One Facility’s Response to Its Nursing Shortage

BY GWEN BOYD, BSN, MA, CCHP

L
ike many states, Missouri is experiencing a significant shortage of registered nurses. This shortage is felt in every health care facility, public and private alike. Still, it is no secret that many state-operated facilities have shortages far worse than in the private sector. Despite the stability of state employment and abundant benefits, these facilities can’t compete in terms of wages and resources, not to mention extravagant lures such as large sign-on bonuses, total tuition or loan reimbursements and other incentives.

However, one state facility has developed a homegrown solution that not only helps the nurses during this critical time but also invests in its workforce by upgrading the skills necessary to meet the challenging care needs of the clients. This approach could help other state facilities deal with their own nursing shortages.

Rising Need for Skilled Care

The St. Louis Psychiatric Rehabilitation Center is a 212-bed inpatient facility operated by the Missouri Department of Mental Health. SLPRC treats adults with severe mental illnesses. About 80% of its clients come from the criminal justice system and were involuntarily committed by the court system. (See page 20 to learn more about SLPRC.)

As the average age of our clients has increased, along with the severity of their mental illnesses and medical diagnoses, so too have their needs for assistance with activities of daily living (bathing, grooming, feeding, etc.). Some of the nurses said that SLPRC is beginning to look like a nursing home, with the advent of indwelling urinary catheters, a gastrostomy tube, tracheostomy care and periodic use of canes, walkers and wheelchairs.

In fact, between 2000 and 2006, about 42% of the clients were discharged to a residential care facility and 12% went to a skilled nursing facility. This shows a clear need for oversight either due to their mental impairment alone or in combination with their physical care needs.

Evolution of a Solution

Faced with this changing psychiatric client profile, the growing demand for nursing care and fewer nurses due to attrition, SLPRC had to find a way to meet these challenges without an influx of new financial resources. Recognizing that employees are our greatest asset, we assessed our human capital and tapped into it.

The psychiatric aides are an invaluable resource. These paraprofessionals outnumber the nursing staff by roughly 4 to 1 and in many instances they interact directly with the clients the most. However, they were in need of an opportunity to upgrade their skills.

In 2005, we launched a certified nursing aide program for the psychiatric aides. As a former nursing home inspector, I was familiar with long-term care regulations and the nurse aide training programs in nursing homes certified by the Centers for Medicare and Medicaid and licensed by the Missouri Department of Health and Senior Services. I applied the same concept to SLPRC, with some modifications. This is the first program of its kind to be offered in a Missouri mental health facility.

To set up the program, I attended a two-day seminar to become a qualified instructor and examiner. I then made application and received permission from the Department of Health and Senior Services for SLPRC to become an on-site training agency.

Other expenses were moderate and included training tapes, manuals and a manikin. Each CNA candidate paid the $50 exam fee. The one training consists of a 16-hour orientation module with emphasis on the needs of geriatric patients— including emergency care, infection control and prevention of abuse and neglect—and 100 hours of on-the-job training in basic nursing. The basic nursing skills include vital signs, signs and symptoms of hyper- and hypoglycemia, amputation, range of motion, normal signs of aging, incontinence care, nutrition, food sanitation, promotion of self-care and basic anatomy and physiology.

The psychiatric aides also are educated on mentoring, leadership, team building, effective communication, conflict resolution and basic psychiatric forensic nursing (including substance abuse awareness and suicide prevention).

Continued on page 20

Continued on page 20

Dental Treatment

Heads Up on New Health Assessment Standard

Managing inmate health care is fraught with difficulty. NCCHC understands that better than anyone. That’s why we are pleased to announce an important change to our Standards for Health Services that will transform health assessment in prisons and jails.

To be unveiled at the National Conference on Correctional Health Care, this forward thinking change permits greater flexibility in health care delivery. The likely consequences are many: better staffing and care, improved patient outcomes, fewer legal risks and potential cost savings.

For over 30 years, NCCHC has led the movement to improve correctional health care, setting national standards that enable facilities of all types to provide constitutionally acceptable care. These standards are endorsed by the medical community and accepted in the courts.

Having guided thousands of facilities of all types and sizes, we are the world’s leading authority on correctional health care. At the same time, we work with our supporting organizations and other leading professional health care associations, and keep close tabs on community practices to ensure that our correctional health care standards are clinically sound and state-of-the-art.

The forthcoming new standards will be reviewed at the National Conference during the preconference seminars on Saturday and a concurrent session on Wednesday. The meeting takes place Oct. 13-17 in Nashville. See the back page for more information, or visit www.ncchc.org.

We look forward to giving you steadfast support throughout the process of transitioning to the new standards.
Did Somebody Say Redesign?

You spoke, we’re listening. As reported in the last issue, our reader survey gave CorrectCare a big thumbs up ... except for that clumsy old tabloid format. So we’ve recruited some creative geniuses to give us a new look and, best of all, a trimmed down size. Stay tuned!

Public Health Agencies Join the Accreditation Bandwagon

A new nonprofit organization will administer a voluntary national accreditation program for state and local public health departments. The Public Health Accreditation Board is the initiative of NCCHC two supporting organizations—the American Public Health Association and the National Association of County and City Health Officials—with the Association of State and Territorial Health Officials and the National Association of Local Boards of Health. According to PHAB, the reasons for offering accreditation are simple: accountability and quality improvement. The program is meant to:

• Promote high performance and continuous quality improvement
• Recognize high performers that meet nationally accepted standards
• Clarify the public’s expectations of state and local health departments
• Increase the visibility and public awareness of governmental public health, leading to greater public trust, increased health department credibility and accountability, and a stronger constituency for public health funding and infrastructure. Learn more at www.phaboard.org.

Board Member Update

NCCHC welcomes the following three new members to its board of directors.

• Patricia Blair, PhD, LLM, JD, MSN, is the representative of the American Bar Association. She is a law health attorney in private practice and an adjunct associate professor at the University of Texas at Tyler.

• Robert Gogats, MA, is the representative of the National Association of County and City Health Officials. He serves as the health officer for the Burlington County Health Department, Westampton, NJ.

• Ronald Wiborg, MBA, is the representative of the National Association of Counties. He is the contracts and grants manager for the Hennepin County Department of Community Corrections, Minneapolis, MN.

In other board news...

• Carl Bell, MD, CCHP, moderated a Capitol Hill briefing in honor of National Children’s Mental Health Awareness Day. A coalition of national mental health, counseling and education organizations attended. Bell is executive director of the Community Mental Health Council, Chicago, and represents the National Medical Association on NCCHC’s board.

• Klemethe Caruso, MSN, CCHP, was elected to the board of directors of the Texas Nurses Association. Caruso is vice president for patient care operations and chief nursing officer at the University of Texas Health Center at Tyler. She represents the American Nurses Association on the NCCHC board.

• Douglas Mack, MD, CCHP, attended the American Medical Association House of Delegates meeting on behalf of NCCHC. Now "retired" in Colorado, he represents the American Association of Public Health Physicians. He also recently completed a 300-mile “Ride the Rockies” biking event.

Let Your Mouse Do the Walking

NCCHC Launches Online Correctional Health Care Buyer Guides

If you source or purchase products for your department, you now have a powerful tool at your fingertips. The NCCHC Buyers Guide is a search engine that continually indexes the Web sites of all companies represented in the directory. Visitors can easily locate products and services unique to this field without the clutter of a general Internet search. The Buyers Guide gives you the option of performing a keyword-driven search that mirrors traditional search engines, or a category-specific search. Both methods produce the most relevant results on the Web. With the downloadable desktop search application, you can search for products and services from a small window on your desktop, making the process both convenient and time-efficient. The Buyers Guide also includes a Request for Proposal (RFP) tool that enables you to contact a group of suppliers with one click of a button.

New Books in the NCCHC Catalog

Bates’ Pocket Guide to Physical Examination and History Taking. This handy book presents the classic Bates approach in a quick-reference outline format, with easy-to-understand technique examples, abnormalities and interpretations, and over 500 color images. This edition gives greater emphasis to patient communication and interview techniques, and has a new chapter on older adults. A CD-ROM has a PDA download with outlines of exam procedures and techniques. LWW (2005). Softcover, 416 pages, $39.95.


Rosen and Barkin’s 5-Minute Emergency Medicine Consult. This best-selling reference is thoroughly updated with practical information on over 600 clinical problems, including current information on emerging infections, new protocols and new treatments. Coverage includes clinical presentation, prehospital, diagnosis, treatment, disposition and more. The fast-access two-page outline format is perfect for on-the-spot consultation, and icons make it easy to quickly spot the information you need. LWW (2006). Hardcover, 1,336 pages, $84.95.
Improve Perceptions, and Budgets, Via Fiscal Self-Defense

BY ROBERT BRADFORD, MHA

O
ternational health care is something like this: (1) Inmates get too much health care, more than free world people, and (2) It costs too much. I’m not exactly sure why this perception is so pervasive; but it is consistent. It’s as if there is a script lying around somewhere. There are a lot of misconceptions about corrections in general so you may be tempted to dismiss it, assuming it is one of those things people choose to believe and probably benign.

Corrections to do this education and exercise some “fiscal self-defense” for correctional health.

First, we looked at how our costs compared to other entities in the managed care industry. We found that our costs were not only comparable, but also often significantly less per capita than entities such as Medicaid and HMOs. Also, we are finding that our system is often ahead of other insurers in terms of utilization management, preventive care and drug formulary management. I don’t mean to cast aspersions on any other provider (they have their own tough challenges) but to provide some perspective and defeat myths.

Next, we started getting the message out by getting an audience with legislators and state fiscal officials whenever and wherever we could. Sometimes our own field staff were our best links since many of them knew legislators in their communities. In these meetings we point out all of the issues that necessitate our services (history, court decisions) and drive our costs (morbidity in the inmate population, the need to bring the care to the patient). Then we let them know every initiative we had done and plan to do. Most were surprised that we had already implemented most advanced care industry tactics and were so competitive with free world providers.

