Helping Jails Do More . . . With More

Smart Laws Alleviate County Health Care Costs

BY RONALD WIBORG, MA, MBA, AND JAIME SHIMKUS

Across the nation, county jails are struggling to provide adequate health care for inmates in the face of daunting financial trends. As populations and acuities rise and budgets flatten or shrink, health services are caught in the squeeze. Clearly, efforts to “do more with less” aren’t enough anymore. What’s needed is sensible and effective reform, along with creative thinking. This article will discuss several approaches for increasing revenues and reducing expenses for jail health care.

Blame It on the Feds?
The issue of using financial resources to defray the costs of health care in county jails is twofold. It could be characterized as the “front end” and the “back end” of incarceration.

At the front end is a federal rule that individuals who receive federal medical benefits are not eligible to receive those benefits while they are in county jails. The U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services applies the rule to inmates of state prisons as well as persons held in county jails and juvenile detention centers.

Most people would agree that states should be responsible for providing total care, including health care, to inmates residing in their prisons. These people have been convicted of felony offenses.

What causes significant financial woes for county governments is that the CMS rule has been interpreted to include persons who have been arrested and held in county jails, before even being charged with, not to mention being convicted of, a crime.

Furthermore, the rule does not differentiate between minor and serious crimes. The result is loss of eligibility for medical assistance for people who are detained, including those arrested for misdemeanor and nuisance crimes, many of whom are mentally ill.

There is a loophole: Those who can drum up the cash to “make bail” are released from custody and their benefits continue. Those who can’t make bail stay in jail, lose their eligibility and are required to reapply for benefits when released from jail. The reapplication process takes up to 90 days, during which the county has to pay for medical care.

Efforts are underway on Capitol Hill in Washington, DC, to modify the rule to require benefit eligibility to continue until the recipient is convicted of a crime and sentenced to a period of secure incarceration. The National Association of Counties is spearheading the effort, with support from counties across the country and several national organizations, including the National Commission on Correctional Health Care, the National Sheriffs’ Association and the National District Attorneys Association.

If this effort succeeds, it would have little financial downside on federal income and indigent people who do receive those benefits while they are incarcerated. According to the National Association of Counties, “Counties have found that the cessation (however temporary) of their benefits leads directly to further criminal activity, perpetuating a cycle of their being in and out of the justice system.”

What States Can Do
The back end of this issue involves finding ways to alleviate the financial burden on counties for health care provided in jails. One way is related to, but not governed by, the CMS rule. Although this is a federal rule, it is up to each individual state to determine the process by which eligibility for medical assistance benefits ceases when a recipient is incarcerated.

States can opt to suspend eligibility rather than terminate. In fact, a May 2004 letter from CMS to all state Medicaid directors encourages states to suspend benefits for recipients who are incarcerated both pretrial and postconviction. At least three states (Minnesota, Oregon and New York) now suspend rather than terminate. State departments of human services for medical assistance benefits cease when a recipient is incarcerated.

Minnnesota has also passed two other laws to help stem jail health care costs. One allows counties to be reimbursed for the medical costs of jail inmates who receive benefits through General Assistance Medical Care (a state-funded program for low-income and indigent people).

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Introducing NCCHC’s 2008 Board Chair
One-on-One With Robert Morris

Growing Involvement

It was because of his job in juvenile justice that Morris became involved with NCCHC, first attending educational conferences, then serving on the juvenile health committee, which he chaired for several years. In 2001 he became the NCCHC board representative for the Society for Adolescent Medicine, where he holds a fellowship.

“It came together nicely,” he says. “It gave me opportunity to bring the needs of kids in juvenile corrections to the wider audience of adolescent medicine. At the same time, I could further the cause of adolescent medicine at the National Commission.”

Indeed, his contributions have been vast.

In a decade where little literature once existed, he has written numerous research articles, presented at countless meetings, helped to develop NCCHC policies and standards and clinical guidelines, and more.

As board chair, he intends to continue promoting youth health care, and sees outreach and collaboration with government and community agencies, as well as academic researchers, as an effective way to do so. In fact, expanding such relationships is a goal that Morris holds for NCCHC as a whole.

“NCCHC already has a lot of interaction with these groups. The problem is that they don’t always talk to each other,” he says. With its broad network of collaborators and contacts, NCCHC fills an important void by sharing information so that everybody “is on the same page.”

With so much going on professionally, Morris has precious little leisure time. How does he spend it? Usually by sitting outside on a chaise lounge with his dog. “Catching up on work.” Single-mindedly indeed!

Curriculum Vitae

Education

• BS in biology, Georgetown University, Washington, DC, 1967
• MD, Temple University Medical School, Philadelphia, PA, 1971
• Internship and residency, Children’s Orthopedic Hospital and Medical Center and the University of Washington, Seattle, 1971-74

Professional Career

• U.S. Army physician, 1974-80; served 2 years in Korea, then based in California; primarily pediatric practice; achieved Lt. Colonel rank
• Various roles in pediatric health at hospitals and health agencies in Southern California, 1980-90
• Various roles in juvenile justice in LA County beginning in 1986
• Professor and administrator, pediatrics and adolescent medicine, UCLA Medical Center, 1986-present
• Substantial to work in public health, juvenile justice and academics (LSU) in Baton Rouge and New Orleans, LA, 2001-2004
• Since 2005, medical director for the California juvenile justice system while still teaching at UCLA

Professional Activities

These are too numerous to summarize, but they include:
• Work as an independent consultant and on several advisory boards
• Service on numerous committees and an institutional review board
• Member, Ambulatory Pediatric Association, Society of Correctional Physicians and other societies
• Extensive research, writing and speaking on a broad array of issues germane to incarcerated youth
• Frequent community service
• Honors include designation as a Los Angeles “Super Doctor” in 2007

Board Member Update

The NCCHC board of directors welcomes two new members:
• Eileen Couture, DO, RN, MS, represents the American College of Emergency Physicians. She is the interim chair of correctional medicine/nursing of Cermak Health Services, which provides health services for the Cook County (IL) Jail. Couture will serve on NCCHC’s juvenile health committee.
• Capt. Nicholas Malderez, DMD, MA, MPH, represents the American Dental Association. He is the chief dentist for the Federal Bureau of Prisons, Washington, DC. Malderez will serve on NCCHC’s education committee.

In other board news...
• Joseph V. Penn, MD, CCHP, was selected by his peers on the board as chair-elect; he will become chair in October 2008. Penn represents the American Academy of Child & Adolescent Psychiatry on the board, and is director of psychiatric services at the Rhode Island Training School, Cranston.
AMA President Shares Views on Correctional Health Care

BY RONALD M. DAVIS, MD

Recentl!y I had the privilege of meeting and speaking to attendees of the annual meeting of the National Commission on Correctional Health Care. Their work is important not only to those who are incarcerated in our nation’s jails, prisons and juvenile confinement facilities (from local detention facilities up to state and federal maximum security prisons), but also for every community.

Successes and Challenges

As a public health physician, I have long been interested in correctional health care, even more so after seeing the 2002 report to Congress, “The Health Status of Soon-To-Be Released Inmates.” It contains essential recommendations on how to decrease risks to patients, staff and our communities—by working harder to diagnose and treat inmates everywhere.

It’s exciting that one major recommendation of this report has been successfully adopted: the development and widespread use of clinical guidelines. NCCHC did this well, beginning with already established guide lines from recognized leading organizations in a particular field, and then adding elements to help providers overcome barriers particular to correctional environments and measure success in disease management.

Yet I am disappointed that much work remains to be done by government agencies with the other recommendations, especially in surveillance. And in planning for discharging inmates, it’s unfortunate that there often is no comparable mechanism on the outside (through community programs or local public health department services) to maintain former inmates’ access to health services once they are released. In part, this is because often they return to a predominantly poor area.

Jails have different challenges. Because they primarily house people who have not been convicted of a crime, the average length of stay is only a few months. Managing depression and infectious disease are the most pressing issues for correctional health care workers there, and suicide is becoming a major and leading cause of prisoner death.

Correctional facilities still face challenges in dealing with HIV. However, I was pleased to learn that because of dramatic improvements in detection and treatment during the last five years, AIDS is no longer the leading cause of death in state prisons. It is now responsible for 7% of all deaths in those facilities—sur passed by heart disease (22% of deaths), cancer (23%) and liver disease (10%).

Important Issues

Current AMA policy (H-190.915 Tobacco Use in Prison Populations) pushes for us to promote the same tobacco control policies for correctional facilities that exist in the outside community, work to stop the manufacture of cigarettes in prisons and jails, work to stop the subsidy of cigarette sales in correctional facilities, and support legislation that bans smoking in prisons and jails. The U.S. Supreme Court, in Helling v. Mc Kinney (1993), ruled that exposure of prisoners to secondhand smoke can be considered cruel and unusual punishment under the Eighth Amendment. A “correctional” issue that has been in the news in recent months is the role of physicians in capital punishment. AMA policy first adopted in 1980 and amended several times since then indicates that “a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.”

AMA Policy Backs NCCHC

The American Medical Association has an official policy of support for NCCHC activities. Key points are as follows:

• Support NCCHC standards that improve the quality of health and mental health care services delivered to correctional facilities.

• Encourage correctional systems to support NCCHC accreditation.

• Encourage NCCHC and its AMA representative to work with corrections departments and public officials to find cost effective and efficient methods to increase funding for health services.

To see the full text of AMA policy D-430.997 Support for Health Care Services to Incarcerated Persons, go to the PolicyFinder search page at www.ama-assn.org.

Well Done

The unsung heroes in correctional health care are making a huge difference. Public servants all, there is no way they’re compensated enough for what they do. And their guiding light, NCCHC, is the very model of a successful partnership, with an impressive diversity of organizations represented on its board. We should all recognize and laud their efforts, which ultimately benefit you, me, and society as a whole.

