Periodontitis and Diabetes
Defusing a Dangerous Duo

Nurse Consultants Help Integrate Care
How Food Budget Cuts Can Improve Diets
Set to take place in Chicago’s bustling and beautiful downtown, the 2008 National Conference will inspire attendees to elevate their standards of professionalism and health care delivery. Join 2,000 colleagues at this multifaceted forum that offers over 100 concurrent sessions plus many other opportunities to extend your knowledge and your professional network.

For more information email conference@ncchc.org, call 773-880-1460, or visit www.ncchc.org.
CorrectCare™ is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by 38 leading national organizations representing the fields of health, law and corrections.
New CD Helps Jails Treat Opioid Abusers

Nearly every jail in the United States houses individuals with substance abuse problems. For many of them, contact with the criminal justice system is the first opportunity for a substance abuse disorder to be recognized and diagnosed by a medical professional. This presents a unique opportunity to begin clinical management and the road to recovery.

To help jails identify and provide appropriate treatment for the substance abusers in their charge, NCCHC has developed an educational CD-ROM and is sending it at no charge to jail administrators nationwide. Others may request a complimentary copy via our Web site, www.ncchc.org.

Produced with support from the Substance Abuse and Mental Health Services Administration, the CD contains information that is vital to understanding the problem and implementing an appropriate response.

Expertise at Your Fingertips

This invaluable resource features commentary from leading correctional and medical experts, who discuss the devastating problem of substance abuse and what jails and the medical community are doing to make our communities safer. The CD also contains downloadable resources.

Kevin Fiscella, MD, MPH, explains the importance of medication assisted therapy in outpatient clinics and the steps needed to treat opioid addiction. He provides guidance on how to comply with federal standards and provide quality care to those addicted to opioids and other substances. Fiscella represents the American Society of Addiction Medicine on NCCHC’s board of directors and is an associate professor at the University of Rochester (NY) School of Medicine.

Viewers also will meet Sheriff B. J. Roberts, Hampton County, VA, who has a deep interest in eradicating drug abuse in our nation. Roberts represents the National Sheriffs’ Association on the NCCHC board. In addition, NCCHC vice president R. Scott Chavez, PhD, MPA, CCHP-A, discusses two SAMHSA treatment improvement protocols (TIPs) on substance abuse treatment topics.

We are proud to present this program as one of the many ways by which NCCHC assists the correctional health care field. Other assistance we offer includes health care standards and accreditation, technical assistance, quality reviews, clinical guidelines, professional certification, educational conferences, publications and more.

<table>
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<tr>
<th>Continuing Education</th>
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<tr>
<td>Managing Addicted Inmates: Medication Assisted Therapy in Corrections</td>
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<tr>
<td>by Kevin Fiscella, MD, MPH</td>
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Physicians, nurses, psychologists and CCHPs may earn 1 hour of continuing education credit upon viewing this program and completing the self-study exam.

Learning Objectives
- Define opioid addiction and its signs and symptoms
- Employ medication assisted therapy to manage addicted inmates
- Apply principles described in SAMHSA’s TIP 44 for substance abuse treatment of adults in corrections

New SAMHSA Grant Supports NCCHC’s OTP Accreditation Program

The Substance Abuse and Mental Health Services Administration has awarded NCCHC funding related to its accreditation program for opioid treatment programs. The grant is part of SAMHSA’s effort to reduce the costs of basic accreditation education and accreditation surveys for OTPs.

In this context, accreditation is the peer-review process by which SAMHSA-approved accrediting bodies such as NCCHC make site visits and review the policies, procedures, practices and patient services of an organization providing opioid treatment. The purpose is to ensure that OTPs meet specific, nationally accepted standards for organizational functioning and patient care.

This latest grant will support quality accreditation services that promote better and more accessible health services for inmates, and that help OTPs to be self-sufficient in maintaining accreditation. A priority is for accredited OTPs to maintain quality of care and to expand their services.

An agency of the U.S. Department of Health and Human Services, SAMHSA is responsible for improving the accountability, capacity and effectiveness of the nation’s substance abuse prevention, addictions treatment and mental health services delivery systems.
A Call for Academic Collaborations

by Warren J. Ferguson, MD

It’s been more than 30 years since medical educators in the United States and Great Britain wrote of the need for collaboration between correctional health and academic medicine. Roll forward and consider that the incarcerated population has eclipsed 2.3 million, that illnesses such as hepatic C are of pandemic proportions in corrections facilities and that 95% of inmates, many with multiple complex medical and mental health issues, will be released.

One might assume that academic medicine has responded to these challenges. So, what progress has been made in linking academe to correctional health?

Over the last 10 years, there has been slow but steady growth in the number of health professions schools developing correctional health programs. Public medical schools in Georgia, Massachusetts, California and now New Jersey have joined the ranks of Texas and Connecticut in contracting with their state prison systems to provide medical and mental health services. At least 30 other academic health science centers are in significant collaborations with jails and prisons. With few exceptions, these collaborations remain largely clinical. NCCHC has also done an excellent job of collaborating with representatives from all of the medical and nursing specialties concerned with correctional health.

Yet, if we step back and evaluate progress through the lens of academe, there is still a lot of work to be done. With the exception of the Journal of Correctional Health Care, there are no peer-reviewed journals that concern themselves exclusively with a unique field caring for 2.3 million adults on any given day. With respect to research, apart from the psychiatric field, only a handful of researchers have research portfolios funded by the National Institutes of Health, and these are mostly confined to infectious disease. And despite a unique set of competencies required for success, clinical training programs focused on correctional health care are few and far between.

However, over the last three years, leaders in correctional health affiliated with academic institutions have begun to organize a consortium of academic correctional health. In the spring of 2007 and 2008, the first and second Academic and Health Policy Conferences on Correctional Health were held in Boston, with an average of 250 participants from 20 states, 3 provinces of Canada and 25 academic institutions. JCHC’s October features some of the proceedings of the 2007 conference, focusing on blueprints for research and training in correctional health [see page 6]. Preconference meetings at both conferences discussed opportunities to develop research networks; create a case for integration of correctional health training into schools of medicine, nursing and public health; and further the design for an Academic Consortium on Correctional Health.

The correctional health field has done a tremendous job over these 30 years to develop quality standards and accreditation, create professional certification programs and share best practices. It is high time now for this excellent progress to receive the legitimacy and support of academic institutions and grant-making organizations to grow the pipeline of future correctional health clinicians and to expand and disseminate the body of best evidence supporting best practices.

Warren J. Ferguson, MD, is associate professor and vice chairman in the department of family medicine and community health, University of Massachusetts Medical School, Worcester. He is co-director of the Third Academic and Health Policy Conference on Correctional Health, to be held in Fort Lauderdale, FL, on Feb. 5-6, 2009. To learn more, visit www.umassmed.edu/commed/ch_conference09.
New Combo Drug Therapy Slows COPD

Patients with moderate to severe chronic obstructive pulmonary disease may benefit from a new drug therapy, according to a study in the American Journal of Respiratory and Critical Care Medicine. A combination of salmeterol, a beta agonist, and fluticasone propionate, an inhaled corticosteroid, proved to reduce the loss of lung function in a randomized, double-blind, placebo-controlled trial of more than 6,000 patients in 42 countries. Until now, no drug has been shown conclusively to slow progression of the disease, and smoking cessation has been the only intervention proven to be effective. The drug therapy produced similar effects regardless of variables such as sex, age, ethnicity and body-mass index. “Although treatment did not abolish the accelerated decline in lung function, it did ameliorate it substantially,” the authors wrote.


FDA Lists Drugs Under Review for Safety

In accordance with the 2007 Food and Drug Administration Amendments Act, the FDA now posts on its Web site a list of drugs being evaluated for potential risks, based on the agency’s review of adverse-event reports submitted by doctors. The list, which is updated quarterly, contains only the drug’s name and the potential problem; it does not reveal the extent of the problem or the number of adverse reports filed, nor does it include all the drugs under FDA review for safety problems. The agency emphasizes that the inclusion of a drug on the list does not mean the medication should not be used.

Source: www.fda.gov/cder/aers/potential_signals

Number of Youth in Custody Trends Down

The number of minors in residential custody in 2006 was 14% lower than in 1999, a year when this population peaked at 107,667, according to a study by the National Council on Crime and Delinquency. A sharper drop, 38%, was seen in the number of youth housed in adult in jails and prisons (13,652 in 1999). The declines stem, in part, from reductions in juvenile crime and arrests, especially for serious offenses related to person or property. However, a New York Times editorial notes that many youth are being confined for minor offenses, and that states seem to be holding in juvenile facilities many youth “who should instead be treated in therapeutic programs near their homes.”


Public Health Emergencies Legal Preparedness

The CDC’s Public Health Law Program has developed a Web-based repository of resources for professionals and policy makers to use in strengthening their agencies’ and jurisdictions’ legal preparedness for all-hazards public health emergencies. The documents and educational courses address a broad range of topics, such as relevant public health laws, the national action agenda, forensic epidemiology, coordination of response measures, mutual aid agreements and more. They were developed with help from practitioners in public health, emergency management, law, law enforcement, the judiciary and corrections to ensure that they speak to the priorities and needs of those with front-line responsibility for dealing with these threats.