Make no mistake, there is no expectation that politicians will ever expend political capital championing health care for prison inmates. But we can already see that some understanding of our issues is taking root with this audience and we hope that will change the discussion in less public forums where decisions are often made. This will surely serve us better in the future than leaving them to their perceptions.

Robert Bradford, MHA, is the managing director of Georgia Correctional Health Care, Augusta, a division of the Medical College of Georgia that provides health care services to the Georgia Department of Corrections.


Put Them in Coach, They Are Ready to Play

It is with wide-eyed astonishment that I read of unfolding events in California and Michigan. Last year, a federal court judge appointed Robert Sullen (a local public health director) to oversee the costly and apparently dismally health care system at the California Department of Corrections. In Michigan, Robert Johnson (a former HMO CEO) has been hired to fold the Department of Corrections health care system into an HMO model due primarily to cost.

These fellows are no doubt superb in every measure and my beef is not with them. Rather, why are systems turning to others when a wealth of experts from outside corrections are manned by our players.

Perhaps the greatest twist of irony is the fact that these new experts will undoubtedly join our team. It is only a matter of time before they adopt our proven integrating strategy. They will begin to play as we do because this is what wins the game. I welcome them, but also lament the fact that our starters never had the chance.

Richard Garden, MD, CCHP
Clinical Director
Utah Department of Corrections

Hep C ‘Cure’ Not All It Seems

I just read the Spring 2007 issue (Vol. 21, Issue 2). One news item struck me as odd. “Study Demonstrates Potential Cure for Hepatitis C” (p.17) makes it sound like 99% of patients who are treated [with peginferon alfa-2a] will be cured of hepatitis C. Even the AIDSinfo At-a-Glance seems to indicate this. This is at odds with my own experience and that of which I’ve read over the years. Indeed, when I checked the study [see www.newswise.com/articles/view/530150], I found that actually meant that 99% of those who responded to the treatment could be cured. This is a big difference because only about 50% or less will respond to the treatment.

You might want to clarify this before there is a big clamor to get everyone identified and treated with this expensive, partially effective, difficult-to-take treatment.

William Rankin, MD
Medical Director
East Moline (IL) Correctional Center
Desire to Help Youth Drives CCHP’s Career

BY MATISSA SAMMONS

For Kelly Robinson-Bethea, MD, CCHP, correctional health care was a track she began very early in her career, and one that would prove to bring fulfillment in many areas of her life. In fact, this path seemingly chose her when in 1997 she began a fellowship at Christiana Care Health Systems, Wilmington, DE, where the correctional health care specialty was part of her training in the division of adolescent and young adult medicine. During the fellowship she served as a medical administrator in Delaware’s juvenile corrections system, where the medical director, who was nearing retirement, primed her to step into that role.

Betha took the position in 2000. It wasn’t all smooth sailing. “It can be a challenge to work within a system you have no control over,” she says. Still, she found great satisfaction and reward working with this population.

Conference Leads to Love
That same year, Bethea attended NCCHC’s National Conference in St. Louis, where she presented a session on substance abuse in the juvenile correctional system. While attending a preconference seminar luncheon, one of many networking events at the conference, Bethea met Vern Bethea, assistant chief operating officer at the New York City Department of Corrections. Bethea says he was very friendly, maybe overly friendly. But that was fine, because she was greatly enjoying herself lunching with other attendees she had befriended that morning.

On her way to dinner that night, she ran into LaVern again. They started talking and found out they had far more in common than correctional health care. They enjoyed spending time together and soon forged a friendship.

Two years later, Bethea moved to New York to become the medical administrator for two small correctional facilities in Brooklyn. She and Vern soon married and they now have two children, ages 16 months and three years.

Positive Impact
Shortly after the St. Louis conference, Bethea pursued certification as a way to strengthen her involvement with and support of the health care of incarcerated youth. She believes that juveniles are a misunderstood population typically viewed as “bad kids” rather than as individuals. She notes that in a range of ages from 11 to 19, some are teenagers, some children, but all are essentially still kids. By and large they’ve had no opportunity, nor role models, to learn to become adults.

Bethea says it is a responsibility, especially when working with juveniles, to appreciate the impact an advocate can make on an impressionable population. With every youth she sees, she asks what they want to be when they get older and a light bulb seems to turn on—a realization that they in fact have a future, and that someone cares to ask.

At present Bethea is an assistant professor of pediatrics and an attending physician for the division of adolescent medicine at Children’s and Women’s Physicians of Westchester, NY. She also serves at two group homes in Pleasantville.

But she is feeling a tug to work with youth in the justice system and is planning to return to some form of correctional health care. “I miss the opportunity to have a positive impact on someone’s life. It’s very rewarding when you help a juvenile to realize their unrecognized potential.”

Matissa Sammons is the certification coordinator at NCCHC.

Board Welcomes New CCHPs
The CCHP board of trustees congratulates the latest professionals to earn certification in correctional health care. Through dedication and study, these new CCHPs have demonstrated mastery of national standards and the knowledge expected of leaders in this field. The 103 individuals listed on page 5 passed proctored examinations in May, June and July at test sites across the country, including Florida, Missouri, Nevada, North Carolina and Wisconsin. They join thousands of correctional health care professionals who have earned this distinguished credential.

Not a CCHP yet? To learn how you can become certified, visit us online www.nechec.org or call 773-880-1460.

CCHP Activities at the National Conference
CCHP Lounge
Kick back and relax in this “VIP club” for CCHPs and their guests. Think of it as an oasis away from the hustle and bustle of the conference activities. Sponsored by the CCHP board of trustees, the lounge is open Monday through Wednesday during regular conference hours.

Advanced CCHP Roundtable
CCHP-As are invited to attend this exclusive meeting of some of the most experienced and knowledgeable leaders in the correctional health care field. Mark your calendar for Tuesday, Oct. 16, 8:15 to 9:15 a.m.

CCHP Exam Dates & Locations
• Oct. 14: Nashville, TN – at the National Conference on Correctional Health Care
• Feb. 23: Regional sites to include Rancho Cucamonga, CA, Ludlow, MA, Guaynabo, PR, and others to be determined
• May 18: San Antonio, TX – at the Updates in Correctional Health Care conference
• Aug. 23: Regional sites to be determined
• Oct. 19: Chicago, IL – at the National Conference on Correctional Health Care

We will try to accommodate candidates who are farther than a three-hour drive from a test site. Please make your request for a test site near you at least 90 days in advance.

Visit the CCHP Web page at www.nechec.org for the most up-to-date list of exam dates and locations. You also can download the application booklet and study guide at the site, and can complete an online application form.

If you are interested in hosting an exam at your facility or volunteering to proctor an exam, please contact certification coordinator Matissa Sammons at cchp@nechec.org or 773-880-1460, ext. 277.
Congratulations to the 103 Newest CCHPs!

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<td>Mark DiAlesandro, MS, CCHP</td>
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<td>Prison Health Services</td>
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<td>Tracy A. Cook, RN, CCHP</td>
<td>Hastings Youth Academy</td>
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<td>Steven P. Ritter, DO, CCHP</td>
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www.nccchc.org SUMMER 2007 • CorrectCare 5
These are some of the activities and events being planned by and for Academy members at the National Conference on Correctional Health Care. For the most up-to-date schedule of events, visit our Web site: www.correctionalhealth.org.

Welcome Reception
Monday, Oct. 15, 4:30 to 5:30 p.m.

The Academy of Correctional Health Professionals is proud to be a cosponsor of the conference. Please join us on Monday afternoon for a welcome reception. This is an ideal opportunity to network with your colleagues. Enjoy light refreshments while you learn more about the Academy and the benefits of membership. Open to all attendees.

Exhibition
Sunday, Oct. 14 - Tuesday, Oct. 16
Stop by the Academy booth (#220) to check out our Web site demo, cast your vote for the board of directors, meet other members and volunteers, sign up to become a mentor or just say “hi.”

Shared Interest Discussion Groups
The Academy’s education committee invites you to participate in the annual roundtable discussions. Based on feedback from past participants, we’re changing the format this year: The discussion groups will take place throughout the conference during regularly scheduled concurrent sessions. This will give each group more room to spread out and make it easier to hear.

The roundtable discussion groups are small, informal gatherings for the purpose of education, information sharing and idea exchange. They also provide a unique opportunity to meet other conference attendees. You need not be an Academy member to participate.

Fifth Annual Academy Day
Tuesday, Oct. 16
Help us celebrate Academy Day by participating in the special activities taking place throughout the day, including raffles in the exhibit hall, special discounts on membership and the annual meeting. Show your pride in the Academy and your profession by wearing your Academy apparel on Tuesday.

Annual Membership Meeting
Tuesday, Oct. 16, 5:15 to 6 p.m.
The annual meeting of Academy members will take place at the convention center immediately after the day’s educational program. The agenda will feature reports from committee chairs and staff, results of the 2007 election, a call for volunteers and time for questions.

Career Advancement Made Easy
The Academy CareerCenter is the premier online career resource for correctional health professionals. We understand your career needs and have the right employers who can appreciate your experience and talent.

Advanced Features to Enhance Your Experience
Whether you are looking to advance your career or just want to update your résumé, the CareerCenter is your first stop in managing your career.

• Job Agent: Set your criteria and have select jobs come to you by RSS or e-mail.

• Document Manager: Post up to five documents—published articles, research papers, partial portfolios and more!

• Manage Your Search: Use Save Favorite Jobs and Application History to manage your job search.

Post Your Résumé Today
The first 50 members to post their résumé (through Nov. 15) will be entered into a raffle to receive one year’s free membership.

Annual Board & Committee Meetings
Members of the Academy’s committees will meet throughout the conference in preparation for their annual report to the members and board of directors. In addition, the newly composed 2008 board of directors will meet to review business from the past year and to establish priorities for the coming year and beyond.

National Conference Scholarship Winners
After careful deliberation of the many applications received, the Academy’s education committee has awarded scholarships to the following members.