Ronald M. Davis, MD, is the president of the Chicago-based American Medical Association and wrote this column for the AMA’s Evolve newsletter. He is the director of the Center for Health Promotion and Disease Prevention at the Henry Ford Health System in Detroit.

Guest Editorial

AMA President Shares Views on Correctional Health Care

It’s no exaggeration to describe the opening ceremony audience at the National Conference on Correctional Health Care as captivated. Not because they were held against their will, but because they were captivated by an amazing event. From start to finish, the 90-minute session pulsed with poignant insights, startling revelations, hard-won wisdom, abundant humor and even soaring song.

Attendees were treated to two outstanding keynote sessions. First, Sheryl Lee Ralph wowed the crowd with a moving speech that affirmed why she is a star of film, television and Broadway, as well as a strong voice in the fight against HIV. Drawing on episodes in her life, she not only advocated for inmate health care but also reminded attendees—the invaluable people who deliver that care—that they must not neglect to care for themselves. She brought a powerful stage presence (see photo), and it was clear she meant every word.

More subdued but with a wry wit that had the audience laughing repeatedly was Ronald Davis, MD, president of the American Medical Association. Informed by a career in preventive medicine and public health, he is a staunch believer in the correctional health care mission and urged accreditation for all facilities. Some of his observations are noted in the letter above. He also delved into two health problems of relevance to inmates: tobacco use and obesity, along with the need for a good diet and physical activity.

Both keynote addresses, NCCHC’s new board chair, Robert Morris, MD, shared his goals for his term, and other board members bestowed the Commission’s annual awards (see page 5). The speakers—presenters and award recipients alike—were seasoned veterans with interlinking professional histories, which lent a special warmth to the proceedings. If you were there, you know: More than a few eyes were moist during this event!
Mental Health Professional Lauded for ‘Heroic’ Service

BY MATISSA SAMMONS

Fredric Friedman, EdD, CCHP, is not the type to call himself a hero. Yet a hero he is to those who have observed—or benefited from—his work helping mentally ill prisoners in Rhode Island. In September, Friedman received the Heroes in the Fight award from the Rhode Island affiliate of the National Alliance on Mental Illness. Heroes in the Fight is a program established by Eli Lilly and Co. in partnership with NAMI and Mental Health America to recognize individuals who provide care and support for persons with severe and persistent mental illness and their families. Friedman is the first correctional health professional to be so honored, which makes this award especially meaningful because it represents progress toward appreciating the contributions of mental health professionals who choose to serve correctional populations.

For Friedman personally, it’s also a tribute to how much he has accomplished since joining the Rhode Island Department of Corrections in 2002 as its first full-time director of mental health and substance abuse. He oversees a team of psychiatrists, psychologists, social workers and substance abuse counselors who deliver services to a system with nearly 4,000 inmates.

Building Linkages

A Massachusetts native who has lived in Rhode Island since 1977, Friedman has worked in the public sector for much of his 35-year career, primarily in hospital and academic settings. But he had some idea of what he was getting into at RIDOC because he had spent 10 years as a psychological consultant for the state parole board. Also, a hospital where he had worked had served inmate-patients. Still, Friedman says he was struck by something he heard at his first NCCHC conference in 2004, in a session by Thomas J. Fagan, PhD, who represents the American Psychological Association on NCCHC’s board of directors. “Everyone wants to lock people up and throw away the key with no realization that these people are coming back out into the community,” he recalls. “Of our 4,000 inmates, only 20 are never leaving, and 60% will be out within a year.” That observation has motivated Friedman to this day. It is why he continually stresses the importance of community awareness and involvement, and why he develops relationships with community partners to ensure continuity of care for patients upon release. “They were mentally ill before they came to us and they will be mentally ill after they leave. They’re ours for only a short period.” He also is involved in initiatives to divert certain mentally ill offenders from incarceration.

The drive to build linkages also helps in Friedman’s ongoing quest to keep his department staffed. “Corrections is like practicing in a different world,” he says. That can be a turnoff to some, who still perceive stigmas associated with correctional practice. But it also can be a powerful selling point, he explains: “Corrections is a great place for mental health professionals to learn and gain experience. It offers opportunities to see psychopathology not often seen in the community and the time to do some good treatment.”

Given the challenging mental health conditions seen in prisons, Friedman strives to recruit the best and brightest. One way he does that is through collaborative endeavors, such as a program being developed by RIDOC, Brown University and Rhode Island Hospital that will produce interns and residents trained in forensic psychiatry.

Staff retention is just as vital, of course, and Friedman credits the CCHP program for providing the tools necessary to succeed in this highly specialized environment.

Staying Put

Pondering the path of his career, Friedman notes that his diverse experiences—providing treatments for a wide range of issues, with patients from juvenile to geriatric—all came into play when he joined the prison system. He also retains his passion for public health service and for helping the disadvantaged—traits that are a must for any professional in this field, he says.

That passion, coupled with experience and expertise, can help to overcome the inevitable frustrations of working within the system constraints of any correctional environment. Having learned how to deal with the system, Friedman plans to stay put. “Why retire? I am fascinated by what I do and I enjoy it too much. As long as they let me out at the end of the day, it’s a good day. My work is challenging, but I am motivated by the long-term rewards of a job well done and inspired by the many good people who work in corrections.”

CCHP Board Gets Three Fresh Faces in 2008

The CCHP board of trustees welcomes three new members. Ruth Wyatt, RN, CCHP, won the election. Becky Pinney, RN, CCHP, is the public appointee and Don Kern, MD, CCHP, is the appointee from the NCCHC board of directors. Ned Megargee, PhD, CCHP, remains chair and Jayne Russell, MD, CCHP, is now vice chair. Also continuing their terms are Margaret Collatt, RN, BSN, CCHP-A, Susan Laffan, RN, CCHP-A, Edward Harrison, CCHP, Joseph Marocco, MPA, CCHP, and Joseph Paris, PhD, MD, CCHP. All board members serve three-year terms.

Stepping down are Joanne Dorman, BS, RN, CCHP-A (elected to two consecutive terms), Anthe Caruso, RN, MSN, CCHP (former vice chair and NCCHC board appointee), and Todd Wilcox, MD, MBA, CCHP (public appointee).

Exam Dates & Locations

- Feb. 23: Regional sites: Rancho Cucamonga, CA, Ludlow, MA, Guaynabo, PR, South Burlington, VT, and others to be determined
- May 18: San Antonio, TX – At the Updates in Correctional Health Care conference
- Aug. 23: Regional sites TBA
- 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.

For the most up-to-date list of exam dates and locations, visit the CCHP page at www.nccchc.org. You can also download the application booklet and study guide and complete an online application form. For a list of the 2007 proctors and information about volunteering, please see page 7.
Annual Awards

Award Recipients Inspire the Audience in Nashville

The National Commission annually honors outstanding individuals, communities, health associations and health care professionals with the most prestigious awards in the field of correctional health care. In a field rich with leaders and innovators, each year a few nominees shine. We congratulate the 2007 winners, who were presented with the awards during the opening ceremony of the National Conference on Correctional Health Care, held in Nashville in October.

Bernard P. Harrison Award of Merit

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

Quentin Young, MD

For mentoring and inspiring countless physicians to become involved in correctional health care.

If it were not for Quentin Young, MD, some of the bright young medical students who passed through Cook County (IL) Hospital in the 1970s and ’80s never would have thought to work in a jail or prison. But as chairman of the hospital’s internal medicine department, he encouraged them to devote their careers to disadvantaged populations, and many of them have gone on to prominent leadership positions in correctional health care today. Today, our field is far better for it.

The Chicago-based physician is well-known as a tireless advocate for populations without a health care safety net, which includes many of those incarcerated in our correctional facilities. Dr. Young’s prominent voice has helped Americans to become attuned to health policy and social justice. For decades, he has worked to formulate and promote policy to meet the needs of the underserved and to forge partnerships that lead to effective programs. In 1980, he founded the Health and Medicine Policy Research Group, an independent, not-for-profit research and advocacy institute to advance such goals; he currently serves as its chairman.

Among his many other professional accomplishments, Dr. Young has served as president of the American Public Health Association and was inducted as a master of the American College of Physicians, where he chaired the organization’s Subcommittee on Human Rights and Medical Practice. He also is the national coordinator of Physicians for a National Health Program, an organization of 14,000 physicians who support single-payer national health insurance.

B. Jaye Anno Award of Excellence in Communication

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

Ken Kerle, PhD

For his significant achievements in raising awareness of health care issues through editorial coverage in American Jails magazine.

In the past 20 years, jail administrators have come a long way in understanding and appreciating correctional health care issues. That, in no small part, is thanks to the efforts of editor Ken Kerle, PhD. At the helm of American Jails since its inception in 1987, Dr. Kerle has consistently, and persistently, made health care a regular topic in the magazine, which is published bimonthly by the American Jail Association and distributed to its members. He understood from the start that health care is an essential element of jail management and operations, and that it merits thorough coverage in keeping with the magazine’s editorial mission.

With more than 30 years of experience in corrections—including work as a correctional officer early in his career—Dr. Kerle is well-qualified for his role in shaping the discourse in this field. And although he reaches a large and important audience through the magazine, that’s not his only contribution to the literature. He also is the author of American Jails: Looking to the Future and Exploring Jail Operations, and has written more than 200 articles, papers and editorials on the topic of local corrections. In addition, he has lectured at colleges and universities and presented at national and international criminal justice conferences.

Facility of the Year Award

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

Montgomery County Correctional Facility & Montgomery County Detention Center

The outstanding performance of the correctional and detention facilities in Montgomery County, Maryland, has earned them NCCHC’s Facility of the Year Award. Accredited since 1977, this two-facility jail system has consistently complied with the Standards for Health Services in Jails, attaining a high quality of health care for inmates.