Source: www2.cdc.gov/phlp/lawmat.asp
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Academic Medicine and Correctional Health: A Meeting of the Minds

What happens when dozens of leading lights in academic medicine, correctional health, public health and policy get together? For one, a whole lot of great ideas are generated. That was a key objective of the first Academic and Health Policy Conference on Correctional Health, hosted by the University of Massachusetts Medical School in March 2007.

The overarching purpose of the two-day meeting was to link academic researchers with correctional health care administrators and clinicians, as well as the broader public health community, to develop an academic consortium on correctional health. UMass Correctional Health, a program of UMass Medical School, convened several work groups to discuss the status quo in correctional health care research, to identify barriers and gaps, and to propose research and education agendas to address those gaps.

The October issue of the Journal of Correctional Health Care features a special section with three articles that summarize the findings of the work groups on infectious disease, mental illness and primary care. In the introduction to the section, Rear Adm. Newton E. Kendig, MD, assistant director of the Health Services Division of the Federal Bureau of Prisons and a commissioned officer of the Public Health Service, writes that “Fruitful collaborations between academic medicine and correctional health care systems are historically uncommon…. Increasingly, however, the academic and correctional health care communities are viewing potential collaborations as not only mutually beneficial, but essential. Significant hurdles still remain, but they no longer seem insurmountable or justifiable.”

The articles note the difficulty in prioritizing investigation of largely unstudied, yet highly prevalent, health conditions of national importance. Kendig observes. Yet they succeed in cataloging a broad range of specific topics for future research and for health professions education. “Ultimately,” he writes, “the ideal research initiatives are those that are of intriguing interest to researchers, offer the promise to improve patient care and public health, hold the potential to enhance the safety of U.S. jails and prisons, and are deemed relevant to private and public funding authorities.”

[See the Guest Editorial, page 3, for more on this topic.]

JCHC Volume 14, Issue 4

Expanded Focus Section

Correctional Health Care and Academic Medicine: Bridging the Gap — Introduction by Newton Kendig, MD

• Infectious Disease in Correctional Health Care: Pursuing a Research Agenda — David Paar, MD, Carol Bova, PhD, RN, Jacques Baillargeon, PhD, William Mazur, MD, and Larry Boly, MD

• Correctional Mental Health Research: Opportunities and Barriers — Kenneth L. Appelbaum, MD

• Correctional Health Primary Care: Research and Educational Opportunities — Janet Fraser Hale, PhD, APRN, FNP, Arthur M. Brewer, MD, CCHP, and Warren Ferguson, MD


Shift Work and Correctional Officers: Effects and Strategies for Adjustment — David X. Swenson, PhD, LP, Daniel Waseleski, MA, and Robert Hartl, MA

Compliance Profile of Depakote ER Compared to Depakote DR and Valproic Acid in Bipolar Patients — Paul J. Morris, RN, CCHP

Each issue of the Journal also has a self-study exam by which physicians, nurses, psychologists and CCHPs may earn continuing education credit.

For information about subscriptions or how to submit an article, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
A decade ago, the Institute of Medicine launched a quality initiative that placed the issues of patient safety and quality of care at the forefront of health care reform. Today, public and private health care systems alike apply a variety of techniques aimed at ensuring patient safety.

In the correctional health care field, NCCHC is a strong advocate for patient safety and has incorporated requirements for safeguards to prevent adverse and near-miss clinical events in its 2008 Standards for Health Services for jails and prisons.

The IOM defines safety as freedom from accidental injury. In health care settings, the goal of patient safety is pursued through appropriate efforts to avoid adverse events related to errors in diagnosis, medication or treatment. But errors that do not result in patient harm are also to be avoided. An adverse clinical event would occur from switching two look-alike medications (such as Prozac and Doxipen) and giving the wrong one to a patient. A near-miss would be dispensing the wrong medication but not actually administering it.

Patient safety systems use redundancy (double checking) procedures to minimize errors and prevent adverse and near-miss clinical events. However, redundancy and back-up procedures alone do not guarantee that patient morbidity and mortality will be reduced. In fact, patient safety literature now identifies the human factor as an essential element in outcomes.

The human factor includes personal issues, task-oriented issues and interactions among staff. Most literature on patient safety calls for cultural changes in health care systems to minimize the human factor.

Personal Issues

Those who lack the knowledge, skill or motivation to improve patient safety are often part of the problem. Unfortunately, some health professionals do not fully appreciate these risks and take a cavalier attitude toward patient safety. Others do care but, due to poor understanding or perhaps a heavy workload, skip the steps designed to prevent errors. In correctional facilities, as in the world outside, it is too easy to become complacent about the status quo, even when safeguards are lacking.

Changes in attitude come when there is a top-down endorsement for a culture of patient safety. Administrators should employ strategies to help health care professionals maintain their interest in quality and safety. Training sessions and staff meetings provide good opportunities to build this culture.

Staff meetings should always reinforce the message that patient safety matters, that attentiveness to what is being done (or not done) is an important aspect of the job. Staff must be strongly encouraged to speak up and promptly report errors or problems that compromise safety. To achieve this culture, it is vital that there be no stigmatization or punitive action toward those who report errors.

Patient safety training should occur in staff orientation, inservices and self-assessment courses, and be incorporated into policies and procedures. Policy and procedure should dictate exactly what to do in an adverse clinical event or near-miss situation. Protocol might address what forms to fill out, who should receive them, corrective steps for different types of errors and other measures.

Task-Oriented Issues

Health system experts are interested in learning how distractions and interruptions in clinical workflow might jeopardize patient safety. A study published last year found 75 distracting events in 406 minutes of observing clinical tasks. These distractions led to 32 interruptions in care; of these, 5 tasks were not completed and 4 were not even remembered by the clinicians. Distractions could result in record-keeping mistakes, impede clinician communication and endanger patients.

Consider the pill line nurse under intense pressure to get the inmates completed before a scheduled and mandatory roll call. Or simply an environment with slamming steel doors, poorly illuminated examination rooms or unavailable health records at clinic appointments. What are the chances of human error occurring under these conditions?

Patient safety concerns are not limited to medication administration or medical records. Distracted health staff may be a root cause of patient falls, hurried staff might skip hand hygiene or an overworked clinician might forget to follow up on an MRI scan.

To minimize risk to the patient, administrators should strive to ensure that health care services are structured—and conducted—with patient safety as a goal.

Professional Interactions

In correctional facilities, health staff must contend with disruptive behavior from inmates and even from other staff members. Such behaviors can lead to preventable adverse events and compromise safety and quality. In a recent study of 4,530 administrators, nurses, doctors and other health professionals at 102 veterans’ hospitals, 77% of the respondents reported having witnessed disruptive behavior by physicians and 65% by nurses, behaviors that were linked with medical errors and patient mortality.

More fundamentally, clear communication among staff is essential to health care delivery. When communication is disrupted or is unclear, safety suffers. Efforts to improve communication and minimize disruptive behavior throughout the facility can improve staff safety and patient safety. Again, this should become part of the culture and reinforced through recognition and awareness, policies and procedures.

continued on page 33
Boyett v. County of Washington (2008, not otherwise published) is an extremely troubling case. Boyett died in the Washington County, UT, Purgatory Correctional Facility under darkly suspicious circumstances, and yet this panel of the 10th Circuit upheld the grant of summary judgment to the crowd of individual defendants even though, in my view, the law on point is perfectly clear. The nagging problems, as is often the case, relate primarily to the facts.

One of the more interesting legal questions is whether dubious care for Boyett’s mental illness can somehow be related to the cause of death, which the medical examiner found to be occlusive coronary artery disease with cirrhosis a contributory cause. There is a debate, which the plaintiffs lost, on the cause of death, so my statement on cause should be viewed as somewhat conditional but certainly of academic interest.

Another issue relates to the fact that, as I read the record, Boyett was seen by several nurses and a physician’s assistant. He was never seen over a 10-day period by a physician. A physician’s standing order for the administration of Thorazine (injected three times) was relied upon. Would a physician’s examination of Boyett have disclosed the heart disease and led to responsive care?

Even if we speculate yes, this panel found that, at worst, this was negligence but not the requisite deliberate indifference. The panel repeatedly stated that there is no requirement that a jail provide inmates with around-the-clock access to a medical doctor. However, Boyett was in custody for some 10 days and suffered from a variety of obvious mental and physical problems. “Around-the-clock access” simply misstates the problem, which, more accurately, is access to a physician when the gravity of the decedent’s medical condition became clear. That, indeed, was well before the time of his death.