The scholarships cover the $325 registration fee and a $300 travel stipend to attend the National Conference on Correctional Health Care in Nashville.

• Diana Antonio, BSN, CCHP, a nurse at the Marvin County Jail, Napa, CA
• Darlene Huff, CCHP, a medical technician at the Abraxas Youth Center, South Mountain, PA
• Amy Randt, LPN, CCHP, a nursing supervisor at the Abraxas Youth Center, South Mountain, PA

Committee members unanimously agreed that these three candidates met the scholarship criteria and cited their dedication and enthusiasm. Says Huff, “I look forward to attending the conference, not only as a break from family and work but also for the opportunity to grow professionally in our greatest pride, the medical care we provide to our kids (clients).”

We look forward to hearing back from our scholarship winners on their conference experience!
“There is also concern that because of past experience with an HSU [health services unit] staff member, an inmate at RCI may target that staff member for harm, because of a perception of inadequate care” from that staff member. The defense decision says, although it gives no more detail about the “past experiences.”

Because the inmate in Simpson was trained not to listen, he offered no expert testimony to challenge the concerns expressed by the defendants.

The Case Law Applied

In both cases, the courts accepted the principle that there is a “Fourth Amendment right to privacy that protects medical information related to a particular inmate’s HIV status from unjustified disclosures by governmental actors.” Both cases grounded their right of privacy conclusion on two circuit court decisions, Doe v. Delie (3rd Cir. 2001) and Poезд v. Schriver (2nd Cir. 1999).

In both those decisions, recognize the right, they agree that its scope is limited by the Turner test. Thus, legitimate penological interests in conflict with the right can reduce its scope. Doe and Poезд both say that in evaluating tensions between the right and legitimate penological interests, courts must give considerable deference to the judgments of prison or jail officials.

In both Richey and Simpson, the court found that the disclosures the plaintiffs complained of did not cross the constitutional line.

In Richey, the court did not use the Turner test magic wand to dismiss the test in the following language: “We do not believe a detainee’s constitutional right to privacy is violated when he is segregated, given meals on foam trays, his activities are restricted, or those he is in close contact with are advised of his HIV positive status. Detention center personnel have an obligation to take necessary measures for their own safety and the reasonable safety of other detainees.” In making this statement, the court did not engage in anything close to a searching examination of reasons behind the defendants’ actions, especially how telling another inmate about Mr. Richey’s HIV status furthered a legitimate penological interest.

In Simpson, the court clearly applied the Turner test, its discussion of the issue beginning with the words: “If the challenged RCI policy is reasonably related to a valid penological interest, there is no constitutional violation.”

Can Who Be Told What?

One of the oldest questions about inmate medical privacy is whether every staff can be given information about an inmate’s medical condition. This question became controversial when HIV arrived in prisons. Could custody staff be told “Inmate X is HIV positive”? The response of the medical profession and from inmate advocates was an emphatic “no.” Telling staff meant that sooner or later, other inmates would know, and at least in the 1980s, that meant the HIV-positive inmate would be in danger.

The alternative was “universal precautions.” Assume everyone has some sort of communicable disease spread through blood or other bodily fluids. While the professional community embraced the concept of universal precautions, courts have never endorsed the medical profession’s hand wagon regarding HIV status disclosures. There is certainly no body of case law that condemns such disclosures or sets bright lines rules about what can and cannot be revealed to custody staff about an inmate’s medical problems.

These two decisions continue that trend. Both involve disclosure of very sensitive information and neither judge spent any time or worry in saying the disclosures did not violate the inmates’ right to privacy, even to the extent not to condone telling an inmate about another inmate’s HIV status.

These cases would help a defendant caught in a similar case to argue for qualified immunity. With these two federal district courts’ results, how can it be said that an inmate has a clearly established right that puts his HIV status (or other sensitive medical information) off limits to nonmedical personnel?

The Pro So Disadvantage

A common problem in a pro se case involving a Turner test legal question is that the plaintiff, who is not an expert, has no expert to support his contentions and must use data obtained through discovery to rebut the defendants’ security assertions.

What is the rational connection between institutional safety and security and telling an inmate that another inmate is HIV positive? Or posting a sign on the inmate’s cell that says “HIV”? Was there a history of inmates from segregation assaulting medical staff. What is the likelihood of disclosure in other prisons? Was there any indication that officers who sat in on medical exams in fact kept whatever they heard confidential?

As an example of the inherent problems the pro se inmate faces, the plaintiff in Simpson argued that the institution’s security needs would be met if the officer remained outside the exam room. Officials said the officer would not be able to make an “immediate response” if the inmate “turned violent” and that the officer’s physical presence deterred aggressive behavior. The plaintiff said these concerns were exaggerated but the court brushed this aside, saying “plaintiff is not a security expert and has not produced evidence from any person with qualifications in the area of prison security to controvert the defendants’ evidence.”

This one-sidedness leaves one wondering if the results might have been different had the plaintiffs been represented by counsel who could have provided expert testimony.

William C. Collins, JD, is the coeditor of Correctional Law Reporter. This article was originally published in the June/July 2007 issue of CLR. ©2007 Civic Research Institute, Inc., and is reprinted here in abridged form with permission of the publisher. All rights reserved. For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 556, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.
Dental Care for the Medically Compromised Patient

BY MARK SZAREJKO, DDS

Many inmates share two basic problems: poor oral health and one or more chronic medical conditions. The extent of decay and periodontal disease leaves many teeth beyond repair, with their surgical removal the only method of definitive treatment.

Oral surgery patients must be able to withstand the physical and emotional demands that the procedure places on them. But a coexisting medical condition can undermine the dentist’s ability to perform even a minor surgical procedure. And if the patient is taking medications for that condition, the normal intraoperative use of antibiotics, analgesics and local anesthesia may need to be modified.

Before initiating any invasive treatment the dentist must review the medical history with the patient. It may have been many months since the initial physical assessment was completed, so it must be noted if any changes have occurred, if medication dosages have changed or if a new medication has been prescribed. This review should be noted on the medical chart. If there is any doubt or conflict as to the accuracy of the medical history, the medical director should be contacted.

This article will highlight how the most common medical conditions can affect the delivery of dental treatment.

Hypertension

Hypertension was the most common medical problem among the dental patients in our jail. The concern is that a surgical procedure may trigger anxiety that can cause an already elevated blood pressure to attain levels that could jeopardize cardiovascular health.

Clinical judgments vary as to the blood pressure levels beyond which surgery should not be performed. I use a reading of 160/100, in any combination, as the cutoff where I would defer oral surgery until the readings were lowered. In several cases, patients have been referred to the medical department when their BP remained elevated.

Many local anesthetics contain vasoconstrictors, such as epinephrine or levonorgestrel, that benefit the patient during the oral surgery. These compounds decrease systemic absorption of the local anesthetic and prolong its effect, and help to minimize bleeding. However, they also can increase blood pressure, so the least amount possible must be used.

Also, since dental pain can raise blood pressure, preoperative analgesics that do not interact with the blood pressure medications can be prescribed.

Cardiac Disease

Closely related to hypertension is cardiac disease, and many patients present with both. In such cases, the precautions used for both conditions must be followed.

When oral surgery was indicated for patients with cardiac disease, my protocol is to consult with the medical director to determine if the cardiac function is of sufficient quality to withstand the rigors of oral surgery.

Elective dental treatment should be deferred for any patient who has had a heart attack in the past six months. It is during this interval that the chance for a second heart attack is the greatest. Similarly, a patient with unstable angina in which chest pain occurs at rest also is not a candidate for oral surgery because this degree of instability could be a precursor to heart attack.

If pain or infection of dental origin requires dental treatment during the six-month period following a heart attack, it should be done in the office of a practitioner or a hospital-based dental program that can monitor vital signs and can respond to a cardiac emergency. The same is true of patients with uncontrolled cardiac arrhythmias.

Many cardiac patients are on anticoagulant medications such as warfarin, clopidogrel and aspirin. These drugs can prevent a blood clot from forming within the extraction site and the resultant oozing can be difficult to control. The dentist must consult with the prescribing physician before surgery is performed on these patients. Usually, the medications can be discontinued before surgery and resumed the day after. The schedule must be followed exactly as directed by the physician, with appropriate orders made in the pre-

Continued on page 9
scribing record. To confirm that the patient has discontinued the anticoagulant therapy, the dentist should check with the nursing staff member who dispenses medications before the patient returns for treatment. It is equally important to make sure that dispensing of these medications is resumed.

Care must be taken when prescribing medications for dental problems in patients with cardiac conditions because these patients may be taking several cardiac medications and drug interactions may result.

Liver Disease

Many inmates are infected with hepatitis B or hepatitis C viruses as a result of years of injection drug abuse and alcohol abuse. The latter also leads to cirrhosis. However, problems associated with the liver may manifest with mild or no symptoms.

The liver is an important organ with a multitude of functions. Those that relate to dentistry include drug metabolism and the synthesis of coagulation factors that help enable blood to clot properly at an extraction site. A liver that is cirrhotic or infected with the hepatitis viruses may not be able to perform these functions.

Several local anesthetics, antibiotics and analgesics used in dentistry are metabolized primarily by the liver. Compromised liver function could reduce the ability to clear these drugs from the system. Therefore, a dosage that is usually safe and effective when the liver functions normally can reach levels that constitute a toxic buildup.

Tests that measure liver function and enzyme levels can be used to assess its ability to work properly. A physician should be consulted about the test results to determine if dental treatment, especially oral surgery, and medication regimens should be modified, deferred or changed completely.

It is a rare occasion when a patient who has had a liver transplant can receive dental treatment in a correctional facility. The medical director must be consulted before any invasive procedure is performed. Immunosuppressive medications designed to minimize the chance of host rejection of the transplant and anti-inflammatory medications such as prednisone will impair the patient’s ability to fight infections and will prolong surgical recovery.