A holistic approach to inmate health care is one positive trait that sets these facilities apart. The nominating surveyors noted a unique emphasis on addressing the needs of the whole individual, and that is evident in the collaborative way health, custody, program and community representatives work to manage inmates’ needs. Multidisciplinary committees and initiatives channel inmates into appropriate medical, mental health and addiction therapies, as well as training programs for educational, occupational and reentry skills. Health services for the nearly 500 inmates (average daily population) are provided by the county.

To learn more about the jail, see the Facility Profile on page 10.

Program of the Year Award

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

Medical Discharge Program

Hillsborough County Sheriff’s Office

While NCCHC’s Standards for Health Services have always called for continuity of care for inmates released to the community, jail administrators increasingly recognize that discharge planning is an essential part of health services. The initiative in Hillsborough County, Florida, is a fine example of how it should be done.

In May 2006, the jail restructured its discharge planning program to comprehensively address inmates’ medical and mental health needs upon release. Surveyors who nominated the program were impressed with the cooperative spirit with which the Sheriff’s Office, the Hillsborough County Department of Health and Human Services, the Tampa Community Health Centers and the jail’s full-time medical discharge planner developed the program. A little more than a year later, the program has already proven to be a success in aiding releases. A bonus: A six-month study found a significant reduction in recidivism.

Exciting Career Opportunity

Director of Accreditation

This key leadership position within NCCHC reports directly to the President, serves as a member of his executive management team and interacts with key committees of the Board of Directors.

The Director of Accreditation is responsible for developing standards and performance measures for health care delivery in a variety of institutional settings. The position also trains, supports and manages effective staff and contractor teams. The individual must not only understand and help to shape organizational vision and strategy, but also undertake task-oriented, hands-on work.

The candidate must be comfortable and adept at building productive relationships throughout the correctional health care field, developing and delivering clear communications with a wide variety of stakeholders, presenting and speaking in public, and thinking on his/her feet. Commitment to building a collaborative environment with staff and volunteers is essential.

If you are interested in this exciting opportunity, please contact us for details about job responsibilities and objectives, candidate qualifications and general information about NCCHC.

Edward Harrison, President
National Commission on Correctional Health Care
1145 W. Diversey Parkway, Chicago, IL 60614
773-880-1460 • info@ncchc.org
Congratulations to the 126 Newest CCHPs!

Connie J. Gope, LPN, CCHP
Prime Care Medical
Kerens, WV
Susan C. Crawford, ASN, RN, CCHP
DHBU/Denver County Jail
Denver, CO
Caren Curtis, EMT-P, CCHP
Denton County Correctional Health
Denton, TX
Karen M. Cygan, RN, CCHP
Los Padrinos Juvenile Jail
Ramco, Cacamanga, CA
Michael E. Duguay, RN, CCHP
Sonnoma County Adult Detention Facilities
Santa Rosa, CA
Angela S. D’Antonio, MSN, RNCS, CCHP
Souza Baranowski Correctional Center
Medford, MA
Henry T. Davis, DO, MA, CCHP
IMA Resources, LLC
Boonville, IN
Claire D. Defore, RN, CCHP
Tarrant County Jail
Fort Worth, TX
William E. Densmore, BS, CCHP
Rhode Island Department of Corrections
Cranston, RI
Becky Dressler, RN, CCHP
Wisconsin Department of Corrections
Chippewa Falls, WI
Maryann R. Hale, BSN, CCHP
Rhode Island Department of Corrections
Coventry, RI
Shelby E. Havens, ARNP, MSN, CCHP
Alachua County Sheriff’s Office
Gaineville, FL
Stephanie A. Heath, CRNP, CCHP
Prison Health Services
Glen Allen, VA
Rosauro O. Hernandez, BSN, CCHP
George Bailey Detention Facility
Clula Vista, CA
Claire M. Hickey, RN, CCHP
Rhode Island Training School
Cranston, RI
Nikki K. Holler, BSN, CCHP
Correctional Medical Care Inc.
Phoenienville, PA
Casey S. Hollingsworth, CCHP
NaphCare Inc.
Las Vegas, NV
Karen S. Holman, RN, BSN, CCHP
Arkansas Department of Corrections
Crossett, AR
Christopher M. Hynum, MD, CCHP
Ventura Youth Correctional Facility
Newbury Park, CA
Carrie L. Johnson, BSN, RN, CCHP
JPS Correctional Health
Grand Prairie, TX
Jared G. Jorgensen, MBA, CCHP
Veterix Healthcare Consulting
Salt Lake City, UT
Carmen D. Kassatly, RN, CCHP
Denver County Jail
Brighton, CO
Jennifer L. Keller, RN, CCHP
Northampton County Prison
Wind Gap, PA
Scott H. Kennedy, MD, CCHP
Prison Health Services
Safety Harbor, FL
Randall Gene Kesseler, DO, CCHP
Denver County Jail and Law Enforcement Center
Denver, CO
John M. Kissingler, EMT-P, CCHP
Denver County Jail Law Enforcement Center
Denton, TX
Lenay L. Lawyer, MD, CCHP
Baltimore, MD
L.C. LeBlanc, MA, CCHP
Mental Health Professionals, LLC
Olympia, WA
Sherry L. Maddox, BSN, CCHP
Public Safety Facility
Brooklyn Center, MN
Jennifer L. Mageau, RN, CCHP
Rhode Island Department of Corrections
Coventry, RI
Kathy D. Martin, BSN, CCHP
Valhalla, NY
Robyn McLaughlin, MA, MPA, CCHP
Rhode Island Department of Corrections
North Providence, RI
Shana C. McNamara, AAS, RN, CCHP
Denver Health Medical Center
Denver, CO
Braxton Jon Miller, MBA, CCHP
Vertis Healthcare Consulting
Salt Lake City, UT
Karen A. Muirhead, LPN, CCHP
Gobi County Adult Detention Center
Mertarita, AR
Karen Murphy, RN, CCHP
PrimeCare Medical
Westchester, PA
Paul W. Navarro, RN, BSN, CCHP
PrimeCare Medical
Harrisburg, PA
Andrea Norris, BSN, RN, CCHP
Pennsylvania Department of Corrections
Elizabethtown, PA
Jeanne M. Ollis, RN, CCHP
Hennepin County Medical Center
Howard Lake, MN
Angela Oslak, CCHP
Correctional Health Services, LLC
LaGrangeville, NY
Anthony Perez, CCHP
Denver County Jail
Highlands Ranch, CO
Douglas C. Peterson, MD, CCHP
California Department of Corrections and Rehabilitation
Sacramento, CA
Wilea G. Pino, CCHP
Montana Women’s Prison
Joliet, MT
Julietta T. Planco, BSN, CRNP
Karnett Correctional Institution
Sanford, NC
Carith B. Poston, RN, CCHP
Carolina Correctional Health
Sylaca, NC
Elena Puruar, MSN, RN, CCHP
California Institution for Men
Yorba Linda, CA
Kelly W. Quinnones, RN, ASN, CCHP
MMC
Eatontown, NJ
Geralynne R. Rader, LYN, CCHP
California Forensic Medical Group
Paradise, CA
Richard G. Ranen, DDS, CCHP
Denturst Dental
Dallas, TX
Michael E. Rochford, RN, CCHP
Santa Rosa County Jail
Milford, FL
Nelda M. Rosales, LVN, CCHP
Comal County Sheriff’s Office
New Braunfels, TX
Debra G. Rowe, MHS, CCHP
District of Columbia Department of Health HIV/AIDS
Upper Marlboro, MD
MaryJane Rule, MA, CCHP
Chesapeake Mental Health Services
Rockville, MD
Valerie T. Shank, BSN, CCHP
Texas Department of Criminal Justice
Coventry, RI
Kathrynn A. Smith, RN, CCHP
Berk County Prison
Minneapolis, MN
Meghan E. Siersma, MSW, LSW, CCHP
Midwest Psychological Center
Indianapolis, IN

The list below represents three groups of examinees. For those who took the exam in August or September, certification began on Oct. 1. For those who took the exam in October, certification will begin on Jan. 1, 2008.

Edward Abrams, RN, BSN, MS, CCHP
Coastline County Jail and Rehabilitation Center
Bristol, NZ
Monica L. Albens, LPN, CCHP
Correctional Healthcare Management
Parker, CO
Phyllis K. Anderson, MSN, CCHP
Burlington Medical Center
Medford, NJ
James W. Arrasmith, EMT, CCHP
Primescare Medical
Harrisburg, PA
Carl B. Ausfeld, MS, RN, CPHQ, CCHP
Correctional Medical Services
Medford Lakes, NJ
Miguel A. Balderrama, MD, CCHP
Pierce County Sheriff’s Department
Tucoma, WA
Marc A. Bellucci, AAS, RN, CCHP
Browns Mills, NJ
Deborah A. Bishop, MS, MPH, CCHP
U.S. Public Health Services
Battavia, NY
Kellie Blanchard, MSW, LSW, PsyD, CCHP
Midwest Psychological Center
Indianapolis, IN
Todd C. Boese, RN, CCHP
Montana State Prison
Deer Lodge, MT
Jennifer A. Boring, RN, CCHP
Ohio Department of Rehabilitation and Correction
Lancaster, OH
John Budan, RN, MA, CCHP
Yamhill County Correctional Facility
McMinville, OR
Deborah L. Burney, BSN, CCHP
Maple Lane School
Rochester, WA
Marcie L. Burr, RN, CCHP
Wyoming Honor Farm
Riverton, WY
Kristina M. Calc, MA, CCHP
NapCare Inc.
Alvarado, TX
Emilia T. Caputo, RN, CCHP
Northampton County Prison
Bethlehem, PA
Marsha Carberry, LYN, CCHP
Contra County Sheriff’s Department
New Braunfels, TX
Dino N. Cardaras, ANN, CCHP
Pickaway Correctional Facility
Bainbridge, OH
John M. Casebolt, MD, CCHP
Department of Correctional Services
Owensa, NE
Kimberly Christie, BSN, CCHP
Correct Care Solutions
Thornton, PA
Richard M. Cole, DO, CCHP
Universal Treatment
Sandusky, OH
Kevin C. Connor, RN, BSN, CCHP
West Valley Detention Center
Redlands, CA
Gretchen H. Cook, RN, CCHP
Department of Health Services
Lake Forest, CA
Robin Cooke, RN, CCHP
Caledonia Correctional Institute
Henrico, IN

Congratulations to the 126 Newest CCHPs!
Hats Off to the 2007 Exam Proctors

Thanks to the volunteers who served as proctors in 2007. As proctors, their primary duty was to administer the exam, ensuring a fair and secure test environment. In many cases, the proctors also made arrangements to become the host site and encouraged their staff members to become certified. A handful of folks even proctored more than one!