Experts Banished
But there is more. The district court excluded as speculative the proffered testimony of the plaintiff’s three expert witnesses. When the expert testimony was excluded, the court determined there was no link between the jail guards—and Purgatory begins to sound like the right name—and the death. Let me reproduce the reviewing court’s description of this matter:

“Plaintiffs’ theory is that Boyett’s rib, rectum, and head injuries were not self-inflicted. They posit Officer Kounalis and perhaps another officer assaulted Boyett sometime between 5:00 p.m. on September 5 and his death the next morning. No direct evidence supports this theory; it rests entirely on (1) an expert report theorizing the injuries could not be self-inflicted, and (2) circumstantial inferences one of the prison guards must have been alone with Boyett and beat him while no one else was looking. We agree with the district court the record does not support Plaintiffs’ theory. One of the proffered medical experts, Dr. Lara, stated Boyett died as a result of: (1) trauma received prior to his death, (2) oversedation from major tranquilizers of a patient with compromised liver functions, and (3) denial of basic emergency care. Dr. Lara posited Boyett was suffering from liver failure, traumatic injuries (i.e., chest trauma, rectal tear, and internal bleeding), and probable overwhelming sepsis. Dr. Lara also stated videos taken of Boyett before his death showed he was able to lift his arms and move about in a manner that would have been impossible had Boyett been suffering from the injuries discovered at his death.

Another medical expert, Dr. Lovell, opined Boyett’s injuries were more likely caused by the guards than by
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Benefits of Attending
This multifaceted forum attracts a diverse group of correctional health practitioners and administrators from all disciplines. The meeting is unparalleled in the quality of professional education it provides. Through lectures, panels, workshops, posters and exhibits, you will receive the latest information on core competencies, best practices and emerging developments. You also will gain new allies in the quest for improvement:
• Discover the latest tools, techniques and solutions from top professionals
• Learn how other organizations have implemented successful programs
• Deepen your knowledge by attending preconference seminars
• Gain insights from eminent dignitaries during keynote presentations
• Earn continuing education credit in your discipline
• Network with colleagues, from top decision makers to in-the-trenches staff
• View new products and services in the Exhibit Hall
• Stock up on valuable resources at the NCCHC Bookstore,
• Explore Chicago through cultural tours and activities

Advance Your Knowledge
With more than 100 content-rich educational sessions, this meeting offers something for every level of experience. Sessions are designated as basic, intermediate or advanced. Here are some of the advanced sessions:
• Addressing Adolescent Health Care Needs: From ADHD to Zits
• Correctional Health Care Staffing: It’s Not an Art, It’s a Science
• Seven Habits of Highly Effective Leaders
• Spend Money to Save Money? Cost-Effectiveness Analyses in Jails
• Ten Years of 7th Circuit Federal Court Decisions on Correctional Litigation

Leadership Series
These interactive, high-level presentations are a hit every year. Designed for managers, both new and experienced, they will help you hone your skills to become a more effective leader.
• Expert faculty with vast experience in and knowledge
• Diverse topics for a well-rounded view of the nuances of leadership
• Practical information to help you become more effective and efficient

Longer Sessions
To provide more in-depth education on selected subjects, four of the concurrent sessions will run longer than the usual 60 minutes. Sessions II and XI will be 120 minutes, and Sessions IX and X will be 90 minutes.

Outstanding Networking
NCCHC conference attendees are the best and brightest in corrections. This meeting offers myriad opportunities for great networking. Learn how others are handling the problems that you face every day.

Make No Little Plans
Chicago is a city that inspires. Set to take place amid the skyscrapers of its bustling and beautiful downtown, the 2008 National Conference will inspire attendees to elevate their standards of professionalism and health care delivery.

Education Objectives
As part of its mission to provide continuing education, NCCHC specifies learning objectives for each conference.
• Demonstrate an understanding of correctional health care issues, including quality of care, access to care, financial management and workforce development
• Identify major health care, research and policy issues facing incarcerated individuals, including infectious diseases, mental illness, substance abuse and special needs (e.g., women’s issues, juvenile health, geriatrics, disability)
• Demonstrate increased understanding of skills necessary to better manage common medical, dental and psychological problems found in correctional settings
• Describe legal, ethical and administrative issues and develop solutions for the correctional setting

Preconference Seminars
Start off right by attending a seminar over the weekend. Presented by some of the most respected names in this field, the seminars provide an in-depth look at fundamental elements of delivering quality health care services in correctional settings. Conference registration is not required to attend. Fees are $170 for full-day seminars and $95 for half-day seminars and include all course materials and refreshment breaks.

Saturday, Oct. 18 (full day sessions)
• An In-Depth Look at NCCHC’s 2008 Standards for Health Services (choose Prisons or Jails)
• An In-Depth Look at NCCHC’s 2008 Standards for Mental Health Services in Correctional Facilities
• An In-Depth Look at NCCHC’s 2008 Standards for Health Services in Juvenile Facilities

Sunday, Oct. 19 (half day sessions)
• Chronic Disease Management
• Suicide Prevention: Components of an Effective Plan
• Practical Preparation for Initial NCCHC Accreditation
• Risk Management in the Correctional Environment

Presented by the National Commission on Correctional Health Care. Find the complete schedule and program updates online at www.ncchc.org.
The maximum hours of CE credit in each category include credits offered at preconference seminars.

- **CCHPs**: Certified Correctional Health Professionals may earn up to 32 contact hours of Category I continuing education for recertification.
- **Nurses**: NCCHC is an approved provider of nursing CE by the Illinois Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. This activity was approved for 32 contact hours.
- **Physicians**: NCCHC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. NCCHC designates this educational activity for a maximum of 32 AMA PRA Category 1 Credits™.
- **Psychologists**: NCCHC is approved by the American Psychological Association to offer continuing education for psychologists. This activity is approved for up to 32 hours of credit. See the final program for a list of presentations appropriate for credit for psychologists.
- **Social Workers**: This program is approved by the National Association of Social Workers for 32 hours of continuing education contact hours.

**Meeting Venue**

All educational activities will take place at the Hyatt Regency Hotel in the heart of downtown Chicago at 151 E. Wacker Drive, 60601; 312-565-1234. Due to a high number of early registrants, the hotel is sold out on several nights of the conference. For other hotel options nearby, please contact A Room With a View booking service: 800-780-4343. Mention the NCCHC conference when making your reservations.

**Exhibit Hall Activities**

With more than 125 companies participating, the exhibit hall will be a hot spot. This provides a unique opportunity to meet with many of the most knowledgeable representatives in our field to learn about the latest products, technologies and services available to aid in delivery of high quality care.

**Educational Poster Display**: Meet one-on-one with the poster authors to discuss their work during the exhibit hall opening reception on Sunday evening. Open for viewing throughout the conference during exhibit hall hours, the posters address a broad range of topics: program innovations, research findings, treatment recommendations and more.

**Exhibit Raffles**: Attendees won’t want to miss the raffle drawings on Tuesday, when they will have the chance to win educational, leisure and monetary gifts. Past prizes have included NCCHC conference registrations, Academy membership vouchers, golf clubs, DVD players, iPods, jewelry, American Express gift cards, computers and much more!

**Registration Information**

Visit www.ncchc.org for online registration or to download a form, or call NCCHC headquarters at 773-880-1460 for other options.

- **Academy Member**: $340. The Academy of Correctional Health Professionals is a conference sponsor. Members save $75 on the full registration fee.
- **Nonmember**: $415. If you are not a an Academy member and wish to join, simply sign up using the conference registration form.
- **One Day**: $195. Select the day you wish to attend. The one-day fee entitles you to participate in all events that day.
- **Guest Registration**: $55. This fee enables guests or spouses of registered attendees to attend all exhibit hall events.
Diabetes mellitus is thought to affect 4.8% of the 2.2 million inmates in the United States, according to estimates in NCCHC’s 2002 Health Status of Soon-to-Be-Released Inmates report. Health care professionals struggle daily to help these patients control their diabetes. Unfortunately, this population tends to have poor compliance with diabetes control regimens, which typically focus on diet, exercise and lifestyle.

But there’s another promising strategy in the fight to control diabetes: good oral health. Several recent studies have reported an association between diabetic control and periodontitis. Although a causal relationship has not been proven, it is believed that oral inflammation associated with periodontitis increases the risk for diabetic complications. (See box on page 13 to learn more about this relationship.)

Many inmates possess risk factors associated with periodontitis, including stress and smoking, as well as backgrounds marked by poverty, poor nutrition and hygiene, lack of education, dental phobia and poor dental treatment. They also are afflicted with diseases predisposing them to periodontitis, such as HIV, TB, syphilis, herpes, cancer and diabetes. In prisons, widespread use of prescription medications contributes to xerostomia, or dry mouth, which also increases the risk. Ethnicity may play a role, as well. It is estimated that periodontal disease affects 35% of Hispanic-Americans and 42% of African-Americans, although the reason for these differences is unclear.

Furthermore, the costs of treating periodontitis and diabetes are staggering. In 2006, researchers evaluated the effects of periodontal disease on the use and cost of medical and dental health care among 4,285 civil officers aged 40-59. Those with severe periodontitis accrued a 21% higher total cost of medical and dental care.

Because periodontal infection may complicate management of diabetes, and because both conditions are so costly to treat, it is important to include periodontal assessment and therapy as part of the diabetic treatment plan in correctional facilities. That’s why the Edna Mahan Correctional Facility for Women, Clinton, NJ, has initiated a performance improvement program to aggressively treat periodontal disease in its diabetic population.