Diabetes

The problem of delayed recovery from surgery also applies to patients with diabetes mellitus. This complex disease poses difficulties for patients of all ages. Dental considerations include delayed surgical healing and a higher potential for postoperative infections. Prophylactic antibiotic coverage and postoperative antibiotic therapy may be needed for these patients.

Insulin-dependent patients should take their normal dosage of insulin and eat their usual allotment on the day of surgery and for their postsurgical course. If eating is difficult due to postoperative pain or the need to avoid surgical sites, liquid supplements can be used to provide nutrition and to maintain the proper blood glucose levels. These levels also should be monitored before the surgery is performed.

It is imperative that diabetes patients understand the dangerous consequences of eating minimally or not at all (because of postoperative pain) while still taking their normal dose of insulin.

Blood glucose levels that are a concern because they are too high or too low before surgery are a reason to defer surgery and to immediately refer these patients to the medical department.

Safety First

Meeting the dental needs of the correctional population in a safe manner requires diligence to identify and monitor any existing medical problems. This discussion has focused on some common medical conditions and their impact on dental treatment. There are numerous other medical problems that affect the inmate population. Each condition must be evaluated and, if necessary, referred to the medical department to determine any treatment modifications that may be needed. Our goal should be to minimize the chance of a dental procedure ending in a medical emergency.

Mark Szarejko, DDS, has practiced in a jail setting in Florida for six years. He will speak on this subject at the 2007 National Conference on Correctional Health Care in Nashville, TN.
Staff Health Fair Celebrates Quality Improvement

By Debbie Raab, Lisa DeBilbo, PhD, and Carl Auffahrl, MS, PA, CPHQ

On June 16, 2007, something strange was happening at the New Jersey Department of Corrections headquarters. There were balloons, juggling, colorful posters, prizes and great food. The crowd was a potpourri, with some people in business attire, some in casual office wear and others in corrections uniforms. All were engaged in lively discussions, celebrating a job well done.

The event was the second annual Performance Improvement Fair. The theme was CQI—Data Mining & Minding Data. Overall, 29 performance improvement teams, representing the work of more than 180 staff, exhibited their work at this festive event. Fourteen correctional facilities proudly displayed examples of their quality improvements at the PI Fair, which provided a forum to share the efforts, the struggles and the results with their colleagues.

The Quality Mission
While continuous quality improvement is a requirement for accreditation by the National Commission on Correctional Health Care, it also is a critical practice for any health care program striving for excellence. NJDOC, like many other correctional departments, has the responsibility to ensure a constitutionally sound health care system in a complex setting that includes a diverse mixture of players and multiple service providers. To this end, the NJDOC is attempting to make PI everyone’s business through multidisciplinary PI teams.

In 2005, the NJDOC’s director of medical services restructured the statewide QI program, emphasizing the partnering of the NJDOC, Correctional Medical Services and University Correctional HealthCare, a component of the Dentistry of New Jersey. This restructuring took existing programs from the two service providers and placed them under the NJDOC umbrella, incorporating elements from both.

This new endeavor also resulted in an expanded QI/PI mission, one that fosters a genuine curiosity in staff to seek opportunities to improve services; dedication to data-driven improvement efforts; and effective dissemination of relevant, accurate and timely information to management and staff. One major outcome of this new focus was the PI Fair.

An important element of this new system is frequent staff training on QI concepts and practices. A general plan/design, measure, assess and improve model was agreed upon by the QI directors for NJDOC, CMS and UCHC. Since 2005, two statewide trainings have been held for CQI participants, presenting key concepts of the model, use of various PI tools and an experiential approach to learning. Small, multidisciplinary groups worked through the steps of the QI model using different tools to develop their own PI initiatives.

The PI teams keep accurate documentation of their efforts, planning sessions and selection of interventions and implementation, as well as monitoring the results. Using guidelines developed by the statewide committee, teams that submit projects will assemble a 36”-by-48” poster to display their efforts. A one-page written summary of each entry is also required to provide an overview of the process and status of the PI activity. This summary is available as a handout at the fair.

A panel of judges representing the three organizations (NJDOC, CMS and UCHC) reviews each poster and

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assigns scores for eight elements: clear planning process, sound and explicit data-gathering design, evidence of use of the QI model, appropriateness of use and analysis of data, evidence of a follow-up plan, visual appeal of the poster, reflection of the NJDOC mission statement ("Protecting the Public—Changing Lives") and a clearly written project summary. The rating is done independently by each judge and then tallied to identify the best performers. The five highest scores determine the winners who receive plaques and ribbons at the event. Afterwards, all posters and awards are displayed at each of the sites and are used for ad hoc training for staff.

On the day of the fair, visitors receive a brochure outlining the day’s activities and projects on display. Senior leadership of NJDOC, CMS and UCHC as well as the PI team members celebrate accomplishment by attending the affair. To keep the event festive, door prizes are raffled off, decorations abound and refreshments are served.

The ceremony acknowledges all staff who worked on PI projects, and all team participants receive a certificate of appreciation.

And the Winners Are...

This year’s first-place team focused on the use of universal precautions in the prison laundry in response to an increase of staph/ MRSA infection cases in 2005. Interventions included use of protective garments for inmates working the soiled-linen line, procedures to protect inmates when changing smocks and washing hands, and ongoing education of laundry workers.

The team reduced MRSA incidence by 36% over a 12-month period. The multidisciplinary team included the director of nursing, the infection control nurse, NJDOC administrator, NJDOC health services manager and the facility laundry supervisor.

Positive clinical outcomes and multidisciplinary collaboration and use of data were the high points of this group.

The second-place team explored the effectiveness of group versus individual therapy at a youth correctional facility. Using a patient self-report outcome measure (BASIS-24), the team found no advantage to one type of treatment over the other. The team concluded that increasing group treatment options might be beneficial because it is a more efficient way to provide treatment and apparently leads to the same patient outcomes. This team was most notable for appropriate use of data.

Increasing “out-of-cell” clinician therapy contacts in administrative segregation was the focus of the third-place PI team. They found that only 50% of administrative segregation inmates had participated in out-of-cell contacts during a three-month period. The team sent brochures to inmates explaining the importance of out-of-cell contacts and letters to escort officers explaining the policy requirement for out-of-cell contact and thanking them for their assistance in achieving compliance with the policy. The team also consulted with custody officers about initiating the use of flexible cuffs.

These interventions resulted in 100% compliance with the out-of-cell contact policy. This PI project highlighted the cooperative efforts of administration, custody and mental health staff. Outstanding accomplishment of positive outcome and inclusion of custody staff are noteworthy.

Other PI teams’ projects include:
- Increasing the number of behavioral health inmates successfully transitioning from different levels of care
- Identification of variablesimpeding the start-up of therapy groups
- Effectiveness of smoking-cessation programs
- The effect of exercise groups on reducing obesity in inmates taking atypical antipsychotic medications
- Still other examples are collaborative efforts to manage diabetes through inmate education, decreasing the use of low-dose Seroquel as treatment for insomnia and reducing the number of inmates returning to the “security threat management” unit.

On the Right Track

After the event, we solicit feedback through a brief survey. Insights gleaned from the results help us to develop better PI fairs and educational offerings for the future. Feedback on this year’s fair was very encouraging, with positive responses for all categories surveyed. The poster presentations were rated on average even higher than the program format, which will change next year to have winning teams give short presentations on their projects.

The QI directors are most pleased with the overall acceptance and commitment to CQI, as fostered by the PI Fair, and plan to continue this pivotal event each year. Teams are already working on projects that will be presented at next year’s fair.

The authors are the quality improvement directors at their respective institutions: Debbie Rosh at the New Jersey Department of Corrections, Trenton; Lisa DeBilo, PhD, at University Correctional Health Care, Trenton, NJ; and Carl Ausfahl, MS, RN, CPHQ, at Correctional Medical Services, Ewing, NJ. To reach them, e-mail deborah.rush@doc.state.nj.us.

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Hand Hygiene: Can We Learn a Lesson From the OR?

BY PETER GRAVES, RN, BSN, CNOR

Multidrug-resistant pathogens such as methicillin-resistant Staphylococcus aureus have become alarmingly common in correctional facilities. Clostridium difficile looms as a potential threat, while others could be lurking in the wings. The risk of transmission and exposure may extend well beyond correctional workers and inmates. Bacteria can be brought home on the hands and clothing of the correctional health care worker, by visitors and by inmates upon release or transfer.

The Centers for Disease Control and Prevention states that the single most important method to reduce the risk of cross-contamination and infection is good hand hygiene. Proper hygiene interrupts the chain of infection and reduces the potential for transmission of infectious agents from the hands of a health care worker. One can never render the skin sterile, but proper hygiene can reduce bacterial counts.

On first glance it seems quite simple, but routine proper performance of hand hygiene is no easy task. In hospitals, where antimicrobial soap, water and waterless hand antiseptics are readily available, hand hygiene compliance has been reported to be surprisingly low. One study found only 48% compliance in a university teaching hospital.

Correctional facilities face even greater impediments, including physical barriers, security and lack of washing facilities. Yet, proper hand hygiene in correctional settings is vital to preventing infections. It must be the cornerstone of every facility’s infection control plan.

So the questions that beg asking in corrections are:

• Does hand hygiene occur with adequate frequency?
• Do the chosen hand hygiene agents have the qualities necessary to disinfect correctional health care providers’ hands?

Back to Basics
To better understand why hand hygiene is so important, we must understand some of the basics, starting with the skin. Skin is our largest organ and serves many roles, one of which is protection. The outer layer is called the stratum corneum. It consists of several layers of cells, layered like loose stonework, which provides an ideal structure and location for bacteria, often called colonizing bacteria, to reproduce.

Bacteria on the skin are classified as either transient or resident. Transient bacteria, such as S. aureus, exist on the surface and are more easily removed or killed with hand hygiene. Resident bacteria reside in the deeper layers and are difficult to remove. Soap (plain or antimicrobial), water and a friction source (e.g., opposing hand) or a waterless antiseptic (alcohol or a combination of alcohol plus an active agent) hand rub are used to remove and/or kill the transient bacteria and as many resident bacteria as possible.