The volunteers are listed alphabetically by last name, followed by the test site city and state.

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@ncchc.org or 773-880-1460, ext. 277.

MedGuard is a brand new concept that offers you the opportunity to take ownership of your health care career. When you invest in a MedGuard franchise, we help you secure a contract to provide health care in a county jail and protect you against liability issues. It's the ideal way to enjoy the professional and personal flexibility that's rare in nursing and other health care jobs. Visit our Web site or call 800-827-6627 to get your chance at entrepreneurial freedom in correctional health care.

www.ncchc.org FALL 2007 • CorrectCare 7

MedGuard is a brand new concept that offers you the opportunity to take ownership of your health care career. When you invest in a MedGuard franchise, we help you secure a contract to provide health care in a county jail and protect you against liability issues. It's the ideal way to enjoy the professional and personal flexibility that's rare in nursing and other health care jobs. Visit our Web site or call 800-827-6627 to get your chance at entrepreneurial freedom in correctional health care.

MEDGUARDHEALTH.COM
Call to Action! Seeking 2008 Committee Members

Academy members have benefited from many new products and services that were implemented during the past year. Much of the credit for these advancements goes to the hard-working volunteer committees that guide the development of the Academy.

Mary Muse, chair of the Academy board of directors, has issued a call for volunteers to assist in her selection of appointments to the 2008 committees. Please consider volunteering your time and talent toward the advancement of our association.

Participating on a committee of the Academy demonstrates your commitment to the association and to the advancement of the correctional health care field. As an Academy committee member, you will not only help the growth of the organization, you will also...

- Enhance your leadership skills and abilities
- Strengthen your professional network
- Establish new personal friendships that will last a lifetime

Step Up to the Plate

The Academy chair is seeking volunteers to serve on the following committees:

- Membership and Recruitment
- Mentoring
- Education

Committees provide member oversight of the programs and activities of the Academy. Although each committee has its own charges and responsibilities (described on our Web site), they all act as a strategic entity of the full board. Committee members are expected to:

- Participate fully in the work of the committee
- Provide thoughtful input to the deliberations of the committee
- Focus on the best interests of the Academy and the committee
- Work toward fulfilling the committee’s goals

If you are interested in being considered for appointment to a committee, please complete and submit the form below or go online at www.correctionalhealth.org/about/volunteer.html. The deadline to volunteer is Feb. 15, 2008.

Academy Election Results

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

This year’s election was closely contested with two highly qualified candidates vying for only one open seat. The board of directors is pleased to announce that Susan Laflan, RN, CCHP-A, was reelected to a third term. Judith P. Robbins, LCSW, JD, CCHP, was appointed from the NCCHC board of directors to a second term and Ralf J. Salkle, BSN, CCHP-A, was appointed from the public sector.

The offices of the board were voted on during the board of directors annual meeting, which took place on Wednesday, Oct. 17. This year’s officers:

- Chair: Mary Muse, MSN, RN, CCHP-A
- Chair-elect: Judith P. Robbins, LCSW, JD, CCHP
- Immediate past chair: Margaret M. Collatt, RN, BSN, CCHP-A
- Treasurer: Ralf J. Salkle, BSN, CCHP-A
- Secretary: Susan Laflan, RN, CCHP-A
- President: Edward A. Harrison, CCHP

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

Academy Volunteer Form

Name_________________________Member ID_________________________
City/State_____________________
Day Phone_____________________
E-mail_________________________

Committees

Please indicate on which committee(s) you would like to serve. If you are interested in more than one, please rank your preference, with 1 being most interested and 3 being least interested.

___Membership and Recruitment
___Mentoring
___Education

Mentor

___Please send me information about becoming a mentor.

Please return this form by Feb. 15 to: Academy of Correctional Health Professionals 
fax: 773-880-2424
online: www.correctionalhealth.org
BOP Not Liable for Inmate’s Brain Hemorrhage

BY FRED COHEN, LLM

I n Watson v. United States (2007), Kortney Lewis’ representative sued the Federal Bureau of Prisons under the Federal Tort Claims Act (FTCA) for negligence in failing to respond to the now severely disabled former inmate’s need for immediate medical care and hospitalization.

Lewis received a fractured skull during a fight with a fellow inmate at the Federal Correctional Institution in El Reno, OK. He underwent surgery at a nearby hospital and after three days of recovery he was discharged as neurologically normal except for mild speech problems.

Lewis received a week of therapy at another hospital and was discharged with directions for further medical care, including special care or immediate follow-up. He was then housed in a special unit at El Reno where medical personnel made daily rounds.

Lewis made no special request for medical assistance although his speech remained slurred. Soon thereafter he appeared to worsen—speech was less clear, he had difficulty walking and in completing sentences—but no medical personnel were called. Minutes later, at 7:25 p.m., Lewis was found lying unconscious in his cell.

Since one of the key issues in the appeal is a challenge to the adequacy of the response to this medical emergency, the factual narrative from this point on is critical.

Staff immediately summoned the health services unit’s physician assistant, who arrived within two minutes and transferred Lewis to the HSU. At 7:42 p.m. —following the 10-12 policy, the physician assistant called the ambulance service closest to the prison. The district court found that plaintiff had not established that the physician assistant had been negligent.

The district court held that the government had not acted negligently in its response to Lewis’ condition and that, even if the prison medical team had been negligent, its conduct was not the proximate cause of his intracerebral hemorrhage or his resultant loss of function.

The trial court’s ruling, then, was based on the district court finding that Lewis was not symptomatic immediately before the hemorrhage, the hemorrhage was sudden and violent, prison officials did not unnecessarily delay summoning or admitting help and prison officials had no role whatsoever in the medical decision to transport Lewis to Parkview Hospital. Accordingly, the district court found that, even under the best of circumstances, Lewis would not have received the appropriate medication or neurosurgery before experiencing the permanent brain damage.

Finding no error in the district court’s ruling on negligence, the court of appeals upheld the lower court’s analysis and conclusion.

Expert Witness Questions

In addition to the ruling on negligence, the court also dealt with two interesting, rarely encountered, evidentiary issues regarding medical experts.

Qualification to Testify

Over repeated objections by plaintiff, the district court upheld the government’s request to present expert testimony. The court found that, by excluding some persons are not required to file reports and that these include individuals who are employed by a party and do not regularly give expert testimony. It is undisputed that Goforth meets exactly this description. Accordingly, the court discerned no violation of the above rule.

Any claim that plaintiff somehow has less than desirable pretrial awareness of Goforth’s opinions are countered by the fact that counsel took his deposition and questioned his background and knowledge of Lewis’ case.

The trial court’s ruling, then, against plaintiff was upheld in every respect.

Fred Cohen, LLM, is the credentialed Correctional Law Reporter. This article was originally published in the August/September 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, 4479 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearch-institute.com.
It Takes a County: Integrated Care Eases Reentry

by Jamie Shumkus

ike it or not, jails are finding themselves responsible for meeting a broad and growing spectrum of inmate needs. From a public health perspective, this makes sense. Back at the lockup, it isn’t always so easy.

That’s why it’s so impressive that more than 10 years ago, the correctional and detention facilities in Montgomery County, Maryland, decided to take a holistic approach to inmate health care.

This is one of several noteworthy aspects of the two-facility jail system that have earned it NCCHC’s 2007 Facility of the Year Award. (See page 5 to learn about the other award winners.) The accreditation surveyors who nominated the system praised its way health, custody, program and community partners collaborate to provide comprehensive care and services tailored to each individual.

The system also was a trailblazer in recognizing the value of national standards for health services: It has all aspects of the two-facility jail system. Mr. Wallenstein and our wardens, William Smith and Robert Green, truly understand the importance of health care,” says health services administrator Anthony Sturgess, MSN, CRNP, CCHP. “They recognize that we have a captive audience, so why not take advantage of this and provide as many opportunities, by way of programs, as we can. Mr. Green often asks, ‘How would you like them to return, as better criminals or as better people?’”

Programs Galore

That enlightened thinking is evident in the array of programs (more than 100) the jail offers, Sturgess says. He started as the sole nurse practitioner 10 years ago and has been the ISA for six years.

The jail gets help from the court and the community, particularly with efforts to facilitate reentry to the community. “Every two weeks, up to 40 individuals from many different agencies meet to discuss who is scheduled to be released,” Sturgess says. “This collaborative case management meeting is to identify services they will need and to link them to these services.”

Agencies represented include the public defender’s office, the county’s Health and Human Services department, parole and probation, faith-based organizations and nonprofit community services. IHS coordinates referrals for substance abuse and mental health services.

IHS is intrinsically involved in inmate services in many other ways. For example, IHS staff screen and assess each new detainee for mental health and substance abuse needs, with diversion to a nonjail setting if appropriate. Other IHS employees at the jail include a tuberculin control nurse and an HIV clinic staff. The agency also operates programs for addiction treatment and for housing the homeless.

Mental Health and More

Clearly, Montgomery County is serious about tackling mental illness and substance abuse, including alcoholism, among inmates. Sturgess cites those as the top two challenges the jail faces, followed by patient needs for multiple pharmaceuticals due to co-occurring medical and mental health conditions.

To address these needs, the jail has a mental health unit managed by Patricia Sollock, MA, CCHP. Although it is distinct from health services on the organizational chart, she and Sturgess, and their staffs, work seamlessly together.