**Taking Measure**

The average population at EMCFW is about 1,000 at any given time. Of these 1,000 women, 80 to 90 have some form of diabetes mellitus, a rate higher than the NCCHC estimate. Our goal was to monitor and improve the periodontal health of the inmates, reduce diabetic complications, increase compliance with treatment regimens and improve continuity of care between medical and dental professionals.

The current standard for periodontal therapy in the New Jersey Department of Corrections is to offer a complete
Causality

Although inconclusive thus far, studies continue to investigate what role periodontitis plays in an individual’s ability to maintain diabetic control. It is fact, however, that diabetes increases the risk for periodontal disease and that periodontal disease initiates the body’s inflammatory response. Here’s how these relationships are presently understood.

Periodontitis is a bacterial infection of the gingiva (gums) and periodontium (the connective tissue and bone supporting the teeth). Such infections may induce chronic inflammation, which, in turn, may decrease insulin-mediated glucose uptake, leading to high blood sugar and reducing diabetic control.

Oral inflammation begins when bacteria accumulate in the mouth and form plaque. These bacteria can release toxins that infiltrate inflamed oral tissue, enter the bloodstream and spread systemically. Circulating toxins can stimulate the immune response and trigger release of inflammatory markers that are thought to increase insulin resistance, boosting glucose levels in diabetics.

The risk runs both ways: Diabetics with poor control of blood sugar get periodontal disease more often and more severely than do persons with good control. Among young adults, those with diabetes have about twice the risk for periodontal disease compared to those without diabetes. In one study of 263 diabetics, the prevalence in individuals aged 19 to 32 was 39%.

What’s the connection? Insulin is needed to take up blood glucose and store it as glycogen in the liver and muscles. Too much sugar in the blood may increase the risk for vascular complications associated with diabetes, such as thickening of blood vessels. Thickened blood vessels may slow the flow of oxygen and nutrients to inflamed oral tissue and hinder the removal of harmful wastes, increasing the risk for gum disease.

Treating periodontitis may lower the rate of vascular complications associated with uncontrolled blood glucose. In fact, complete metabolic control of diabetes may not be possible when periodontal infection is present, according to the National Diabetes Information Clearinghouse.

Collaboration between medical and dental professionals will strengthen as research continues to investigate the oral-systemic link.

Target Patients

After deciding on these oral indices, we consulted the medical staff to determine the target population among the 81 diabetes patients we had at that time. The medical staff actively monitors all diabetes patients for HbA1c level (a measure of the glycosylated hemoglobin in the blood). An HbA1c level close to or within a range of 4% to 5.9% indicates good glucose control; levels exceeding 7% indicate compromised control. When this project began, 31 inmates were labeled “uncontrolled” with HbA1c levels greater than 7%. These inmates became the target population for aggressive treatment of periodontal disease.

The women were recalled for periodontal assessment and therapy as needed. At each visit, oral indices for periodontal disease were documented. Depending on the degree of infection, the women were rescheduled from two weeks to three months later for aggressive periodontal therapy. The disease was considered localized when less than 30% of bleeding sites remained. The patients were then scheduled for a dental prophylaxis in one year.

During this time, the dental hygienist also monitored the HbA1c level of these uncontrolled diabetic inmates using the medical record. The HbA1c level was documented...
Measurable Improvement

Of the 31 inmates targeted for aggressive periodontal treatment, 22 accepted treatment (the other nine were either released, transferred to another prison, refused to participate or had no teeth). The average HbA1c level of the uncontrolled diabetic inmates before aggressive periodontal treatment was 8.2. After the intervention, the average level was 7.3. Furthermore, the HbA1c level remained the same or decreased in 17 inmates. Of the remaining five inmates, two had a higher HbA1c level, but no data were available for the other three.

Approximately six months after we started the performance improvement project, the periodontium of 10 of the 22 diabetic inmates was considered healthy. The remaining 12 continued to be actively rescheduled for periodontal treatment, and at this writing, only five of the inmates still have an HbA1c level above 7%. Thus, good diabetic control has been restored for more than three-fourths of the women in this study.

Monitoring and tracking HbA1c levels of diabetic inmates by dental staff also has improved continuity of care. On intake, through collaborative efforts of all health care professionals, inmates can be educated to help them understand the relationship between diabetes and periodontal disease. Signs and symptoms of periodontal disease can be explained to promote their acceptance of preventive oral health care.

In addition, diabetes patients with uncontrolled blood glucose levels can be referred for periodontal screening and follow-up. Active monitoring of HbA1c levels by dental staff and aggressive periodontal intervention may improve diabetic compliance and reduce complications. The benefits add up to much more than just a healthy mouth.

Lori Strunck, RDH, is a dental hygienist at the Edna Mahan Correctional Facility for Women in Clinton, NJ. She can be reached by e-mail at ljstrunck@yahoo.com.

Carl B. Ausfahl, RN, MS, CCHP, is the quality improvement director for Correctional Medical Services’ Maryland office; at the time this article was written, he served in the same role in the CMS New Jersey office.
**DRUG INTERACTIONS**

Emtricitabine and Tenofovir DF: Other important drug interaction information for ATRIPLA is summarized in the table below. Drug interactions described are based on studies conducted with efavirenz, emtricitabine and/or tenofovir DF as individual agents or are potential drug interactions; no drug interaction studies have been conducted using ATRIPLA. The list includes potentially significant interactions, but are not all inclusive.

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| Efavirenz |EFV inhibits the CYP3A4 enzyme. Use caution if the patient is or might become pregnant. |}

**Emtricitabine**

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**Tenofovir DF**

Tenofovir DF is contraindicated with didanosine. Use caution when used with other nucleoside analogs or nucleotide analogs.

**Efavirenz**

Efavirenz has been shown in vivo to induce CYP3A. Other compounds that are substrates of CYP3A may have decreased plasma concentrations when coadministered with efavirenz. In vitro studies have demonstrated that efavirenz inhibits most of the CYP3A enzymes, including 3A4, and 3A4 inhibitors in the moderate range may decrease the clearance of drugs that use CYP3A enzyme activity (e.g. phenobarbital, ritonavir, rifampin) to be expected to increase the clearance of efavirenz resulting in lower plasma concentrations. Emtricitabine and tenofovir DF are primarily eliminated by the kidneys. Coadministration of ATRIPLA (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) with drugs that are cleared by the kidneys may result in decreases in plasma concentrations of one or both of the agents. Coadministration of tenofovir DF and didanosine should be undertaken with caution and patients receiving this combination should be monitored closely for didanosine-associated adverse reactions. Didanosine should be discontinued in patients who develop didanosine-associated adverse reactions. Didanosine should be discontinued in patients who develop tenofovir-associated adverse reactions. ATRIPLA should be discontinued in patients who develop tenofovir-associated adverse reactions. Coadministration of tenofovir DF with ATRIPLA is not recommended. There are insufficient data to support dosing recommendations for atazanavir, with or without ritonavir.

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Nursing organizations in the hospital field talk openly and proudly about their multidisciplinary approach to patient care. Many prisons and jails would like to have the same approach, but environmental issues, short staffing, and sheer patient numbers and acuity tend to intensify the divisions. Correctional settings add a third element—custody—to the equation, which often further divides staff.

The California Department of Corrections and Rehabilitation nurses who provide care to patients in 33 prisons with approximately 175,000 inmates endure the same challenges. And they must do so in the context of two ongoing lawsuits that guide care provided in mental health and medical services.

The arrival of a new court-appointed receiver who values the integration of services in a collaborative forum has inspired hope among these nurses. However, in the southern region, nurse consultants for program review (NCPRs) for both medical and mental health started that integration process long before the new receiver stepped in.

Diverse Challenges
During the post-lawsuit era, CDCR management recognized the difficulty of uniformly making changes and of communicating those changes across the system. In response, the NCPR position was developed to integrate, coordinate and evaluate health care in the system. The NCPRs take a major role in bridging the gaps. For instance, the NCPR has the opportunity to relate best practices used at one prison to others and to assure their implementation.

The CDCR employs both medical and mental health nurse consultants and assigns each to a specific region. Working as a nurse consultant in this system presents many diverse challenges that virtually assure job satisfaction. The NCPRs contact all prisons in their region and assist the health care staff in meeting the needs of their patients and facility. Troubleshooting, helping the staff to bridge gaps with custody, conducting and reviewing audits, and participating with the staff in meetings, staff interviews, quality management, utilization review and educational seminars are just some of the duties assigned to NCPRs.

But although they share many of the same duties, the NCPRs in the two programs were not unified. The mere size of each prison, number of potential patients and sprawling land surrounding multitudes of buildings make it difficult to communicate with nurses in another yard, let alone those in another discipline or department such as mental health.