Germs can be passed between people and objects by direct and indirect contact. Hands can become contaminated with bacteria, viruses and soils during normal activities such as unlocking doors or typing on a keyboard, as well as physical contact.

A recent study found that for every 1,000 hospital admissions, 46 patients were infected or colonized with MRSA. This rate is about 10 times greater than previous findings. Are correctional facilities cleaner than hospitals? Anecdotal data indicates that the MRSA infection/colonization rate among inmates probably exceeds that in hospitals.

Clearly, it is important to break the chain of infection. When an opportunity for hand hygiene is missed or it is done improperly, bacteria and soils can be left on the skin. All it takes is a break in the skin for those germs to penetrate the body’s protective system. They only need an opportunity to cause an infection or to be transferred.

Simple Prevention
Routinely washing the hands when gloves are removed or when hands become soiled will increase hand hygiene frequency compared with the current norm. The Association of Professionals in Infection Control and Epidemiology states that gloves should not be a substitute for hand washing.

There are several cleansing agents from which to choose. One obvious choice is plain soap and water. This is recommended when hands are visi-
The Science of Hand Hygiene
Persistence: The ability of the antimicrobial agent to continue to inhibit the regrowth of bacteria after the initial application period.
Cumulative effect: A progressive decrease in the numbers of microorganisms contaminating the site after repeated application of an antimicrobial agent.
Residual kill: The ability of the active agent to continue killing bacteria after the application is complete. Typically measured in hours.

Handwashing facilities can be difficult in overcrowded settings, but if they can be made available, they should be widely and freely available. While barriers to handwashing—such as time constraints, lack of facilities, and unreasonable expectations—may be present, there is no doubt that handwashing is essential. In the context of adverse drug reactions, it is important to understand that handwashing forms an important part of the management of these conditions.

It is important to understand that handwashing forms an important part of the management of these conditions.

In general, infection control programs should be aimed at a combination of the following strategies to control the spread of microorganisms in healthcare settings:

1. Implementing standard precautions
2. Using personal protective equipment
3. Practicing proper hand hygiene
4. Proper disposal of healthcare waste
5. Providing proper isolation

These strategies can help reduce the spread of microorganisms and prevent the occurrence of nosocomial infections. However, it is important to note that the effectiveness of these strategies depends on the adherence to them by healthcare workers and the availability of necessary resources.

In conclusion, handwashing is a crucial component of infection control programs in healthcare settings. It is essential to ensure that healthcare workers are trained to adhere to proper handwashing techniques and have access to necessary resources to implement infection control strategies effectively. Regular monitoring and evaluation of infection control programs are necessary to ensure their effectiveness.

Peter Graves, RN, BSN, CNOR, is a senior clinical nurse consultant with Mohaly Health Care US, LLC, Norcross, GA. Reach him by e-mail at peter.graves@mohaly.com.

Brustey Mosher Squibb GILEAD

Pepper City, CA 34940

FTC + TDF + EFV (n=257), AZT/3TC + EFV (n=254), respectively: diarrhea (7%, 4%), nausea (8%, 6%), vomiting (7%, 4%), pyrexia (4%, 8%), and abnormal liver function tests (6%, 6%). The most common treatment discontinuation events were due to adverse events, reported in 12% of patients in the FTC + TDF + EFV group and 8% of patients in the AZT/3TC + EFV group, respectively. The most common adverse events associated with treatment discontinuation were nausea (3%), vomiting (2%), and abnormal liver function tests (2%). In all 48-week treatment groups, 1% or fewer patients discontinued treatment due to the following events: abnormal liver function tests, hepatitis, neutropenia, and pancreatitis. The incidence of abnormal liver function tests in the FTC + TDF + EFV group was approximately 1.7-fold that in humans receiving the 600-mg/day dose. The exposure in rats was lower than that in humans.

Table 1: The effect of ATRIPLA on the mean didanosine concentration. Higher didanosine concentrations could potentiate didanosine-associated adverse events. For additional information, please consult the Videx/Videx EC (didanosine) prescribing information.

Table 2: The effect of ATRIPLA on the mean saquinavir concentration. Should not be used in patients receiving saquinavir.

Table 3: The effect of ATRIPLA on the mean efavirenz concentration. Efavirenz and fixed-dose zidovudine/lamivudine were hepatitis C antibody positive. Among these HCV coinfected patients, one (1/16) in the fixed-dose zidovudine/lamivudine arm had elevations in ALT to greater than five times the upper limit of normal; no HCV coinfected patients in the FTC + TDF + EFV or AZT/3TC + EFV arms had elevations in ALT.

Table 4: The effect of ATRIPLA on the mean tenofovir concentration. No increases in tumor incidence above background were observed. The systemic exposure (based on AUCs) in rats was approximately 1.7-fold that in humans receiving the 600-mg/day dose. The exposure in rats was lower than that in humans.

Table 5: The effect of ATRIPLA on the mean FTC concentration. FTC is required for the pharmacokinetic interaction described in the discussion of the individual components of ATRIPLA. The exposure in rats was approximately 1.7-fold that in humans receiving the 600-mg/day dose. The exposure in rats was lower than that in humans.

Table 6: The effect of ATRIPLA on the mean TDF concentration. Higher TDF concentrations could potentiate TDF-associated adverse events. For additional information, please consult the Stavudine/penciclovir prescribing information.

Table 7: The effect of ATRIPLA on the mean EFV concentration. Efavirenz: see WARNINGS, Nervous System Symptoms, psychosis (see WARNINGS, Psychotomimetic, and risk for mania).

Table 8: The effect of ATRIPLA on the mean TIBH concentration. Higher TIBH concentrations could potentiate TIBH-associated adverse events. For additional information, please consult the Tenofovir DF prescribing information.
The University of Texas Medical Branch at Galveston is the principal source of health care for the Texas Department of Criminal Justice. UTMB-Correctional Managed Care provides medical, dental and psychiatric care to 120,000 inmates in a geographically scattered prison system.

To better serve their needs, UTMB-CMC has developed an extensive telemedicine network. Since the service was implemented in the early 1990s, telemedicine has evolved into a highly practical and dependable method of conducting specialty clinics, with specialists at the UTMB campus in Galveston evaluating and managing the care of inmates in remote prisons. The development of better otoscopes, stethoscopes and other devices has expanded the utility of telemedicine.

More recently, UTMB-CMC has combined telemedicine technology with a customized electronic medical record system. This network, known as Digital Medical Services, serves TDCJ units throughout the state to facilitate specialty services to inmates with infectious and chronic diseases.

Because of our success in providing specialty care via telemedicine, we embarked on a pilot project in the summer of 2006 to determine the utility of the DMS network for providing primary care to TDCJ units that had chronic or temporary provider shortages.

Project Design

Several remote units with provider shortages took part in the project. UTMB-CMC employees at these units were selected to operate the DMS equipment, present the patients to the DMS primary care provider (PCP) and perform other tasks to facilitate the telemedicine consultation. Although these employees could be RNs or LVNs, they also included clerical staff or nurse’s aides trained in the DMS process and equipment operation. In fact, because of the relatively short supply of nurses at these units, we decided to use trained, competent non-nursing personnel whenever possible.

A central scheduling coordinator was chosen and a scheduling process developed. All requests for DMS services from the units were scheduled through this coordinator’s office.

We identified a group of experienced correctional midlevel providers from units near Houston who could provide primary care consultations via DMS. We also created and filled a midlevel position for this district to help provide this service. The Houston area was selected because it would be easier to recruit providers from this large metropolitan area.

In addition, a physician who had an interest in this project had DMS equipment installed in his home and conducted visits from this setting.

The PCPs were rotated daily and were available for consultations 8 hours per day, Monday through Friday, 6 a.m. to 2 p.m. They worked from TDCJ offices near a prison in Sugar Land, TX (adjacent to Houston).

On a typical day, DMS hosted three clinics, each for a different prison unit. Each session was usually scheduled for 2 hours and with an average of 20 to 25 patients. This number was chosen based on an estimated 10%-20% no-show rate. The providers would either type their notes into the EMR during the telemedicine session or make handwritten notes and enter the data into the EMR after the clinic ended.

When a unit needed to schedule a DMS-PCP clinic, it would contact the central coordinator for a date and time. The day before the clinic, a list of patients from that unit was sent to the DMS coordinator, who would provide it to the PCP.

Shortly before the DMS visit, the inmate’s vital signs were taken and recorded. When required, laboratory measurements such as fingerstick glucose testing, peak flow assessment and dip-stick urinalysis were also performed.

Lessons Learned

• A nurse need not be present at or involved in a DMS primary care consultation provided that the presenter at the patients’ unit is thoroughly familiar with the EMR and DMS equipment.
• Scheduling multiple clinics at different sites requires strict adherence to the time allotted for each clinic, and clinics must not start late or run late. All participants should be in place and ready to begin on time; patients usually must arrive an hour or so before their appointment.
Unit “count” times must be taken into consideration.

- Security plays an important role in facilitating the smooth flow of traffic during this busy and highly productive time.

- Providers requiring an interpreter should be identified before the clinic so that a single interpreter can be present to translate.

- Inmates with less complicated medical conditions are not candidates for the DMS-PCP clinic as they tend to require lengthy visits, which disrupts the clinic schedule.

- Providers are supposed to conduct consultations from outside the prison circumvents security issues and allows more time for seeing patients. Any needed technical adjustments or changes to the equipment can be done more easily in this setting.

- Additional telemedicine clinics can be scheduled and the time frame for seeing patients extends in cases of poor road conditions that might prevent providers from driving to some units. We learned this serendipitously during a severe ice storm.

- Some DMS patients required referral to a unit provider because the provider’s physical presence was needed to further evaluate or treat the patient. This situation occurred with no more than 5% of patients.