About 18% of the jail population has a mental illness that requires medication, according to Sollock, and yet others receive mental health care without meds. A hallmark of the mental health unit is dialectic behavior therapy, an evidence-based program that involves individual and group sessions to help the patient improve life functioning skills. Also notable is a 56-bed crisis intervention unit, the largest inpatient psychiatric unit in the county.

Inmates bring with them a host of medical problems, too, including chronic diseases such as diabetes, hypertension and cardiovascular disease. Chronic pain disorders, dental health and injection-drug-related infections are also common.

The jail strives to minimize inmate movement within the facility so it brings contracted specialty providers on site to provide a full range of services at the community standard of care (see box above).

Quality health care doesn’t come cheap, so to keep expenses in check, Sturgess uses a third-party agent to renegotiate bills, which has saved the jail tens of thousands of dollars per year. But with costs continually rising, he has a few other creative ideas for controlling them. He promises to report back, so stay tuned!
What to Expect in the 2008 Jail and Prison Standards

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

Having guided thousands of facilities, NCCHC is the world’s foremost authority on correctional health care. At the same time, we enlist the help of our supporting organizations and other leading health care associations and monitor community practices to ensure that the standards are clinically sound and in keeping with community practice. Thus, each edition of the Standards is informed by expertise that is state-of-the-art. New editions of the Standards for Health Services for jails and prisons have been approved by the NCCHC board of directors and are due to be published in Spring 2008. For a standard-by-standard guide to the differences between the 2003 and 2008 editions, please visit the Resources page at www.ncchc.org.

Executive Summary of Changes

The Standards format: no changes
• Standard — the essence of the standard itself
• Compliance Indicators — the usual way compliance is achieved (general expectation for accreditation). The requirement for a “written policy and procedure” is now the last rather than the first Compliance Indicator. This emphasizes the focus on actual services and outcome, although written policies and procedures are needed to guide the actions.
• Discussion — elaboration on ways to meet the standard and additional background information
• Optional Recommendations — suggestions for best practices and ways to expand beyond basic requirements. “Recommendations” was changed to “Optional Recommendations” to emphasize the nature of this information.
• Intent — the reason for the standard, expressed in the first sentence of the Discussion.

General Numbering System: no changes
• First letter represents the version (P = prison, J = jail).
• Next letter represents the section (A-I).
• Some number changes were necessary within sections.

Essential vs. Important Classification
• One change: G-01 Chronic Disease Services is essential; previously this was labeled G-02 Management of Chronic Disease and was classified as important.

Number of Standards
• Jail: 67 (vs. 72 in 2003 edition); Prison: 65 (vs. 73 in 2003 edition)

(continued from page 1)

New Option for Health Assessment

One major change is the option for certain facilities to not conduct an initial health assessment on all new intakes. Under the new standards, if the jail or prison assigns a qualified health professional to do a more rigorous initial screening than what was required in the past, and there is no indication of serious medical issues, it is not necessary to also do a full health assessment of that inmate. If the facility does not choose that option, then the requirement remains for a full assessment as soon as possible, but no later than 14 days in jail and 7 days in prisons.

This modification changes a paradigm that dates back 30 years, when NCCHC was a project within the American Medical Association, but the time is right. “This approach reflects contemporary community medical practice and is supported in the medical literature,” according to Ronald Hamsky, MD, who served on the task force. “There is no need to waste valuable resources on health assessments of healthy inmates.”

By identifying problems early through more in-depth screening, correctional facilities have the opportunity to allocate resources where they are needed most: on the sick.

Senior accreditation surveyor Jayne Russo, MA, CCHP-A, also a task force member, noted that the first few days of incarceration is a critical time to identify illness and begin treatment for those in need, thus avoiding morbidity, emergency room visits and other unwanted outcomes. An added bonus: This new option might even result in cost savings.

The Receiving Screening standard was also changed, both to reflect the above option and to emphasize the importance of starting a problem list and treatment, when warranted, on those with identified problems.

Focus on Quality

The standard on Continuous Quality Improvement was improved, as well. “We simplified the standard to make sure that the field is focusing on problem solving rather than paper pushing,” says Anno. “Of course people want to confirm they are doing a good job, but the philosophy behind CQI is that you are always looking for areas to improve and embrace the opportunity to do so.”

Some standards were eliminated and several were rewritten to ensure they clearly focused on the provision of necessary health services. “We’ve seen tremendous improvement in the overall quality of patient care throughout the country over the past few decades,” says Robby Morris, MD, NCCHC board chair. The revised standards reflect the importance of quality health services and are sensitive to the ever-present concerns of operational effectiveness and efficiency.

Timeline for Transition

1. The 2003 standards will be the basis of NCCHC accreditation surveys through the end of April 2008.
2. From May through December 2008, accredited facilities have the option of compliance with either the 2003 or 2008 standards, in whole or in part.
3. Starting in May 2008, accreditation of jails and prisons will be governed by the 2008 standards.
   a. Facilities applying for initial accreditation are to be in compliance with the 2008 standards.
   b. In accredited facilities, from May through December 2008:
      i. Standards in compliance with the 2003 version will be judged to be in compliance provided that there is a plan to transition policy and practice completely by Dec. 31, 2008.
      ii. Standards not in compliance with the 2003 version require corrective action based on the 2008 standard requirements.
      iii. All facilities must be in complete compliance with the 2008 standards by Dec. 31, 2008.
5. Should publication be delayed, time lines for transition will be revised to give facilities at least six months to come into full compliance. As with all accreditation decisions, the Accreditation Committee may make individual facility exceptions in keeping with the intent of the standards.

New Mental Health Standards and Accreditation Program in 2008

NCCHC is introducing standards specifically for mental health services in prisons and jails, to be accompanied by a voluntary accreditation program that will begin in late 2008. These tools can help facilities determine proper levels of care, organize systems more effectively and efficiently, and demonstrate that constitutional requirements are being met.

This program is designed for mental health services that operate under an authority different from health services. Ideally both would seek accreditation together, but in cases where that does not happen, this program provides another option for the facility’s mental health component.

The mental health services accreditation program will operate in the same manner as that for health services. That is, it involves an on-site survey and professional judgment as to whether the applicant meets the NCCHC Standards for Mental Health Services in Correctional Facilities.

Likewise, the mental health standards parallel those for health services in both format and substance. The difference is that they make more explicit what the standards require for adequate delivery of mental health services. The standards cover the general areas of care and treatment, clinical records, administration, personnel and relevant legal issues.

As always, NCCHC will assist correctional facilities in meeting the standards and in their ongoing improvement in delivery of care.
Juveniles Justice in the News

- “The transfer of youth to the adult criminal justice system typically results in greater subsequent crime, including violent crime, among transferred youth [and therefore] is counterproductive.” That’s the bottom line from a study conducted by the Task Force on Community Preventive Services and published Nov. 30 in the CDC’s Morbidity and Mortality Weekly Report. The independent task force reviewed published scientific evidence to determine what effect laws or policies that facilitate such transfers have on interpersonal violence. According to the report, one rationale for placing juvenile offenders in adult systems is to deter future criminal activity, but the study authors conclude that these transfer policies do more harm than good. The report is posted at www.campaignforyouthjustice.org.

- Studies such as those described above, along with new research on the adolescent brain, are prompting states to reevaluate—and reform—juvenile sentencing laws, according to a Dec. 2 Associated Press article. Advocates for juvenile justice reform argue that harsh policies adopted in the 1990s, when juvenile crime rates soared, often went too far. Nearly all states made it easier to transfer youth to adult criminal court by giving prosecutors more power to do so, or by lowering the age or expanding the list of crimes making it mandatory for a case to be tried there. About 200,000 defendants under age 18 are sent or transferred to adult court each year, the article notes. About half of the states are undertaking reforms, including taking more youth out of the adult system, providing more mental health and community based-services and improving conditions at detention centers.

HIV Rates Up Among Young Adults

Despite years of intensive efforts at prevention and education, the number of teens and young adults newly infected with HIV is on the rise in the United States, according to CDC data reported in a Nov. 30 HealthDay News article. From 2001 to 2005, the number of new HIV cases among 15-to-19-year-olds rose from 1,010 to 1,213, a 20% jump. For people aged 20 to 24, new cases of infection rose 22%, from 3,184 to 3,876.

HCV Treatment for Psych Patients

Use of interferon to treat hepatitis C may cause or worsen psychiatric symptoms in some patients, including about 20% who have no history of psychiatric disorders. But treatment can be successful, according to a study in the November issue of American Journal of Gastroenterology. The researchers studied 46 HCV-infected veterans with a psychiatric history and 33 without such a history. During treatment, the psychiatric group had minor fluctuations in depression scores. The nonpsychiatric group, however, had a significant increase in scores, were more likely to require treatment with antidepressants and needed drug treatment earlier. Treatment significantly lowered depression scores in both groups, although they remained higher than at baseline. A sustained viral response was achieved in 47% of all patients.

GERD Drugs Don’t Increase Heart Risks

Recent studies raised a question about whether long-term use of Prilosec and Nexium increases the risk of heart attacks, heart failure and heart-related sudden death in patients taking either of those drugs for gastroesophageal reflux disease. The FDA conducted a comprehensive review of safety data and concluded that long-term use of the drugs is unlikely to be associated with an increased risk of heart problems. Learn more at www.fda.gov/bbs/topics/news/2007/new01754.html.
Prevention in Practice: Access to Condoms in California

BY MARY SYLLA, JD, MPH

Providing inmates with access to condoms is controversial. To some it seems hypocritical—why would we give inmates condoms when they areChemical: Long-term applicability studies in mice and rats were conducted with oral lamivudine. Mice were dosed by oral gavage for 29, 15, 5, 2, and 0.5 mg/kg/day for 26 months. Rats were dosed by oral gavage for 5, 2.5, 1.25, 0.625, 0.3125, and 0 mg/kg/day for 24 months.