In the southern region, the medical and mental health NCPRs recognized early on that although there are two lawsuits to which those services respond and two different budget processes overseen by the courts and state government, nursing did not have to follow that delineation. After all, the patient is still one and the same. Care delivery is moving forward to a quality model, so why shouldn’t nursing relationships move in that direction as well? Nurses in the facilities that NCPRs visit have many of the same concerns about the need for integration and collaboration to produce better patient outcomes.

This group of NCPRs and their regional director of nursing quickly realized that we wanted to work together, we didn’t want to duplicate work and we wanted to facilitate coordinated care by one discipline—and that each group had information and expertise that could complement the other. Even though mental health and medical NCPRs’ goals and directives were sometimes bipolar and often directed them away from physically working with each other, the commitment to collaborate continued.

Common Ground
Medical NCPRs are greater in number than mental health NCPRs and do not report through the same organizational structure, but the contributions of both groups are equally valuable. For instance, the task of medication management is important to medical and psychiatric patients alike in the prison, and it was a common starting ground for communication between NCPRs.

At the outset, the regional DON introduced the mental health NCPRs to the various on-site directors of nursing as a person with whom the local staff should work, which sends the message that the mental health NCPR is a person of value and knowledge. It clears the way for contacts and communication.

Now, the mental health NCPRs make a point to check in with the director of nursing at each visit and to inform the DON of their task for the day. When the regional DON holds monthly staff meetings, the mental health nurses are always invited and they do attend. Projects, common issues and resolutions are routinely discussed at those meetings. Information about changes in management, regional staff and local facility staff are also shared with each other.
Whenever possible the NCPRs visit the facilities together. This unity lends credibility to the NCPRs and promotes a sense of teamwork to the nursing and facility management staff. More concretely, NCPRs from medical and mental health use each other’s extensive specialized backgrounds to collaborate on educational in-services and in their contributions to nursing orientations.

**Case in Point**

A mental health NCPR was asked to intervene in a facility for a situation where registered nurses were being replaced with licensed psychiatric technicians for certain needs that are usually exclusive to the RN staff. Disagreements about which discipline was to be responsible for which assignments escalated into an issue with the RN labor union.

But the medical and mental health NCPRs jointly attended the next labor-management meeting and together came up with workable resolutions to which the union agreed that pleased nurses, technicians and management.

The mental health NCPR had experience writing exam questions for the LVN/LPT state board exams and is highly knowledgeable about their scope of practice. At the meeting, she clarified the LVN/LPT scope of practice for the department and for the union. The two NCPRs convinced the union that the LPT could and should complete the task under the direction of an RN. This solution not only adheres to practice guidelines but also gave both medical and mental health a role in the solution and in creating a shared vision for patient care.

**A Bright Future**

The southern region’s collaborative approach is now being shared with other regional groups at joint NCPR meetings, and these groups are looking forward to even more exciting endeavors in the near future. A new pharmacy system, new psychiatric technician job statements and joint educational endeavors are planned. Joint efforts have produced a new restraint and seclusion policy, identified new and expanded roles for facility nurses and presented an example of a true team approach for other prisons and jails to emulate.

So while the judges, monitors, special masters, receiver and a litany of attorneys meet to decide the integrated fate of the medical and mental health care at California state prisons, the NCPRs vow that they will move forward full steam ahead as a team, no matter what.

_Deborah Lucas, RNC, MSN, CCHP, was a nursing consultant with the California Department of Corrections and Rehabilitation, Mental Health Services. She is now chief nursing officer at Gateways Mental Health Hospital and Community Mental Health Centers, Los Angeles. She can be reached at dlucas@gatewayshospital.org._
Maintaining good nutrition in correctional food service is a continual challenge as budgets grow tighter, costs increase and dietary standards and guidelines become more stringent. These trends affect menu planning, medical diet programs and overall food service operations. Corrections dietitians are tasked with developing nutritionally adequate menus and therapeutic diets while staying within budget constraints.

Earlier this year, media coverage of healthy meals in the New York City Department of Corrections sparked extensive discussion among corrections dietitians. Across the nation, more and more menu modifications are being made to control costs, and the initial changes are often through eliminating or reducing items such as coffee, sugar, fat and milk, either in type or quantity. The good news is that these alterations are resulting in more heart-healthy menus, which should lead to better health outcomes.

This article highlights some of the approaches being taken in various jurisdictions.

Nutrition in New York City

According to Paulette Johnson, MS, RD, CDN, assistant commissioner of the NYC DOC nutrition services division, the agency has made many changes toward achieving a heart-healthy menu, such as eliminating or reducing sugar and butter. Below are some details of the menu:

**Sugar**
- Effective July 2008, all desserts such as baked goods, ice cream and canned pudding are sugar-free.
- The one exception is cake, served only on holidays. Carrot cake will be served for Thanksgiving and Christmas.
- Sugar-free muffins are served once per week.
- Canned fruits are packed in natural juice.
- Sugar packets are still available.

**Fat**
- Butter has been replaced with margarine.
- 1% and skim milk are the only types of milk served now.
- Trans-fats were eliminated from NYC jails six months before the city banned them in restaurants.
- Fried foods have not been served for more than a decade.

**Fiber**
- Fiber content has increased by offering whole wheat bread and fiber-rich cereals.
- Fresh fruit is served daily.

**Sodium**
- Low-sodium products are served. This includes processed meats, prepared entrees and canned vegetables.

In addition, nutrition classes are conducted for inmates who are on therapeutic diets.

NYC DOC Commissioner Martin Horn credits Johnson with bringing better nutrition and healthy diets to the city’s jails. “[Johnson] recognized a decade ago that many of our inmates come into custody with poor health and unhealthy eating habits, and that providing nutritious food with more fiber, less fat and fewer calories was actually a public health opportunity.”

Providing a healthy diet is “part and parcel” of the jail system’s mission to provide care, custody and control, Horn adds, and is in keeping with the goals of a citywide nutrition task force established by Mayor Michael Bloomberg. “We serve 42,000 healthy meals every day, many to inmates who are in our custody a short time,” he says. “Nutritious food can be served at no greater cost than less healthy food, and it’s our hope that detainees and sentenced inmates benefit from the nutrition while they are with us and after they return to the community.”

Horn has reported that the recent menu changes have had no net effect on food costs, which he says are about $2.50 per inmate per day.

Sampling the Fare

Research for this article found that other correctional systems are using a variety of cost-cutting measures that have contributed to healthier menu offerings. Most commonly, these efforts focus on eliminating or reducing usage of coffee, sugars, fats and sodium, and reducing or switching to a different type of milk, including fortified milk substitutes. While such practices have been the norm (in varying degrees) in some systems for awhile, they are becoming a trend across the country as administrators strive to reduce costs and improve outcomes.

In Michigan, the state Department of Corrections has been serving a “healthy choice” menu since 2001. In addition to serving skim milk, facilities offer a choice of dessert or fruit (fresh and juice-packed); regular and dietetic jelly, sweeteners, salad dressings and beverages; and meat and meatless entrees.

This proactive, “choice” approach has reduced the need for therapeutic diet trays, says foodservice program manager Gatha McClellan, RD. “It also increases flexibility in placement of prisoners and reduces cost of prisoner transfers.”

Significantly, it also has led to stable food costs over the past four years, with average per capita meal costs actually a few cents lower in 2006 and 2007 compared to the two years prior. “We do not believe the choice menu increases food cost because prisoners frequently take the less expensive item and they take only the food they will eat,” McClellan notes.

But 2008 is proving to be more of a challenge, with major price increases in various foods. To offset the higher prices, the DOC plans to make some menu changes, such as using less costly vegetables, eliminating the option for a

continued on page 19
third slice of bread and decreasing calories. But good nutrition remains the focus: “We do not plan on using imitation foods, which would be a quick fix but in the long run would increase health care costs,” McClellan says. Planned operational changes will also help shave expenses.

In January, the Federal Bureau of Prisons implemented a national menu that incorporates healthy alternatives, according to Tom Issermoyer, the FBOP’s national food service administrator. It is similar to the Michigan menu and also offers heart-healthy alternative entrées along with meat-free entrées.

The Minnesota Department of Corrections has approved the adoption of heart-healthy menu standards, to begin in 2010. The menu is based primarily on the 2005 Dietary Guidelines for Americans issued by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. The guidelines provide authoritative advice about how good dietary habits can promote health and reduce risk for major chronic diseases. They also are the basis for federal food and nutrition education programs.

The committee responsible for implementation is still developing the specific approaches and timelines for meeting the new guidelines. For example, they must make decisions on the use of skim milk, sugar-free soda, fish and vegetable bars. Plans are already in place, though, to create salt-free and low-fat recipes and to explore meatless entrées.

In the Los Angeles County jail system, Benson Li, manager of the food services unit, serves approximately 21,500 inmates. This includes meals to those housed in a 200-bed treatment center and more than 1,600 medical diets for outpatients. The meals, which omit coffee, sugar and margarine, cost about $2.50 per inmate per day.

The system operates under a state regulation known as Title 15, which governs all county jails in California and has some of the most stringent jail food service standards in the nation. At the county level, the Board of Supervisors has a zero trans-fat mandate, copied from New York, and since July has required the use of environmentally friendly chemicals and disposable wares.