## Crunching the Numbers

Before the DMS-PCP pilot program, we had only one viable option for delivering care to the poorly staffed units: use of a contract service at $200 per hour. This service was estimated to be capable of seeing a maximum of 8 patients per hour. At a cost of $1,600 per 8 hours and a maximum of 64 patients, the estimated cost per patient visit would be $25. The cost would increase with fewer patients per unit and with longer visits.

In planning the DMS-PCP pilot, we would use currently employed and experienced midlevel providers at an estimated hourly cost of $40. We also hypothesized that other unit providers could see more patients per hour (i.e., 10) because of their familiarity with the TDCJ system, the unit facility, and our customized EMR. If these numbers were achieved, the unit providers, at a daily cost of $320 per 80 patients, could provide care for $4 per patient visit.

During this pilot, 941 provider hours were expended in conducting 5,321 telemedicine visits, yielding an average of 6 patients per hour at an average cost of $8.58 per patient visit. DMS-PCP savings averaged $9,629 per month. In comparison, the contracted services would have cost $339,100 per projected annualized costs for delivered services.

The contract between the TDCJ-CMC and TDCJ stipulates that inmates must be examined within our provider time limits after they request medical care. Thus, we collect monthly “access to care” data. To gauge access at facilities involved in the DMS-PCP project, we compared their overall performance scores from the 5 months before the pilot with those from the first 5 months of the pilot. We found that the scores had increased from 90.3% to 94.4%, for a net improvement of 5.1%.

Clearly, using DMS is an effective way to evaluate and treat primary care patients in remote prisons. This model can accommodate many types of health care requests on a predictable schedule and allows units with limited on-site provider time to focus on issues that require the physical presence of a provider (e.g., digital rectal exams, more detailed physical exams, pelvic exams, minor surgical procedures). The DMS also can be used for many of the chronic care conditions (e.g., hypertension, diabetes) that TDCJ-CMC monitors regularly, and for follow-up visits.

The authors are affiliated with the Southern Division of UTMB Correctional Managed Care. Charles D. Adamson, MPH, is medical director; Stephen Smock, MBA, is director of operations; and Gary J. Eubanks, RN, MSN, is director of nursing.
Emtricitabine and tenofovir disoproxil fumarate: Truvada should not be coadministered with Atripla, Emtriva, or Viread in patients with renal dysfunction who received Truvada using these dosing schedules. Dosing interval adjustment of Truvada and close monitoring of renal function are recommended for patients with moderate to severe renal impairment, including those who require hemodialysis. The effects of Truvada were associated with an increased risk for bone effects when compared to patients receiving Emtriva in various populations, including patients who were HIV-infected, were coinfected with HBV and HIV, and had discontinued Emtriva or Viread. In patients coinfected with HBV and HIV, severe acute exacerbations of chronic hepatitis B have been reported in patients with moderate to severe renal impairment treated with Truvada. However, the clinical relevance of these findings is unknown. A causal relationship has not been established.

Dosage:

- Emtricitabine and tenofovir disoproxil fumarate: Truvada for oral solution contains 300 mg of emtricitabine for oral solution and 300 mg of tenofovir disoproxil fumarate for oral solution. The solution should be prepared according to the package insert before administration. The solution should be administered with or without food. The recommended dosage for treatment-experienced patients is one 280-mg tablet twice daily. The recommended dosage for treatment-naive patients is one 280-mg tablet twice daily (see Table below) or one 280-mg tablet taken once daily with food (see WARNINGS).

- Tablets: Truvada tablets contain 300 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate. The tablets should be administered with food. The recommended dosage for treatment-experienced patients is one 280-mg tablet twice daily. The recommended dosage for treatment-naive patients is one 280-mg tablet twice daily (see Table below) or one 280-mg tablet taken once daily with food (see WARNINGS).

- Truvada for oral solution and tablets are indicated for antiretroviral therapy for the treatment of HIV infection.

- Truvada for oral solution is indicated for antiretroviral therapy for the treatment of HIV infection in pediatric patients aged 2 to 17 years.

- Truvada for oral solution is indicated for antiretroviral therapy for the treatment of HIV infection in adults and pediatric patients aged 2 to 17 years who are coinfected with HBV and HIV.

- Truvada for oral solution is indicated for antiretroviral therapy for the treatment of HIV infection in adults and pediatric patients aged 2 to 17 years who are coinfected with HBV and HIV and have discontinued Emtriva or Viread.

- Truvada is not recommended for patients who have not completed 48 weeks of therapy with Viread or Emtriva or Emtriva and Viread.

- Truvada is contraindicated in patients with previous evidence of hereditary or acquired hyperamylasemia or hyperlipasemia.

- Truvada should not be administered to patients with moderate to severe renal impairment including those who require hemodialysis.

- Truvada should not be administered to patients with moderate to severe hepatic impairment (Child-Pugh class B or C) without close monitoring of liver function.

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Treating ADHD Vital to Reduce Recidivism in Youth

by Robert F. Emé, Ph.D

Attention-deficit/hyperactivity disorder is the most commonly diagnosed behavioral condition among youth in the United States, with an estimated prevalence rate of about 7% in children. However, ADHD is seen far more often among incarcerated juveniles, affecting at least 25% and maybe as many as 50% of these youth. In the general population, ADHD is more common among males than females, but in correctional settings, the opposite may be true. Despite these statistics, the impact of ADHD in juvenile justice systems and institutions is just starting to be understood. Given that ADHD increases the risk of recidivism, it is critically important to identify and treat this condition in youth.

What is ADHD?

ADHD is a neurobiological disorder that impairs the brain's executive or management functions, thereby impairing self-regulation and self-control. About 80% of youth with ADHD have impairing self-regulation and self-critically important to identify and increase the risk of recidivism, it is understood. Given that ADHD and institutions is just starting to be of ADHD in juvenile justice systems and opposite may be true.

Deficits in executive function may lead to behaviors such as:

• Impulsivity, nonthinking, thrill-seeking, impatience in delaying gratification, insatiability
• Failure to start, procrastination
• Disorganization, histrionic money management skills, inability to save
• Failure to sustain effort, follow through and complete tasks
• Overreaction, poor emotional regulation, low tolerance of frustration, explosive temper, irritability, suggestibility

In turn, ODD often leads to development of conduct disorder, which is the mental disorder equivalent of delinquency. Studies indicate that ADHD be present in 50% of youth with CD. These problematic behaviors increase the risk of life difficulties such as substance abuse and failures in academics, the work world and personal relationships. What’s more, the toxic brew of ADHD/CD often leads to criminal behavior and recidivism, especially among youth who use illicit drugs. Clearly, identification and treatment of ADHD is an essential component of mental health services in any system that aims to prevent youth delinquency and reduce recidivism.

An essential first step in any best practices model would be to require education on ADHD for lawyers, judges, probation and parole officers, and others who work in the juvenile justice system. This would enable them to more competently serve the youth they deal with.

Robert F. Emé, Ph.D is a professor of psychology at Argosy University, Schaumburg (IL) Campus. He will represent a session on this subject at the 2007 National Conference on Correctional Health Care in Nashville.
In the News

Youth Suicide on the Rise

After a decade of falling rates, suicides among youth rose 5% from 2003 to 2004, according to a CDC study reported in the Sept. 7 Morbidity and Mortality Weekly Report. In contrast, suicide rates among youth in the 10-24 age group fell 28% from 1990 to 2003. The study found significant increases particularly among girls ages 10-19, with no changes in their suicide methods.

The report offers no reasons for the reversal. However, in a Sept. 6 HealthDay News article,三点 to points to FDA warnings of a few years ago that use of SSRI antidepressants can increase teens’ risk of suicide. In the years before those warnings, use of antidepressants was increasing and suicide rates were decreasing. When prescribing decreased, suicides increased.

While saying that this pattern is a concern, the director of the FDA’s Division of Psychopharmacology Products, Center for Drug Evaluation and Research, also noted the agency’s obligation to report on drug risks. The CDC report calls for closer examination of these warning signals, and for prevention activities that focus on these groups. The study is available at http://www.cdc.gov/mmwr.

Youth Drug Use Declines

Now some good news: The rate of adolescents 12 to 17 acknowledging drug use in the past month dropped from 19.3% in 1992 to 13.0% in 2006, according to a new analysis of data from the Monitoring the Future survey by the National Institute on Drug Abuse.

However, the overall rate rose from 9.8% in 2006, the U.S. Substance Abuse and Mental Health Services Administration recently announced.

The findings are from the 2006 National Survey on Drug Use and Health, which also reported that cigarette use decreased over the same period for people ages 18 to 25.

Data on drug use by age group reflects the use of prescription drugs, mainly pain relievers, increased among young adults, from 5.4% in 2002 to 6.4% in 2006. The level of underage drinking (ages 12 to 17) also rose slightly in 2006 to 41.9% from 40.9% in 2005.

Substance abuse problems and mental illness often co-occur. For example, 34.6% of 12- to 17-year-olds who had a major depressive episode in the past year had used illicit drugs, compared to 18.2% who had not experienced a major depressive episode.

Survey findings are posted on the Web at http://oas.samhsa.gov/nhsdatatst.htm.

First Antipsychotic for Kids

The FDA has approved the use of Risperdal (risperidone) in youth to treat schizophrenia (ages 13-17) and for short-term treatment of bipolar disorder in children ages 10-12. Previously, no drug had been approved for adolescent schizophrenia and only lithium was approved for bipolar disorder for youth ages 12 and older.

Risperdal is a potent antipsychotic drug that had been commonly used off-label to treat these conditions in youth. The new approval is based on effective dosages for these patients.

More information can be found at www.fda.gov/oc/pt/default.htm.

First Drug in New Class of Anti-HIV Meds

The FDA has approved Selevzor (maraviroc), the first drug to be approved in the CCR5 co-receptor antagonist type of drug, which targets CCR5 co-receptor activity of HIV. Maraviroc is approved for use in combination with other antiretrovirals for the treatment of adults who have exclusively CCR5-tropic HIV virus, evidence of viral replication and resistance to multiple antiretroviral medications.