Toxicokinetic properties have been studied in animal models. Lamivudine is metabolized to 3'-O-β-D-glucuronosyl-L-tyrosine, which is excreted in the urine. The pharmacokinetic profile of lamivudine is dependent on the route of administration, dosage, and species. Lamivudine distributes to the brain, placenta, and breast milk. Lamivudine and its metabolites are detected in human plasma up to 24 hours after an oral dose.

The mean elimination half-life of lamivudine is about 1 hour. The elimination half-life of lamivudine in children is shorter than in adults, ranging from 0.5 to 1.5 hours. The pharmacokinetics of lamivudine are not significantly affected by the presence of food or other antiretroviral agents. Lamivudine is extensively metabolized to an inactive glucuronic acid conjugate that is excreted in the urine. The metabolic clearance of lamivudine is not age-dependent. Lamivudine is primarily metabolized by the liver, with renal excretion accounting for only a small fraction of the total body clearance. Lamivudine is extensively bound to plasma proteins (95% to 99%).

In patients with renal impairment, lamivudine exposure increases with increasing levels of renal impairment. In patients with moderate to severe renal impairment, dose reduction is recommended. For patients with severe renal impairment (creatinine clearance <30 mL/min), the starting dose should be 150 mg twice daily. In patients with severe renal impairment who have developed resistance to zidovudine, the dosage of lamivudine may be increased to 300 mg twice daily under the close supervision of a specialist in antiretroviral therapy.

In patients with mild to moderate hepatic impairment, lamivudine exposure increases with increasing levels of hepatic impairment. In patients with mild hepatic impairment, lamivudine exposure is not significantly affected. Patients with moderate to severe hepatic impairment should be monitored closely for adverse events, and lamivudine should be used with caution due to the potential for increased drug interactions. Lamivudine is not metabolized by liver enzymes, and the dose does not need to be adjusted in patients with hepatic impairment.

Lamivudine is contraindicated in patients with severe renal impairment (creatinine clearance <30 mL/min). Lamivudine is associated with the development of drug-resistant mutations in the HIV-1 reverse transcriptase gene. Lamivudine should be used in combination with other antiretroviral agents to reduce the risk of resistance development.

The recommended dosage of lamivudine is 150 mg twice daily. The maximum recommended daily dose is 600 mg. Lamivudine is available as a delayed-release capsule containing 150 mg lamivudine and as a delayed-release tablet containing 300 mg lamivudine.

Lamivudine is not recommended for use in patients with a history of severe hypersensitivity reactions to any component of the formulation. Lamivudine should be used with caution in patients with a history of severe hypersensitivity reactions to other antiretroviral agents. Lamivudine should be used with caution in patients with a history of severe hypersensitivity reactions to other antiretroviral agents.

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a community-based AIDS service provider distribute about 200 condoms to inmates each month.

In Philadelphia, inmates can get condoms from the medical services department or through the commissary.

Two Pilot Programs in California

The Los Angeles County Jail Model

The Los Angeles condom access program was the result of a unique set of circumstances: A new custody chief—who had just been promoted from medical services—approached the Center for Health Justice about the possibility of designing a program that could provide gay male inmates in dormitory-style housing units with access to condoms without involving custody staff or time.

The program today exists as it did when implemented: Once a week a health educator from the Center for Health Justice goes into each dorm, provides a brief, interactive HIV education session, explains the rules of the program (including that sex is still illegal in jail under California law and that the condoms are not to leave the dorm or they will be considered contraband) and hands one condom to each inmate who lines up to receive one.

Although the average has changed over time, the Center for Health Justice currently distributes about 120 condoms per week to the 300+ inmates in this unit.

To evaluate this program, 101 of the approximately 300 inmates who live in the unit for segregated gay males were asked a series of questions through a computer-assisted self-interview program. Although the formal data analysis has not been completed, interesting statistics compiled so far include that 93% of respondents were aware of the condom program and 92% had received at least one condom from the program.

Fifty-three percent of respondents reported anal sex during the past 30 days—but despite access to condoms, 75% of those individuals said it was unprotected. The three top reasons for not using condoms were (1) my partner and I are both HIV negative (or positive), (2) I ran out of condoms and (3) I don’t like the way condoms feel.

Information was gathered about other methods of condom access: 66% preferred the current method of distribution; other methods of distribution cited were medical (41%), vending (10%) or canteen (8%).

Charles R. Drew University’s Nina Harawa, PhD, MPH, and the Center for Health Justice (with funding from the Institute for Community Health Research, itself funded by the California HIV/AIDS Research Program) are evaluating the pilot program to determine whether it is reducing sexual risk activity. The results of this evaluation will be finalized and published during the coming year, but they support the assertion that some risk-reduction is achieved in this population through access to condoms.

The San Francisco County Jail Model

In San Francisco, the Center for AIDS Prevention Studies and Olga Grinstead, PhD, MPH, are conducting research on a novel way to provide inmates with access to condoms that has been successful in other countries.

As mentioned above, in San Francisco, inmates have had access to condoms since 1987 through the Forensic AIDS Project. In the fall of 2006, the Center for Health Justice, Dr. Grinstead and the Forensic AIDS Project approached the sheriff of San Francisco about installing a condom dispensing machine, in part because of reports from Forensic AIDS Project staff that the demographic characteristics of the health educator seemed to influence whether a inmate being counseled took a condom. The Center for Health Justice sought to evaluate a method of providing access to condoms that is more anonymous as well as less staff-intensive.

The dispensing machine program and its pilot feasibility are being conducted by the Center for Health Justice in collaboration with the Forensic AIDS Project. The machine was installed in April 2007 in a gym to which 800 inmates have access every week for their three hours of recreation. Sheriff Michael Hennessy himself, to provide a large number of inmates with access to the machine, suggested the precise location.

Before the machine was installed, brief written surveys were conducted.
with inmates to elicit baseline information about their HIV status, knowledge of the existing condom program and risk behavior. Interviews were conducted with sheriff’s department staff to assess attitudes about condom access for inmates and to determine potential security concerns. Center for Health Justice staff also made presentations to all deputy staff and inmates affected by the program before the machine was installed. The same written survey and similar interviews were conducted after the machine was operational for four months.

The machine itself is a low-profile, tamper-resistant unit, designed to withstand break-in attempts. It dispenses condoms in a cellophane-wrapped paper box, into which the condoms are enclosed in another cellophane wrapper. The “Condom Machine Rules” posted next to the machine indicate that condoms are to be removed from the box and carried only in the clear wrapper, with the condom inside visible.

During the study period the Center for Health Justice has successfully installed, stocked and maintained the condom machine. Data analyses of the pre- and post-surveys and interviews are currently underway. Preliminary data analyses indicate that inmate self-report of sexual activity did not increase during the study period. In addition, the custody staff have reported no increase in reported sexual activity or any other security problems related to increased condom access.

We have encountered few operational problems, the most notable failing being a lack of instruction to use the machine: the machine was difficult to open and close for restocking and sometimes jammed. A new model of machine has been purchased to address these problems.

Condoms Coming Soon to a Facility Near You

While controversial, there is a trend toward increased inmate access to condoms. The CDC now recommends that prison systems with existing condom distribution programs evaluate those programs, and those without such programs consider the feasibility of implementing them.

Gov. Schwarzenegger’s “friendly veto” of legislation requiring inmate access to condoms may result in a pilot project across the state. At the federal level, California Rep. Barbara Lee’s JUSTICE Act of 2007 (H.R. 178), modeled on the California bill, requires federal prisoners to have access to condoms. Even where legislation is not pending, jails and prisons are considering the issue.

Regardless, programs that involve corrections cannot be successful without the support of the administration of corrections systems. The best circumstances for risk reduction involve input at the development stage, and any success these programs have is a credit to the professionalism of the corrections staff in the facilities where they exist.

Mary Sylla, JD, MPH, is the director of policy and advocacy at the Center for Health Justice, located in West Hollywood and Larkspur, CA; http://healthjustice.net. This article is a written version of a presentation given at the National Conference on Correctional Health Care in Nashville on Oct. 17, 2007. It is a slightly abridged version of an article that appeared in the October-November issue of IDC.

Condom Machine Rules
• Take only one condom per visit to the gym.
• Immediately open condom package and discard the external paper box and cellophane wrapper.
• Condoms enclosed in the clear sealed plastic wrapper are not contraband.
• Condoms remaining in the box or removed from the clear sealed plastic wrapper are contraband and will be confiscated.
• Having sex in jail is illegal under California Penal Code § 266(c).
• Failure to obey these rules will result in discontinuation of this condom access program.

Indication and usage
TRUVADA is indicated in combination with other antiretroviral agents (such as non-nucleoside reverse transcriptase inhibitors or protease inhibitors) for the treatment of HIV-1 infection. It is not recommended that TRUVADA be used as a component of a triple nucleoside regimen.

TRUVADA should not be coadministered with Atelvitra® (tenofovir/emtricitabine), Efavir® (emtricitabine), VIREAD® (tenofovir disoproxil fumarate), or lamivudine-containing products.

TRUVADA should be used in treatment-experienced patients, the use of TRUVADA should be guided by laboratory testing and treatment history.

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

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

Emtricitabine and tenofovir are primarily eliminated by the kidney. Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hyperphosphatemia), has been reported in association with the use of VIREAD.

It is recommended that creatinine clearance be calculated in all patients prior to initiating therapy and as clinically appropriate during therapy with TRUVADA. Routine monitoring of calculated creatinine clearance and serum phosphorus should be performed in patients at risk for renal impairment.

Components of TRUVADA have been studied in long-term clinical trials with Reyataz® and Kaletra®

TRUVADA is well matched for use with leading Pls°

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EMTRIVA should not be coadministered with Atelvitra™ (tenofovir/emtricitabine), Efavir™ (emtricitabine), VIREAD™ (tenofovir disoproxil fumarate), or lamivudine-containing products.