Overall, offering heart-healthy alternatives is consistent with the 2005 Dietary Guidelines in terms of increased fiber, controlled fat, reduced sodium and food variety. In combination with education on nutrition and diet, this contributes to positive overall health and reduced need for therapeutic diets, with an end result of lower costs in both food services and health services.

A caveat, though, is that all of these measures can reduce overall calories, which must be considered when a calorie requirement is part of the jurisdiction’s standards.

Also, food service programs that give inmates the option of choosing healthier foods are usually feasible only in systems or facilities that have cafeteria-style meal service.

**Nutrient and Cost Trends**

Numerous factors come into play when correctional facilities seek to make informed decisions about diet changes.

**Cost-Per-Nutrient Values**

This term has not come into common parlance, but the practice of evaluating the cost per nutrient is becoming more widespread when modifying correctional menus.

Eliminating or limiting “empty” calories such as coffee and sugar reduces nonnutritive costs as well as overall calories. This has a positive effect on health concerns related to obesity, diabetes and cardiac disease, among others. Likewise, eliminating or limiting margarine and fried foods reduces overall intake of calories and fats, with a corresponding impact on cardiac disease and weight management along with overall health. Removing sugar and fats opens the door for more nutrient-dense foods such as fruit to be offered in place of baked sweets. This boosts intake of vitamins, minerals and fiber and reduces sodium intake.

**Milk/Dairy Alternatives**

Currently, milk is served as often as three times daily on general population menus in America’s correctional institutions. California law mandates three servings of milk and/or milk products daily in jails, while Wisconsin, a dairy-producing state can afford to offer three servings.

However, rising prices of dairy products are prompting corrections dietitians to consider cost-effective substitutes that meet nutritional needs. Not surprisingly, milk alternatives and fortified foods are growing more popular as supplements or even replacements for liquid milk.

In an effort to control costs, some facilities are switching to fat-free skim milk and still further limiting liquid milk to one serving per day or less. Many are using powdered milk for drinking as well as cooking. This reduction in the quantity of milk served has opened the door for fortified milk.

*continued on page 20*
replacement beverages and other nutrient fortified products such as puddings and bread dough.

These modifications in milk usage contribute to an overall reduction of fats, cholesterol and calories provided, which again is beneficial to health. But care must be taken to ensure that similar nutrient needs are met using these alternate milk choices.

In fact, some have questioned whether use of these products violates the NCCHC Standards for Health Services. The Standards recognize the importance of diet in maintaining health. In the 2008 editions for jails and prisons, standard F-01 Healthy Lifestyle Promotion recommends serving appropriate diets that are based on the principles expressed in the government’s MyPyramid food guidance system and that meet the recommended dietary allowances of nutrients. Proper nutrition is particularly important for adolescents, so the standards for juvenile facilities go into even more detail.

According to NCCHC, milk and dairy products are optimal, but use of substitutes approved by nutritional experts as being nutritionally adequate would be in compliance with the standards. Certain populations, such as those on special medical diets or adolescents, may be exceptions and such should be clearly spelled out in directives issued jointly by the medical director and dietician consultant.

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### Diets (continued from page 19)

**Bread Products**

Some correctional kitchens are making their own bread products (from scratch or mix) to help offset the costs of purchased, sliced bread. Fresh-made items such as biscuits, cornbread, dinner rolls and buns are appearing on main population menus and diet menus, when possible. A typical serving of cornbread provides calories and fiber similar to that of two slices of bread, but much more economically. Dinner rolls and buns also provide a fresh quality product, which can be made a defined size and allow for the use of whole wheat flour, which improves the nutrient and fiber content. To increase desirable nutrients, one company even manufactures a calcium-fortified bread dough for the corrections market.

### Other Trends

- **Education**: Teaching inmates about nutrition and diet education is becoming more popular. The information is typically provided from the medical department in the form of a handout, according to a recent survey of corrections dietitians. This knowledge enables inmates to understand their nutritional needs, both for general and medical diets, and to make healthier food choices.
- **Fuel surcharges**: In addition to rising food prices, fuel surcharges for food deliveries are becoming more common. This is yet another factor to consider in cost containment.
- **Fortified foods**: Many corrections suppliers are creating foods designed to help meet nutrient requirements economically. Fortified beverages, puddings/desserts and bread dough are common, as are reduced-sodium meats.

### Getting More With Less

Moving toward more heart-healthy options by limiting empty calories and offering nutrient-dense foods ultimately reduces the overall costs associated with both food service and health care needs. These trends are consistent with the rationale of the NCCHC standards.

Surprisingly, not all administrators view these trends as a positive for the climate in their facilities; some still believe that they must keep inmates full and happy at mealtime to avoid potential security problems. But the long-term outcome—healthier inmates, lower expenses—is a perfect example of getting more with less.

Barbara Wakeen, MA, RD, LD, is the principal of Correctional Nutrition Consultants and is based in North Canton, OH. She represents the American Dietetic Association on the NCCHC board of directors and contributed the Dietary Guidelines appendix to NCCHC’s 2008 Standards. She also is the author of Nutrition and Foodservice Management in Correctional Facilities, 3rd Edition. To reach her, e-mail bwa-keen@neo.rr.com.
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SUSTIVA in combination with other antiretroviral agents is indicated for the treatment of HIV-1 infection. This indication is based on two clinical trials of at least one year duration that demonstrated prolonged suppression of HIV RNA.

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- Coconcurrent use of SUSTIVA and St. John’s wort (Hypericum perforatum) is contraindicated. If SUSTIVA is coadministered with voriconazole, the voriconazole maintenance dose should be increased to 400 mg every 12 hours and the SUSTIVA dose should be decreased to 300 mg once daily using the capsule formulation. SUSTIVA tablets should not be broken.

- Concomitant use of SUSTIVA and St. John’s wort (Hypericum perforatum) or St. John’s wort containing products is not recommended.

- Serious psychiatric adverse experiences, including severe depression (2.4%), suicidal ideation (0.7%), nonfatal suicide attempts (0.5%), aggressive behavior (0.4%), paranoid reactions (0.4%), and manic reactions (0.2%), have been reported in patients treated with SUSTIVA. In addition to SUSTIVA, factors identified in a clinical study that were associated with an increase in psychiatric symptoms included history of injection drug use, psychiatric history, and use of psychiatric medication. There have been occasional reports of suicide, delusions, and psychosis-like behavior, but it could not be determined if SUSTIVA was the cause. Patients with serious psychiatric adverse experiences should be evaluated immediately to determine whether the risks of continued therapy outweigh the benefits.

- Fifty-three percent of patients reported central nervous system symptoms, including dizziness (28.1%), insomnia (16.3%), impaired concentration (8.3%), abnormal dreams (6.2%), and hallucinations (1.2%), when taking SUSTIVA compared to 25% of patients receiving placebo. These symptoms usually begin during Days 1-2 of therapy and generally resolve after the first 2-4 weeks of therapy; they were severe in 2.0% of patients and 2.1% of patients discontinued therapy. After 4 weeks of therapy, the prevalence of nervous system symptoms of at least moderate severity ranged from 5% to 9% in patients treated with regimens containing SUSTIVA. Nervous system symptoms are not predictive of less frequent serious psychiatric symptoms.

- SUSTIVA may cause fetal harm when administered during the first trimester to a pregnant woman. Women should not become pregnant or breast-feed while taking SUSTIVA. Barrier contraception must always be used in combination with other methods of contraception (eg, oral or other hormonal contraceptives). Because of the long half-life of efavirenz, adequate contraceptive measures are recommended for 12 weeks after discontinuation of SUSTIVA. If the patient becomes pregnant while taking SUSTIVA, she should be apprised of the potential harm to the fetus.

- Mild-to-moderate rash is a common side effect of SUSTIVA. In controlled clinical trials, 26% of patients treated with SUSTIVA experienced new-onset skin rash compared with 17% of patients treated in control groups. SUSTIVA should be discontinued in patients developing severe rash associated with blistering, desquamation, mucosal involvement, or fever. Rash is more common and often more severe in pediatric patients.

- Liver enzymes should be monitored in patients with known or suspected hepatitis B or C, in patients treated with other medications associated with liver toxicity, and when SUSTIVA is administered with ritonavir.

- Use SUSTIVA with caution in patients with a history of seizures. Convulsions have been observed in patients receiving efavirenz, generally in the presence of known medical history of seizures.

- Rash is more common and often more severe in pediatric patients.

- Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including SUSTIVA.

- Saquinavir should not be used as the only protease inhibitor in combination with SUSTIVA.

- Redistribution and/or accumulation of body fat have been seen in patients treated with SUSTIVA.

- Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including SUSTIVA.

- Saquinavir should not be used as the only protease inhibitor in combination with SUSTIVA. Please see the SUSTIVA Full Prescribing Information for complete list of drug interactions.