Rather than fighting HIV inside white blood cells, like most antiretrovirals used to treat HIV infection, maraviroc prevents the virus from entering uninfected cells by blocking the predominant route of entry, the CCR5 coreceptor, a protein on the surface of immune cells affected by HIV. Among patients who have previously received HIV medications, about 50% to 60% have circulating CCR5-tropic HIV.

Vitamin D Enhances Immunity to TB

A single oral dose of 2.5 mg of vitamin D has been shown to enhance natural immunity in healthy people who had contact with someone with tuberculosis, according to a study in the July 15 American Journal of Respiratory and Critical Medicine. The article notes that vitamin D was used to treat TB in the “preantibiotic era.”

Table 1: Drugs That Are Not Recommended for Use with SUSTIVA

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<th>Drug Class</th>
<th>Drug Name</th>
<th>Common Clinical Conditions</th>
<th>Common to Be Avoided</th>
<th>Contraindications, Precautions</th>
<th>Comments</th>
<th>Full Prescribing Information</th>
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<tr>
<td>Drug Interactions</td>
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Empathy: How Do Correctional Docs Measure Up?

Empathy is an important factor in good physician-patient relations. It contributes to patient satisfaction, but even more fundamentally, it can help a physician to get an adequate history and it can motivate patients to adhere to their treatments. Recognizing that the correctional environment subjects physicians and patients alike to “unique stressors,” researchers from the University of California sought to determine whether correctional physicians differed from those in the community in their levels and expression of empathy.

In an exploratory study, they surveyed correctional and noncorrectional physicians in California using a modified version of the Interpersonal Reactivity Index. Questionnaires were returned from 42 doctors who work in correctional facilities, of whom 20 work exclusively in such settings, and 36 who work solely in non correctional settings.

The construct of “empathy” was divided into four subcomponents: emotional resonance, intrinsic curiosity, tolerance of emotional ambivalence and compassion. The study results are reported in the latest issue of the Journal of Correctional Health Care (see issue information below).

Similar, Yet Different

For the most part, the two groups were found to be similar in their responses, with both displaying empathy and compassion. But the researchers did detect differences. Correctional physicians reported greater satisfaction with their work, but the study points out that this satisfaction from work may or may not reflect empathy.

Findings suggest that “cognitive physicians may not be as emotionally attuned to their patients and may display less curiosity about their feelings. Therefore, their work satisfaction may not be derived from the interpersonal component of medical care.”

That said, some correctional physicians interviewed during the study’s preliminary field work described a “developmental course in which they become increasingly able to empathize with inmates... These physicians initially experienced discom fort when working with inmate populations and the perceived pressures were reflected in their practice, but they eventually learned to deal with them.” They said they gained greater empathy after many years oflistening to inmates’ life stories and problems.

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- Readers Write: Insights From Practicing Correctional Health Professionals. When is a decision not to treat the right choice?
- The Role of Cognition, Impulsivity, and Age in Program Adherence for Inmates Under Prehabilitation Treatment Facility: A Preliminary Report — Scott Sulcakova, Ph.D., David A. Studnicka, Ph.D., Jennifer J. Waite, Ph.D., Bradley Sussner, Ph.D., Erik Faust, Ph.D., Seung Joon Lee
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- Methicillin-Resistant Staphylococcus aureus Nasal Carriage Rate in Texas County Jail Inmates — Marilyn Felker, PhD, Rodney E. Rohde, MS, Anna Maria Valle-Ricera, PhD, Tamarra Baldwin, L.P. (Sky) Neusome

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many commented that they learned a lot and that their job performance had improved. The director of nursing noticed improvements in both the aides’ skills and their ability to identify changes in client conditions before and/or mental decline. Besides enhancing competency and morale, these portable skills enable the aides to earn extra money by moonlighting as a CNA, one of Missouri’s fastest growing occupations. Recently, after examining her first group of CNA candidates from SLPRC, one RN examiner said, “This is the best group I’ve ever seen.” They’re so organized and meticulous ... I’m really impressed! They should be in nursing school.”

Bright Prospects

The post-training surveys of the current CNAs showed that 58% planned to further their education in the field of nursing. Ninety-four percent planned to remain with SLPRC until retirement. Based on these findings, it was concluded that the CNAs would be invaluable to the nursing field since they are very well-trained for continuous learning. In fact, internal SLPRC policies are already in place to provide educational leave until retirement, although these benefits are currently unexplored.

Other homegrown nurse solutions do not involve internal training and use of certified medication technicians (who must first be CNAs), and improved marketing of an already successful state employee benefits package to attract new staff. Overweight is the fact that many of these patients get little exercise, and many take antipsychotic drugs that cause weight gain. Well over 50% of the clients smoke cigarettes.
Forcing Psychotropic Medications

When the physician writes an order for forced psychotropic medication, often the inmate is already in or being placed in restraints, or, at a minimum, being held by correctional staff. Just as the shot is about to be given, the inmate appears calm. Can we force the medication? Also, the psychiatrist usually orders a kind of “cocktail,” which may be a mixture of short- and long-term medications. Should our nurses not administer the shot because the inmate is “calm” and the long-term medication is a therapeutic intervention?

Anyone know Solomon’s phone number? Let’s start with the intent of standard I-02 Emergency Psychotropic Medication: “...to have a protocol for emergency situations when an inmate is dangerous to self or others due to a medical or mental illness and when forced psychotropic medications are not used to prevent harm, based on a physician’s order.”

This emergency intervention by physician’s order is a therapeutic intervention that is used when all else fails. The longer effect of some portion of the medication is a positive outcome for such interventions, and medications are often chosen precisely for this effect. If the inmate can clinically tolerate it, such a 2/1 intervention can be the door that opens the inmate to healing. The nurses need to discuss the issues with the ordering physician so they understand such orders. For example, at staff meetings ask the psychiatrist to explain the therapeutic effects. That is why you consulted the psychiatrist in the first place—for expertise in safely calming an inmate.

The restraint is merely a temporary calm in the storm; without the medications, you soon will be back where you started. If the inmate appears calm when you are ready to give the injection, you certainly should ask if he or she will take the medications voluntarily. If the inmate says yes, administer them with permission. If not, then force it as the physician ordered.

The whole intervention should be done with care and at the time the inmate is upset; in fact, that is the only time a physician can order such an intervention. Usually, once the medications take effect, the restraints can be removed. The physician usually writes the restraint order as “up to X hours until in control.”

You can ask the physician to write the injection order such that it’s up to the judgment of the staff that’s about to give the med, but that would lead me to wonder if you are using the forced medication intervention to casually. Many inmates requiring such intervention will fight the restraints and the shot.

Fit for Confinement

Is the inmate talking with health staff at the local hospital emergency room, the question arose as to whether there is a definition of “fit for confinement” that ER physicians could refer to when deciding if an inmate can be cleared for a jail. Can NCCHC help?

I assume this is a situation in which an inmate was sent to the ER for an evaluation for a medical and/or mental health problem, and the ER is trying to decide if the inmate can be sent back to the jail.

Your best bet is to consult NCCHC’s Standards for Health Services in Jails, specifically essential standards J-01 Access to Care and J-E-02 Receiving Screen and Important standard J-D-05 Hospital and Specialty Care. Here is a summary of how these standards address your question.

Inmates have a constitutional right to access to care for their significant health problems. If the level of care needed is not available at the facility, inmates are to be treated in a setting that can meet their specific health needs, such as a community hospital or ER, or perhaps a better equipped (i.e., health staff and services) correctional facility with which the original facility has transfer arrangements.

The ER physician involved in deciding if the inmate can be appropriately treated at the jail must consider several things. Foremost is the level of health or mental health services needed for follow-up if the inmate-patient is released, and whether the available jail health resources are at that level.

Sometimes when opinions differ between community ER physicians and jail physicians, it is because the ER physician does not really know what is available at the jail. A visit to the jail and an exchange of information about its health staffing and capabilities are essential to good planning between jail and ER health administrators and physicians.

One way for the ER physician to think about a return to jail is to regard it as a return to home care. That is, if the inmate were a regular community patient with a home and minimally supportive situation, would the hospital send the patient home? Does the inmate-patient simply need observation that could be done by minimally trained correctional officers, or does he or she inmate-patient need nursing care that is (or is not) available on-site? If the jail has an infirmary, what scope of care is available? Is there a sheltered housing area where the inmate can receive the necessary services? For example, is there a negative-pressure room to house contagious TB patients, or does the patient need to stay at the hospital until the contagious phase has passed?

Some ER physicians mistakenly assume that jails have 24/7 health staff and supports. While that may be true in a few jails, particularly in the mega-systems, most have limited onsite health resources. On the other hand, if you or I were treated in an ER and then sent home and not hospitalized, jails should expect that the ER will want to do the same for inmate-patients treated for the same conditions.

Given the possibility that little attention may be given to a returning inmate, the ERs may be advised to hold the inmate-patient for a little longer observation if there is any doubt. Some jails and ERs create a “locked ward” at the hospital when such patient volume is high.
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Check out the CDOC on line at www.doc.state.co.us.
products for every type of wound. Part I gives detailed guidelines on wound care and prevention, and related professional and legal issues. Part II features profiles and photos of over 300 wound care products. Part III has charts of over 200 additional dressings and products. Appendices include assessment tools and multiple treatment algorithms. A manufacturer guide includes addresses, phone numbers, Web sites and manufacturer-sponsored educational programs. Edited by Cathy Hess, RN, BSN, CWOCN. Lippincott Williams & Wilkins (2004). Spiral-bound softcover, 544 pages, $39.95

Rosen and Barkin’s 5-Minute Emergency Medicine Consult, 3rd Ed. This best-selling reference has been thoroughly updated. The foremost authorities provide practical information on over 600 clinical problems in a fast-access two-page outline format that’s perfect for on-the-spot consultation. Coverage of each disorder includes clinical presentation, prehospital, diagnosis, treatment, disposition and more. Icons enable practitioners to quickly spot the information they need. This edition provides current information on emerging infections, new protocols and new treatments. By Jeffrey Schneider, MD, Stephen Hayden, MD, Richard Wolfe, MD, Roger Barkin, MD, MPH, & Peter Rosen, MD.