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Pandemic Flu Planning Checklist for Correctional Facilities

Before prescribing, see full Prescribing Information, including boxed WARNINGS. The following is a brief summary for TRUVADA ® (emtricitabine/tenofovir disoproxil fumarate) Capsules, Tablets, for the treatment of HIV-1 infection in adults.

**INDICATIONS AND USAGE**

TRUVADA is indicated for the treatment of HIV-1 infection in adults and pediatric patients weighing ≥30 kg. The safety and efficacy of TRUVADA in pediatric patients weighing <30 kg have not been established. TRUVADA should be used in conjunction with a protease inhibitor and/or reverse transcriptase inhibitor. TRUVADA is not a treatment for pre-exposure prophylaxis (PrEP) to prevent HIV-1 infection.

Publications

TRUVADA is indicated to reduce the risk of transmission of HIV-1 from infected father to child during pregnancy, labor, delivery, and breastfeeding.

**CONTRAINDICATIONS**

TRUVADA is contraindicated in patients with previously documented hypersensitivity to tenofovir or emtricitabine.

**WARNINGS**

RTV + 3TC + EFV in HIV-1 infected patients who have been exposed to RTV + 3TC with or without EFV or with RTV when used as a component of a combination regimen for the treatment of HIV-1 infection in adults.

**ADVERSE REACTIONS**

The following is a list of adverse experiences that have been reported with the use of TRUVADA. These adverse experiences, which were reported during clinical trials or post-marketing, have been either confirmed by clinical studies or closely resemble an adverse reaction observed in another drug with a similar mechanism of action. The frequency of adverse reactions varies by study design and data collection methods. The frequency is defined using the following scale: very common (≥1/10), common (≥1/100 to <1/10), rare (≥1/1000 to <1/100), very rare (≥1/10,000).

**Efficacy of TRUVADA Have Not Been Established in Patients With Other HIV-1 Subtypes**

For the safety and efficacy of TRUVADA, see full Prescribing Information. Before prescribing, see full Prescribing Information, including boxed WARNINGS. The following is a brief summary for TRUVADA ® (emtricitabine/tenofovir disoproxil fumarate) Capsules, Tablets, for the treatment of HIV-1 infection in adults.

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Correctional Health Care Professionals’ Response to Inmate Abuse

INTRODUCTION

Through national standards, public openness, litigation, and accreditation, correctional facilities continue to improve professionalism and safety in our prisons, jails, and juvenile confinement facilities. Today’s professional correctional administrator strives to protect personal safety in a secure environment. To accomplish these goals, a philosophy of professional and moral accountability, followed by appropriate policies, methods, and procedures, is necessary to maintain inmate safety and respect for the rights of inmates.

NCCHC Position Statement

NCCHC is committed to the humane and professional treatment of inmates. However, the draught of individuals and groups has and continues to challenge the standards set forth by the American Medical Association, the American Psychological Association, the American Psychiatric Association, the American College of Physicians, and the American Bar Association. This position statement is the result of these efforts and concludes that the recommendations of these organizations, including the American Medical Association, the American Psychiatric Association, and the American Psychological Association, regarding correctional health care professionals’ response to inmate abuse are well-established in the medical profession. The principle of medical autonomy dictates that the health professional act primarily in patients’ interests above all others and dictates that medical judgments be based on the needs of patients. In general, patients’ legitimate medical needs take priority over nonmedical matters in governing the actions of the health professional.

The principle of nonmaleficence dictates that health professionals refrain from participating in actions that may cause harm to patients. This principle is probably most familiar as the phrase “First, do no harm.”

Medical neutrality: The principle of medical neutrality dictates that the health professional treats patients regardless of their background, status, affiliations, or position. It is commonly cited in the practice of treating all wounded in time of war, whether the wounded are comrades or enemies.

The discussion also inevitably includes the key conflict of dual loyalty. Dual loyalty is defined as a conflict of interest.
between professional duties to a patient and obligations—express or implied, real or perceived—to the interests of a third party such as an employer, insurer, or the state. Dual loyalty is a potent and common moral conflict for health care professionals in institutional and managed care settings. Health professionals may find the principles of autonomy, nonmaleficence, or medical neutrality challenged by conflicting objectives of their institution.

Definitions
Mistreatment is the preferred general clinical term used to identify actual or potential harm to a patient from another person. Mistreatment may include physical abuse, sexual abuse, emotional abuse, neglect, and financial exploitation. Some forms of mistreatment may be unintentional. Other forms of mistreatment are more serious, and may lead to civil and even criminal sanctions.

Abuse is a more specific term that usually assumes deliberate intent. It has been defined as “the willful infliction of physical pain, injury or mental anguish; unreasonable confinement; or the willful deprivation of services which are necessary to maintain a person’s physical or mental health.” In the free world as well as in corrections, staff who observe patient abuse are usually required to report the incident to the proper authorities.

A third term, most often applied in a technical and legal sense to military and government action, is torture. While the word may sometimes be used more casually in common parlance, the technical term should apply only to extreme forms of mistreatment, and then only when accompanied by a specific purpose such as obtaining information or a confession.

Position Statement
Should correctional health staff witness or become aware of an inmate being subjected to harm in any of the forms described above, it is their duty to report this activity to the appropriate authorities in order to protect patients and other inmates. The following principles are to guide correctional health care professionals in averting and reporting the mistreatment of inmates.

1. Correctional health care professionals’ duty is to the clinical care, physical safety, and psychological wellness of their patients.

2. Correctional health care professionals should not condone or participate in cruel, inhumane, or degrading treatment of inmates. When such abusive treatment is either witnessed or suspected, they should identify and report such incidents to the appropriate authority.

3. Correctional health care professionals should refrain from participating, directly or indirectly, in efforts to certify inmates as medically or psychologically fit to be subjected to abusive treatment.

4. Correctional health care professionals should refrain from being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation.

5. Correctional health care professionals should refrain from gathering health information for forensic purposes or sharing confidential health information or its interpretation to authorities for use in cruel, inhumane, or degrading treatment of inmates.

6. Correctional health care professionals should abstain from authorizing or approving any physical punishment of their patients, and should refrain from being used as an instrument of their employer to weaken the physical or mental resistance of inmates.

7. Correctional health care professionals should review their employer’s policies and procedures, and work to ensure that they appropriately address how inmates are to be managed and what staff should do when abusive actions are suspected or witnessed.

8. Correctional administrators should ensure that policies and procedures address protections for employees who report the abusive actions of others.

9. Professional custody and health administrators should support efforts to eliminate abusive behavior toward inmates by assuring that all staff receive regular training on appropriate and professional behavior in dealing with inmates. Use of experts outside of the correctional system can be helpful in providing objective training on this issue.


Note: The two footnotes were omitted here; for the full version and all other NCCHC Position Statements, see www.ncchc.org/resources.
Impact of Estelle Still Felt Today

BY JOHN R. MILES, MPA

The January 2008 issue of the Journal of Correctional Health Care features something special: Our first Expanded Focus section. The idea is to invite leaders and experts to comment on a specific topic from their varied perspectives.

The first topic: Thirty Years After Estelle v. Gamble. With six contributors, this section examines the impact of this landmark U.S. Supreme Court ruling on correctional health care. The commentaries and articles highlight the important role litigation has played to bring about change in correctional health care, but they also demonstrate how the public perception of the “standard of decency” has supported improved access, accreditation and the growing recognition of correctional health care as a professional discipline. They also focus attention on how the process begun by Estelle continues to evolve to improve current practice and foster future improvements.

I thank Dave Doolen, a JCHC editorial board member, for his instance in the development of this section, and the authors for taking the time to write their material. I also encourage you to take a moment to send me your comments via letters to the editor and to provide short essays on topics of interest to you for our Readers Write column. Your thoughts and insights from your own experiences are always a welcome addition to the Journal and provide me with ideas for future issues. As always, I also encourage you to share your insights, opinions and experiences by submitting an article for publication.

John R. Miles, MPA, is editor of the Journal of Correctional Health Care; contact him at journal@ncchc.org.

JCHC Volume 14, Issue 1

- Readers Write: Insights From Practicing Correctional Health Professionals — Elder care in jails and prisons: Are we prepared?
- Effectiveness of Motivational Interviewing Techniques on Changes in Fitness, Blood Lipids, and Exercise Adherence of Police Officers: An Outcome-Based Action Study — Mark H. Anshel, PhD, Minsoo Kang, PhD

Expanded Focus Section: Thirty Years After Estelle v. Gamble

- Guest Editor’s Note — David Doolen
- Introduction — B. Jaye Amo, PhD, CCJHP-A
- Thirty Years After Estelle v. Gamble: A Legal Retrospective — William J. Rold, JD, CCJHP-A
- The Evolving Standard of Decency: Postrelease Planning? — Jeff Mello, PhD, Robert B. Greifinger, MD
- Health Care in Prison Thirty Years After Estelle v. Gamble — Lester N. Wright, MD, MPH
- Afterthoughts: A Correctional Health Care Perspective — John R. Miles, MPA

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Call for Papers

The Journal of Correctional Health Care is the only national, peer-reviewed scientific journal to address correctional health care topics exclusively. JCHC welcomes manuscripts on topics such as clinical health care, health services and support, personnel and staffing, ethical issues, clinical services, medical records, continuous quality improvement, risk management, medical-legal issues and more. Please send queries to editor John R. Miles, MPA, 250 Gatsby Place, Alpharetta, GA 30022; journal@ncchc.org. For author guidelines, visit the Web at http://jchc.sagepub.com.
Advocate for Counties Fights for Funding Reforms

Ronald Wiborg says he’s reached the age where he could simply retire. Not a chance. He’s too busy fighting for reforms in correctional health care funding at the county, state and federal levels.