- The most common adverse events (≥5%) observed in clinical studies with SUSTIVA include fatigue, pain, dizziness, headache, insomnia, impaired concentration, nausea, vomiting, diarrhea, depression, rash, and pruritus. The dose of SUSTIVA is one tablet once daily taken orally on an empty stomach, preferably at bedtime, in combination therapy. The increased concentrations following administration of SUSTIVA with food may lead to an increase in frequency of adverse events. Dosing at bedtime may improve the tolerability of nervous system symptoms.
Patients should be informed that SUSTIVA (efavirenz) is not a cure for HIV-1 infection and that they may continue to develop opportunistic infections and other complications associated with HIV disease. Patients should be advised to take SUSTIVA as prescribed and to continue taking other antiretroviral drugs.停用SUSTIVA可导致病毒耐药性增加，提示患者应继续服用本品，而不要停药，以便继续评估患者对本品的反应。

Patients should be informed that SUSTIVA may increase the risk of developing hepatic HBV/HCV infections in HBsAg-positive/HCV-positive patients (see PRECAUTIONS, Drug Interactions).

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Clinical trials are presented in Table 1 below.

### Table 1: Selected Treatment-Emergent AEs of Moderate or Severe Intensity Reported in ≥2% of SUSTIVA-Treated Patients in Studies 006 and ACTG 364

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>SUSTIVA® + ZDV/LAM</th>
<th>SUSTIVA® + ZDV/LAM Ind</th>
<th>Nelfinavir + ZDV/LAM</th>
<th>Nelfinavir + NRTIs</th>
<th>Nelfinavir + NRTIs + MTXs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any AEs</strong></td>
<td>80.9%</td>
<td>81.4%</td>
<td>86.6%</td>
<td>86.7%</td>
<td>86.6%</td>
</tr>
<tr>
<td><strong>Serious AEs</strong></td>
<td>3.1%</td>
<td>2.6%</td>
<td>2.2%</td>
<td>3.2%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

### Table 2: Selected Grade 3-4 Laboratory Abnormalities Reported in ≥2% of SUSTIVA-Treated Patients in Studies 006 and ACTG 364

<table>
<thead>
<tr>
<th>Variable</th>
<th>Limit</th>
<th>Study 006</th>
<th>Study 006 ACTG 364</th>
<th>Study 006 ACTG 364</th>
<th>Study 006 ACTG 364</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT &gt;100 U/L</td>
<td>5%</td>
<td>6%</td>
<td>2%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>AST &gt;100 U/L</td>
<td>5%</td>
<td>6%</td>
<td>2%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>GGT &gt;5xULN</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Triglycerides &gt;1150 mg/dl</td>
<td>9%</td>
<td>6%</td>
<td>11%</td>
<td>9%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### Nervous System Symptoms

Psychiatric: serious psychiatric adverse experiences have been reported in patients treated with SUSTIVA. In controlled studies, the frequency of specific serious psychiatric symptoms among patients who received SUSTIVA or control regimens, respectively, were: depression (13%, 8%), anxiety (24%, 15%), insomnia (7%, 2%), headache (15%, 12%), nervousness (5%, 2%).

### Skin Rash

Skin rash occurs are usually mild to moderately severe maculopapular eruptions similar to those reported with efavirenz. The frequency and severity of skin rash were generally similar among pediatric patients treated with SUSTIVA- and control regimens, respectively.

### Pediatric Use

SUSTIVA has not been studied in pediatric patients below 3 years of age or who weigh less than 13 kg. At 48 weeks, the type and frequency of rash were similar regardless of sex, race, or body weight and regardless of use of cotherapy with other antiretroviral agents.

### Pregnancy Category

D: Reproductive Risk Potential

### Postmarketing Experience

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Percent of Patients Treated with Nelfinavir (n=65)</th>
<th>Percent of Patients Treated with SUSTIVA (n=66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fat Redistribution</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### Laboratory Abnormalities

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (Range)</th>
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</thead>
<tbody>
<tr>
<td>AST &gt;5xULN</td>
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<td>6%</td>
</tr>
<tr>
<td>GGT &gt;5xULN</td>
<td>8%</td>
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</tr>
<tr>
<td>Triglycerides &gt;1000 mg/dl</td>
<td>9%</td>
<td>6%</td>
</tr>
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### Postmarketing Experience

Liver function tests should be monitored in patients with a history of hepatitis B and/or C. In the long-term data set from Study 006, 137 patients treated with a combination containing efavirenz (median duration of therapy, 68 weeks) and 64 treated with a combination containing nevirapine (median duration, 66 weeks) had a history of hepatitis B/C. No change in alanine aminotransferase, aspartate aminotransferase, or alkaline phosphatase was detected in patients treated with efavirenz.

### General

Experience with SUSTIVA in patients who discontinued other antiretroviral agents of the NNRTI class is limited. Nineteen patients who discontinued nevirapine because of rash have been treated with SUSTIVA. Nine of these patients developed mild-to-moderate rash while SUSTIVA was restarted. SUSTIVA should be discontinued in patients developing severe rash associated with blistering, desquamation, or ulceration.

### Additional Psychiatric

Serious psychiatric adverse experiences have been reported in patients treated with SUSTIVA. In controlled trials, the frequency of specific serious psychiatric symptoms among patients who received SUSTIVA or control regimens, respectively, were: depression (13%, 8%), anxiety (24%, 15%), insomnia (7%, 2%), headache (15%, 12%), nervousness (5%, 2%).

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</tr>
<tr>
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<td>6%</td>
<td>3%</td>
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Boyett himself. Dr. Lovell’s expert report stated, “The severe wound on posterior scalp is in such a position that it was more likely than not caused by an external blow rather than a fall.” Dr. Lovell also stated the linear tear in Boyett’s anus “was undoubtedly penetration with a blunt foreign body.” Nevertheless, Dr. Lovell ultimately agreed with the medical examiner that Boyett died of “cardiac arrest.”

A former state medical examiner, Dr. Graham, performed an autopsy on Boyett’s body more than one month after Dr. Leis’s official autopsy had been completed. Dr. Graham’s autopsy report contained an “anatomical summary” listing the most important findings of the autopsy. Those findings were: (1) multiple cutaneous contusions and abrasions, including forehead, left hand, right foreleg, right and left foot; (2) multiple rib fractures (L 8, 9, 10, 11), lacerations (parietal pleura), and intercostal hematomas; (3) laceration (anus); (4) multiple scalp contusions; (5) coronary artery atherosclerosis-stenosis; (6) cirrhosis of the liver; (7) pulmonary emphysema; and (8) hematoma (omentum).... According to Plaintiffs, the conclusion that Washington County officials inflicted serious and deadly injury upon Boyett flows inescapably from the medical observations of these three experts. We disagree.

The problem, of course, is not the description of injuries or even linking these presumably humanly inflicted injuries to heart failure; it is the inability to show a perpetrator. “That which is done in silence and in the dark cannot be undone nor the lethal hand exposed.” The panel concluded that none of these experts can link either the supposed mechanism or perpetrator to Boyett’s injuries. The plaintiffs, rather ingeniously, invoke the legal decline of res ipsa loquitur: the thing speaks for itself. The sponges left in the chest cavity after surgery is a prime example of negligence on its face. The court didn’t reject this proof theory, noting only that the most it can prove is negligence. The case requires “malicious and sadistic” use of force or deliberate indifference as to medical care.

Municipal Liability
Failing to prevail on individual liability, plaintiffs then sought to hold the municipality liable. There is no vicarious liability under Section 1983, so the plaintiffs’ burden was to show an unconstitutional policy, practice or failure to train. That is, the municipality must be directly linked to the conduct that caused the harm.

However, the plaintiffs showed no such policy or practice. Pointing to the practice of injecting Thorazine in unknown amounts and frequency without records and based on “standing orders” failed because Boyett died from trauma or a heart attack unrelated to the Thorazine claims.

Conclusion
As I noted earlier, this is an extremely troubling case and an unsatisfactory outcome. Mental illness combined with physical ailments and unexplained trauma (the rectum tear!) leading to death—but no liability. The perfect crime? Maybe.

Fred Cohen, LLM, is the editor of the Correctional Mental Health Report. This is an abridged version of an article from Vol. 10, Issue 4, November/December, of the report, © 2008 Civic Research Institute, Inc. It is reprinted here with permission of the publisher. All rights reserved.

For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.
TRUVADA is a once a day backbone for combination therapy in adults with HIV-1.