Lippincott Williams & Wilkins (2006). Hardcover, 1,336 pages, $84.95

Substance Abuse Treatment with Correctional Clients. This book provides key research findings and policy implications for treating addicted clients. Topics include theoretical explanations for substance abuse, best practice treatment programs, the use of coerced mandated treatment; correctional settings; community-based treatment programs; and special treatment populations, including juveniles. Edited by Barbara Sims. Haworth (2005). Hardcover, 258+ pages, $39.95

Health Issues Among Incarcerated Women. The 20 essays in this comprehensive book address the challenges of health care delivery that meets the unique physical and mental needs of female inmates. Edited by Ronald Braithwaite, Kimberly Jacob Arriola & 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 and psychiatrists in the unique applications and interpretations of the most widely used and thoroughly researched personality assessment instrument in correctional settings. By Edwin Megargee. University of Minnesota Press (2006). Softcover, 480 pages, $50

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**Meetings**

NCCHC’s National Conference. The premier meeting in correctional health care takes place Oct. 13-17 in Nashville, TN. For a schedule of events and online registration, see www.ncchc.org; to obtain a brochure, call 773-880-1460. Also see the back page for more information.


Regional HIV Meeting. The Southwest Regional HIV/AIDS Conference is being held Nov. 1-2 in Scottsdale, AZ. Hosted by the nonprofit Body Positive and the Arizona Department of Health Services, the meeting offers CEs. Learn more at www.bodypositive.org.

Public Health. Washington, DC, will be the site of the American Public Health Association’s Annual Meeting and Exposition, Nov. 3-7. Find info at www.apha.org, or call 202-777-2742.

Sheriffs’ Meeting. The National Sheriffs’ Association will hold its annual winter conference Jan. 16-20 at the J.W. Marriott in New Orleans, LA. Information is posted at www.sheriffs.org, or call 703-836-7827.

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**Watch Your Career Grow**

Correctional Medical Services is the ideal destination to advance your career and thrive in a unique environment providing leadership in correctional healthcare.

Director of Nursing and Health Service Administrator
Management opportunities available. Call Courtney Penning at 800.342.4809, ext 9526.


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**Public Health Seattle & King County**

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

David Fleming, MD, Director and Health Officer

**Psychiatrist**

Work for the Public Health Department of Seattle & King County providing mental health care in the Seattle metropolitan area! Seattle is a beautiful, progressive city with a quality of life most consider among the best in the country. Public Health seeks a psychiatrist to join the Psych Services team treating incarcerated persons in the King County Correctional Facility; most of the work is in the downtown facility but may also include work in the Kent facility. We have a strong community mental health focus and work closely with our medical colleagues in the jail.

**Senior Staff Physician**

Senior Staff Physicians provide direct patient care to jail inmates.

Other responsibilities include participation in quality improvement / quality assurance programs to support Jail Health Services care goals; medical oversight, consultation, and management of specialized health care programs for Jail Health Services.

Both Jobs Salary: $119,579.20 - $151,569.60 annually
Location: Seattle & Kent, Washington
Benefits: comprehensive package of benefits to Career Service.
Apply On-line: http://www.metrokc.gov/health/about/jobs.htm

For further inquiries, please contact

Martha Driver(martha.driver@metrokc.gov)

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**Accreditation**

**Opioid Treatment Programs in Corrections**

Is your prison, jail or juvenile facility considering an on-site opioid treatment program? By law, OTPs based in correctional facilities must be certified by the U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration. But to become certified, an OTP first must be accredited by a federally approved body.

The National Commission on Correctional Health Care is one of only six agencies authorized to accredit opioid treatment programs, and the only one to focus on correctional facilities. NCCHC’s Standards for OTPs are applicable with federal regulations while recognizing the special nature of these facilities.

Visit the Web to obtain an informational brochure or to order the Standards. Or contact NCCHC for more information.

www.ncchc.org

OTPinfo@ncchc.org

(773) 880-1460
The Stage Is Set! You can make no better time investment—professionally and personally—than by attending this conference. Sharing and learning will take on a fresh new look at this event. A robust, forward-thinking curriculum featuring the thought leaders in this field will stimulate new ideas about how best to deliver care and foster professionalism. We are confident that this program will be time well spent—and perhaps the most valuable educational program of the year. You will come away renewed and committed to change, armed with a wealth of new strategies and connections you’ll find nowhere else.

Sessions for Every Level of Experience

Whether you’re a seasoned leader or a newcomer to corrections, you will find valuable guidance at the conference. With sessions geared toward basic, intermediate and advanced levels of experience and knowledge, the program will deliver an unparalleled array of opportunities to learn and grow.

Below are just a few of the outstanding sessions designed for advanced learners.
- Advanced Wound Care in the Correctional Environment
- Best Practices for Becoming an Inspired Leader in Corrections
- Bioethics Discussion Behind Bars
- Correctional Health Care Staffing: It’s Not an Art, It’s a Science
- Creation of a Metabolic Monitoring Program for Atypical Antipsychotics
- Fiscal Self-Defense: Defending Your Budget to Commissioners, Legislators and the Public
- Overcoming Imposed Budget Cuts While Maintaining Vital Services
- We Thought We Had a Disaster Plan: What Hurricane Katrina Taught Us
- Why Did the Inmate Sue Us? An Advanced Look at Litigation Trends and Prevention

Advancing Your Education

Nearly 40% of our conference attendees have been working in this field for 10 or more years! With you in mind, we’ve developed a significant number of advanced level sessions. The Schedule at a Glance and Abstracts indicate the skill level for each session using the labels Basic (B), Intermediate (I) and Advanced (A).

Leadership Series

This series was a hit last year so we’re bringing it back. Designed for managers, both new and experienced, these sessions will help you hone your skills to become a more effective leader. Look for the keyword “Leadership” in the Schedule at a Glance.
- Interactive and high-level educational experiences
- Expert faculty with vast experience in and knowledge of correctional health care
- Diverse topics for a well-rounded view of the elements of leadership and management
- Practical information to help you become more effective and efficient

New! Speaker Q&A

Did you ever wish you had a chance to pick the speaker’s brain after the session ended? Now you can. Selected speakers will stay for a roundtable Q&A. These discussions are scheduled to extend through the session period that follows their talk.

New! Longer Sessions

To provide more in-depth education on selected subjects, two of the concurrent sessions will run for two hours instead of the usual one. Check the schedule for presentations during these sessions:
- Session 2: Monday, 1:15 pm to 3:15 pm
- Session 11: Wednesday, 1:15 pm to 3:15 pm

A Special Guest With Star Power

Ready for a little more glamour with your education? Sheryl Lee Ralph—of Dreamgirls, Moesha and Sister Act II fame—will open the exhibit hall on Sunday evening and deliver the keynote address on Monday morning. Sheryl Lee is more than just a gorgeous, multitalented celebrity. She also is an activist and motivation speaker who in 1990 established the Diva Foundation to create awareness of and combat against HIV/AIDS. That will be the focus of her talk on Monday. On Sunday, however, she promises to thrill the audience with a song. You don’t want to miss it!

Exceptional Exhibition

Besides the star power of Sheryl Lee, the exhibit hall is the nexus of so much good stuff. That includes the exhibitors themselves, of course, our vital partners in the provision of high quality health care (see page 16 for a list of organizations that will be represented at the meeting).

Let’s not forget the exhibit hall raffles, during which NCCHC’s very own in-house divas hand out tantalizing prizes, many of them donated by generous exhibitors, to dozens of attendees. (Don’t lose that raffle ticket! Please write legibly!)

10 Things You Can Do Only in Nashville

1. In Music City can you hear jazz, blues, R&B, country and rock any night of the week. Check out the club scene all around town. It never sleeps.

2. Stroll down Second Avenue and Printers Alley, the downtown HQ of Nashville’s after-hours beat. Or try The Gulch or Jefferson Street areas for more action.

3. Some of the Civil War’s fiercest battles were fought on Nashville soil. See what both Union and Confederate armies saw from the spectacular vantage point of Fort Negley, built by free African Americans.

4. Head to Fisk University to explore one of MSN.com’s Top 10 American black history sites. You’ll also find two of the city’s visual arts treasures: the Aaron Douglas Gallery and the Carl Van Vechten Gallery.

5. A bounty of Southern and Soul cooking awaits you at a number of homey restaurants. Pass the biscuits and save room for pie.

6. Learn about the city’s pivotal role in civil rights history from the Civil Rights Collection at the Nashville Public Library.

7. Visit the campus of Meharry Medical College, the nation’s first medical education program established for African Americans.

8. Soak in the proud sports legacy of Tennessee State University: Wilma Rudolph and the Tiger Belles, most notably basketball and football.

9. The County Music Hall of Fame and Museum features the exhibition “I Can’t Stop Loving You: Ray Charles and Country Music,” tracing the lifelong love affair the “genius of soul” had with country music that redefined American popular music.


Nashville Area Welcome Committee

It can be hard to decide what to do with your free time when you’re in an unfamiliar city. That’s why Academy members from Tennessee have created an insider’s guide to Nashville. From favorite restaurants to site seeing to travel advice, their tips will help you make the most of your conference experience. Check out their recommendations at the Academy booth in the exhibit hall.

Thanks to our conference cohosts

NCCHC and the Academy thank our cohosts for their support of the National Conference on Correctional Health Care.
- Tennessee Department of Correction
- Tennessee Department of Children’s Services
- Tennessee Sheriffs’ Association
- Davidson County Sheriff’s Office

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

To obtain a preliminary program with registration form, visit our Web site, e-mail info@ncchc.org, or call 773-880-1460.