He’s just the man for the job. For 20 years, Wiborg has been the contracts and grants manager for the Hennepin County (MN) Department of Community Corrections, gaining firsthand knowledge of jail economics. He’s a member of the National Association of Counties, serving on the Large Urban County Caucus steering committee and working on criminal justice and local correctional health care issues. (He also represents NACo on the NCCHC board of directors). And he’s a savvy and effective lobbyist.

Some of the legislative projects that Wiborg and his collaborators have undertaken have helped jails throughout Minnesota and could easily be replicated elsewhere. Others, particularly the work to change the HHS rule, would bring about radical change.

— Jaime Shinkus

Minnesota Statutes for Payment of Medical Services in County Correctional Facilities

Suspension, not Termination of Medical Assistance Eligibility

M.S. 256B.055, subd. 14: An individual who is enrolled in medical assistance who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

Continue General Assistance Medical Care While Incarcerated in County Jails

M.S. 256D.03, subd. (3)(j): General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet the other eligibility requirements of this subdivision.

Collect from Insurance Companies

M.S. 641.15, subd. 2: If a prisoner is covered by health or medical insurance or other health plan when medical services are provided, the county providing the medical services has a right of subrogation to be reimbursed by the insurance carrier for all sums spent by it for medical services to the prisoner that are covered by the policy of insurance or health plan, in accordance with the benefits, limitations, exclusions, provider restrictions, and other provisions of the policy or health plan. The county may maintain an action to enforce this subrogation right.

not qualify for federal programs).

The other law allows counties to be reimbursed for medical services provided to jail inmates who have private medical insurance. Perhaps surprisingly, the insurance industry offered no resistance to this legislation. Because it applies to hospital care, those providers did question their role in collecting this money, but it is the county’s responsibility to collect.

Why did the Minnesota state legislators agree to pass these laws? It’s simple: property taxes. Counties pay for jail health care through property taxes, so any costs avoided have a direct effect on taxes—and voters. Counties themselves can take steps to control costs while at the same time helping inmates to reenter the community. In Minnesota, the Hennepin County Adult Correctional Facility houses people convicted and sentenced for up to one year. Those inmates are screened for economic assistance from federal and state programs, and their applications are processed while they are incarcerated. They are covered the same day they walk out of jail.

Ronald Wiborg, MA, MBA, is the contracts and grants manager for the Hennepin County (MN) Department of Community Corrections. Jaime Shinkus is the editor of CORRECTCare.
Expert Advice on NCCHC Standards for Health Services

BY JUDITH A. STANLEY, MS, CCHP-A, AND R. SCOTT CHAVEZ, PhD, MPA, CCHP-A

‘Clearance’ for Pepper Spray

Custody staff often seek medical clearance before using pepper spray on an inmate. Does this act of clearance, giving the “yes or nay,” qualify as partaking in a disciplinary proceeding? Does such an act undermine the intent of the forensic information standard? One can argue that if health staff did not participate, it would cause more harm than good (because those with contraindications would be sprayed). However, reasonable people could conclude that any participation undermines the credibility of health professionals.

All health and custody staff should be able to reference a written protocol as to any health intervention required after the spray is used. Any inmates who do receive pepper spray are taken to medical staff for appropriate interventions.

You imply that health staff may not participate in disciplinary proceedings. Actually, health staff may consult in disciplinary hearings or decisions provided that they do not make the decision. In such cases, health staff, including mental health staff, should indicate whether any health or mental health condition may have contributed to the behavior in question. Health staff also may alert custody to the potential negative effects on the inmate of the proposed disciplinary action, and to help find appropriate alternate measures if the disciplinary action is contraindicated.

Footwear Regulations

I cannot find any information on the issue of correctional health staff wearing open-toed shoes. Any comment?

NCCHC’s Standards for Health Services manuals do not address this issue directly. Professional health staff should dress appropriately, of course. In many correctional facilities, open-toed shoes are considered a security or safety hazard. For example, inmates may step on toes or objects may fall on the toes, and open-toed styles may provide less support if a quick movement or response is needed. Correctional authorities in individual facilities or systems may ban such shoe styles for staff, just as dangling jewelry, loose ties and inappropriate-ly tight or provocative clothing are often banned. Standard A-03 Medical Autonomy defines when health staff are the decision makers, but also states that they are “subject to the same security regulations as other facility employees” in nonclinical matters (Compliance Indicator 4). If the facility forbids open-toed shoes, health staff are expected to comply.

Time to Prepare for New Standards

We heard that the 2008 jail Standards will be published in the spring. We are scheduled to have an accreditation survey in the fall. Does that give us enough time to prepare?

To give facilities time to adjust to the revisions, we always provide a transition period of at least six months. For details, see page 11.

Judith A. Stanley, MS, CCHP-A, is NCCHC’s director of accreditation and oversees the development and revision of standards. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee.

Send your question to Standards Q&A, c/o NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614; e-mail info@ncchc.org; fax 773-880-2424.

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Looking for an opportunity to enjoy all that life has to offer? Come join our team in Colorado! Physicians, Nurse Practitioners, and Physician Assistants for the Colorado Department of Corrections enjoy a balanced work schedule and professional challenge while pursuing all that Colorado has to offer! Our professional staff benefits from competitive salaries, excellent employee benefits, minimal call schedules, and hospital privileges. Our staff pursues their own interests by skiing, fishing, and hiking in the mountains as well as enjoying exquisite dining and cultural events in Colorado’s finest cities.

Come join the Colorado Department of Corrections where Quality of Care and Quality of life are truly enjoyed!

For more information, contact Anna Marie Campbell at 719-226-4536, or annamarie.campbell@doc.state.co.us. Check out the CDOC on line at www.doc.state.co.us.
Exhibitor Opportunity

Updates in Correctional Health Care
San Antonio, Texas • May 17-20, 2008

High Quality Contacts
If you want to rub elbows with the leaders in this field, your company needs to exhibit at Updates 2008. This meeting consistently attracts the best and brightest in correctional health care, professionals who care about their jobs and want to know how they can improve service delivery in their institutions. In other words, they want to know what you have to offer. Don’t miss this chance to make connections, stand out from your competitors and increase your company’s presence with this influential audience.

Exhibitor Benefits
- 1,000 high-quality attendees: These professionals are looking for solutions to the challenges they face.
- Premier educational programming: Share in the success of a proven winner.
- Exclusive exhibit hall hours: Develop valuable prospects and reconnect with customers through one-on-one networking during three days of scheduled activities and breaks (Sunday evening through Tuesday at noon).
- Long-term benefits: Your company will receive a free listing in NCCHC’s exciting new online Buyers Guide.

Other benefits include the following:
- 75-word listing in the final program (deadline applies)
- Electronic attendee registration list for pre-and post-show marketing
- Opportunity to add a marketing giveaway to the conference attendee bags
- Exclusive opportunity to participate in raffle drawings
- Ability to raise visibility by sponsoring NCCHC activities
- Special advertising discounts for CorrectCare and the conference program
- Priority booth selection for the 2008 National Conference on Correctional Health Care in Chicago

Who Should Exhibit?
- Associations; consultants; contract management; dental supplies/equipment; diagnostic equipment; educational materials/training; emergency preparation; EMR/health records; infection control; info tech/software; medical devices/equipment/supplies; pharmaceuticals and pharmacy services; publications; recruitment/staffing; suicide prevention; uniforms/scrubs; universities

Sponsorship Opportunities
- Pump up your presence and maximize marketing dollars through these outstanding sponsorship opportunities.
- Premier Educational Programming: Sponsorship of educational sessions on hot topics demonstrates support of the correctional field and provides great exposure.
- Proceedings Manual: Distributed in popular CD format, the manual provides a lasting record of each concurrent session, including abstracts, handouts and PowerPoints.
- The sponsor will be acknowledged on the CD cover.
- The Internet Cafe: Enjoy a high-tech presence by sponsoring the exhibit hall computer stations, where attendees gather to check e-mail and browse the Web.
- Exhibit Hall Reception/Luncheon/Breaks: These scheduled events enable attendees to meet with exhibitors and network with colleagues while enjoying refreshments.
- Other Opportunities: Registration bags, lanyards, caps, badges, banners—all are good ways to boost visibility.

Registration Information
- 10’ x 10’ booths start at $1,100. Double-size and premium spaces are available. Prices include one full and two exhibit-only registrations. Other company representatives may register at a discount. For a prospectus and reservation form, visit www.ncchc.org, e-mail info@ncchc.org, or call Lauren Bauer at 773-880-1460, ext. 298.

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

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

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 2 for contact information.

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

Physician Supervisor/Associate Medical Director

Physician
Are you ready to get away from the hassles of HMOs and filing insurance claims? Would you like to be part of a team addressing population health? If so, we have the positions for you.

Physician: vacancies (full-time or part-time) at Taycheedah Correctional Institution and Oshkosh Correctional Institution. Starting salary up to $167,712 annually, depending on qualifications, with supplemental pay for Board Certification eligibility between $9.27 to $18.54 per hour, plus an excellent benefits package.

Physician Supervisor/Associate Medical Director: vacancy at Oshkosh Correctional Institution. This position reports to the systems Medical Director. Starting salary up to $178,440 annually, including board certification and supervisory add-ons, plus an excellent benefits package.

Excellent benefits package to include: immediate coverage under the Wisconsin Retirement System. Health Plans available to meet your needs at low premiums, Sick Leave (5 hrs/pay period), Unused sick time converted to extended health care benefits upon retirement, 3 weeks paid vacation, 4.5 personal days/year, 9 paid legal holidays/year, Life insurance, Supplemental retirement saving program, Worker’s compensation and malpractice insurance is covered.

Application Information
For a detailed job description and application information, please see www.wi-doc.com. EOE
Public Health Behind Bars: From Prisons to Communities
This new book examines the burden of illness in the growing prison population, analyzes the impact on public health as prisoners are released and explores how care can be coordinated between correctional and community health care providers. Over 40 practitioners, researchers and scholars in correctional health, mental health, law and public policy offer recommendations for care that is humane for the health, law and public policy offer recommendations for care that is humane for the...
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