100 educational sessions at the 2006 National Conference in Atlanta.

Addressing clinical issues, administration, mental health, legal topics, juvenile health and more, this is a great resource in a convenient format. $10

Meetings

Sheriffs’ Conference. The National Sheriffs’ Association is holding its winter conference Jan. 31 through Feb. 4 at the JW Marriott hotel in Washington, DC. For information, visit www.sherriff.org, or e-mail rosmin@sheriffs.org.

American-Canadians and AIDS. The 2007 National Conference on African-Americans and AIDS will take place Feb. 12-13 at the Sheraton Philadelphia City Center. The meeting is hosted by Minority Healthcare Communications, Inc. For more information, visit www.minorityhealthcare.com, or call 610-396-6670.


Addiction Medicine. The American Society of Addiction Medicine will hold its 36th Annual Medical Scientific Conference April 26-29 at the Doral Resort and Spa in Miami, FL. Learn more at www.asam.org, or call 305-656-3920.

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Thirty years after the first National Conference on Correctional Health Care, this annual meeting is unparalleled in terms of the professionals who attend, the education it provides and the networking it offers. And this year was something special. NCCHC and Academy conference planners aimed to take this meeting to the next level, and they did. Held in hospitable Atlanta, GA, the meeting offered significantly more advanced level sessions, including a track devoted to longer sessions on leadership topics. Another track focused exclusively on hospice care, a growing concern in corrections. A popular extracurricular activity was a tour of Centers for Disease Control facilities. As always, the meeting also featured in-depth preconference seminars, a chance to meet and mingle during the opening reception in the exhibit hall (which was packed with the top companies serving this field), sessions on the hottest topics by knowledgeable presenters, keynote addresses by eminent dignitaries and so much more. And since the Tuesday night party fell on Halloween ... well, the pictures are worth a thousand words.

**Leading lights.** After his moving speech, Harrison Award of Merit winner David Satcher, MD, PhD, shared a moment with Academy board chair Michael Adu-Tutu, DDS, MBA, CCHP-A (L) and NCCHC board chair George Pramstaller, DO, CCHP (R). Satcher’s impressive resume includes a term as U.S. Surgeon General. (See page 3 to learn more.)

**Editor exemplar.** When Mike Puisis, DO, rose to accept the Anno Award of Excellence in Communication on behalf of *Clinical Practice in Correctional Medicine*, he was accompanied by nearly a dozen of the 60-plus associate editors and authors who contributed to the book.

**Well represented.** The NCCHC booth was in capable hands when these ace accreditaton surveyors were in charge. L-R: Janice Hill, RN, MPH, Charles Lawrence, RP, PD, CCHP, and Ellyn Presley, RN, CCHP.

**Learning for leaders.** The Leadership Series sessions were packed with correctional health pros who are, or want to become, leaders in this dynamic field.

**Take a load off.** Nothing wrong with putting your feet up during a long day of high-quality education!

**Persuasive.** No, these lovely ladies were not demonstrating new procedures for gaining patient medication compliance. But they did attract a lot of attention on the dance floor at the Halloween party on Tuesday night.

**Mob scene.** The award-winning *Clinical Practice* was already a bestseller for NCCHC, but it really flew off the shelves at the conference bookstore. If we sold out before you bought your copy, don’t worry: We have plenty more back at HQ.

**Celebrity boxers.** Exhibitors provided oodles of fab prizes for the exhibit hall raffles, but one of the zaniest was boxer shorts autographed by Sheriff Joe of Maricopa County, AZ. (Thanks to the lady pirates at Medical Staffing Network for livening up the exhibition?)

**Incongnito.** Not sure who these Halloween party-goers are, but maybe that’s just as well: Their authentic gangster get-ups were just a tad intimidating!