Treat HIV confidently with TRUVADA in correctional facilities

- Demonstrated efficacy and tolerability through 3 years in Studies 934 and 903**

- TRUVADA or its components have been DHFS preferred since 2004*

- TRUVADA or its components have been partnered in long-term clinical trials with leading PIs†

  - Reyataz® (atazanavir sulfate)
  - Prezista™ (darunavir)
  - Kaletra® (lopinavir/ritonavir)
  - Lexiva® (emtricitabine)

Depend on TRUVADA to be your partner with PIs

Drug interactions have been observed between tenofavir DF and atazanavir or lopinavir/ritonavir. Atazanavir 300 mg should be boosted with ritonavir 100 mg and taken with food when administered with TRUVADA. Atazanavir without ritonavir should not be coadministered with TRUVADA. Patients on atazanavir or lopinavir/ritonavir plus TRUVADA should be monitored for TRUVADA-associated adverse reactions. TRUVADA should be discontinued in patients who develop TRUVADA-associated adverse reactions.2

WARNINGS

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

TRUVADA is not 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-1. Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV-1 and 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-1 and HBV and discontinue TRUVADA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

Warnings and Precautions

- New or worsening renal impairment:
  - Emtricitabine and tenofovir are principally eliminated by the kidney. Renal impairment can include acute renal failure and Fanconi syndrome
  - Assess creatinine clearance (CrCl) before initiating treatment with TRUVADA. Routinely monitor CrCl and serum phosphates in patients at risk
  - No dose adjustment is necessary for patients with mild renal impairment (CrCl 50–80 mL/min)
  - Dynamic internal adjustment of TRUVADA and close monitoring of renal function are recommended in all patients with CrCl <30 mL/min. No safety or efficacy data are available in patients with renal impairment who received TRUVADA using these dosing guidelines, so the potential benefit of TRUVADA therapy should be assessed against the potential risk of renal toxicity. TRUVADA should not be administered to patients with CrCl <30 mL/min or patients requiring hemodialysis
  - Avoid administering TRUVADA with concurrent or recent use of nephrotoxic drugs
  - Co-administration of TRUVADA with drugs that are eliminated by active tubular secretion may increase concentrations of emtricitabine, tenofovir, and/or the coadministered drug. Drugs that decrease renal function may increase concentrations of emtricitabine and/or tenofovir
  - Decreases in bone mineral density (BMD). Consider monitoring BMD in patients with a history of osteoporosis or who are at risk for osteoporosis
  - Decreases in bone mineral density (BMD). Consider monitoring BMD in patients with a history of osteoporosis or who are at risk for osteoporosis
  - RedISTRIBUTION/ACCUMULATION OF BODY FAT: Observed in patients receiving antiretroviral therapy
  - Immune reconstitution syndrome: May necessitate further evaluation and treatment

Drug Interactions

- Dolutegravir (dolutegravir) increases tenofovir concentrations. Consider dose reductions or discontinuations of dolutegravir if warranted

- Atazanavir (ATV): Co-administration decreases ATV concentrations and increases tenofovir concentrations. Use of TRUVADA with ATV is not recommended

Lopinavir/ritonavir (LPV/r). Coadministration decreases tenofovir concentrations. Monitor for evidence of TRUVADA-associated adverse reactions

Adverse Reactions

- The most common (incidence ≥10%) adverse reactions occurring in ≥5% of patients are:
  - Nausea, vomiting, rash, headache, diarrhea, and dizziness

- Nausea, vomiting, rash, headache, diarrhea, and dizziness are more common in patients with mild-to-moderate renal impairment (CrCl 50–80 mL/min) and in patients receiving concomitant antiretroviral therapy

- Other adverse reactions that occurred in at least 3% of patients receiving EMTRIVA or VIREAD with other antiretroviral agents in clinical trials include:
  - Abdominal pain, arthralgia, back pain, constipation, diarrhea, dyspepsia, dysuria, flatulence, headache, infusion site reactions, myalgia, paresthesia, rash, and upper respiratory tract infections

References:


Please see brief summary of full Prescribing Information on following page, including boxed WARNING information about lactic acidosis, severe hepatomegaly with steatosis, and exacerbations of hepatitis B upon discontinuation of therapy.
WARNINGS: LACTIC ACIDOSIS, SEVERE HEPATOPATHY WITH HISTOLOGICAL FEATURES OF ACUTE FATTY LIVER, ACUTE OR CHRONIC INFLAMMATION OF HEPATITIS B.

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs including emtricitabine in combination with other antiretrovirals (See Warnings and Precautions).

TRUVADA® (emtricitabine/tenofovir disoproxil fumarate) is not approved for the treatment of chronic hepatitis B virus infection.

TRUVADA® (emtricitabine/tenofovir disoproxil fumarate) is indicated in combination with other antiretroviral agents for the treatment of initial or treatment-experienced HIV-1-infected adults and pediatric subjects aged 12 years and older.

TRUVADA® (emtricitabine/tenofovir disoproxil fumarate) is contraindicated in patients with a history of hypersensitivity to any of the components of the product.

WARNINGS

Indications and Usage

The dose of TRUVADA is one tablet (containing 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate) once daily taken orally with or without food.

Dosing Interval Adjustment

Dosage Adjustment for Patients with Altered Creatinine Clearance

In a 144-week study of treatment-naive patients, changes in bone mineral density at the lumbar spine were greater in patients receiving VIREAD and/or EMTRIVA, including diarrhea, nausea, vomiting, fatigue, rash, edema, peripheral neuropathy, and systemic fungal infections (including candidiasis). TRUVADA is not indicated for the prevention of opportunistic infections. Drug Interactions

No drug interactions have been conducted using TRUVADA tablets. Drug interaction studies have been conducted with emtricitabine and tenofovir disoproxil fumarate. This section describes clinically relevant drug interactions observed in patients receiving VIREAD and/or EMTRIVA, including diarrhea, nausea, vomiting, fatigue, rash, edema, peripheral neuropathy, and systemic fungal infections (including candidiasis).

For additional information, please consult the VIREAD prescribing information.

The following adverse reactions have been identified during postmarketing use of VIREAD and EMTRIVA in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals. A majority of these reactions are consistent with the reactions associated with the use of nucleoside analogs alone or in combination with other antiretrovirals.

Truvada (emtricitabine/tenofovir disoproxil fumarate) tablet regimen should be considered in patients who have a history of pathologic bone loss or are at risk for osteoporosis. Although the effect of supplementation with calcium and vitamin D on bone health is not well studied, such supplementation may be beneficial for all patients. Bone abnormalities should be assessed and monitored appropriately.

To monitor fetal outcomes of pregnant women due to tenofovir.

There are, however, no adequate and well-controlled studies in pregnant women. Therefore, breastfeeding is not recommended in women taking TRUVADA, EMTRIVA, or VIREAD, or with tenofovir-containing products (See Warnings and Precautions).

Other than tenofovir, no other antiretroviral is a component of either TRUVADA or its components.

Increase in Lactic Acidosis

Patients with a history of pancreatitis should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HBV and HIV and discontinue TRUVADA. If appropriate, initiation of anti-Hepatitis B infection and in adults.

Bone mineral density monitoring should be considered in patients who have a history of pathologic bone loss or are at risk for osteoporosis. Although the effect of supplementation with calcium and vitamin D on bone health is not well studied, such supplementation may be beneficial for all patients. Bone abnormalities should be assessed and monitored appropriately.

TRUVADA should be administered to patients with creatinine clearance <30 mL/min and in patients with eGFR <30 mL/min and in patients with eGFR <30 mL/min.

Redistribution/accumulation of body fat including central obesity and redistribution of subcutaneous fat to extremities or residual opportunistic infections [such as Mycobacterium avium infection, Pneumocystis carinii pneumonia (PCP), or candidiasis] may also occur.

Pediatric Use:

TRUVADA tablets are for oral use only.

Basal bone density values were similar between the two study groups at the start of the study (week 0). At week 144, the mean percentage decrease in lumbar spine BMD was higher in patients receiving VIREAD and EMTRIVA compared to those receiving EMTRIVA alone. In patients treated with combination antiretroviral therapy, the overall risk of bone loss was no greater than in other treatment regimens for HIV-1-infected adults. However, the effects of long-term tenofovir use on bone density and health and future fracture risk are unknown. For additional information, please consult the VIREAD prescribing information.

Adverse Reactions

It is recommended that creatinine clearance be calculated in all patients prior to initiating therapy and as clinically appropriate during therapy with TRUVADA. Routine clinical monitoring of creatinine and serum phosphorus should be performed at least monthly in patients (See Warnings and Precautions).

In patients administered to patients with moderate renal impairment, including cases of acute renal failure, TRUVADA should not be administered to patients with creatinine clearance <30 mL/min and in patients with eGFR <30 mL/min. Baseline renal function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HBV and HIV and discontinue TRUVADA. If appropriate, initiation of anti-Hepatitis B infection and in adults.

Acute or chronic inflammation of hepatitis B is uncommon and has not been reported in patients established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients coinfected with HBV and HIV-1 and have discontinued EMTRIVA or VIREAD. Patients coinfected with HBV and HIV-1 should be tested for the presence of chronic HBV before initiating antiretroviral therapy. The mechanism and long-term consequences of these events are currently not well established. Immunoreconstitution Syndrome: Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including EMTRIVA and VIREAD. During the initial phase of combination antiretroviral treatment, patients whose immune system responds may develop an inflammatory response to indolent or residual opportunistic infections (such as MAC abscess, avascular sinus. A causal relationship has not been established. Lactic acidosis is an uncommon adverse reaction to nucleoside analogs alone or in combination with other antiretrovirals.

The dose of TRUVADA is one tablet (containing 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate) once daily taken orally with or without food.

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**CME Opportunity**

**Improving Therapeutic Outcomes in HIV Patients**

NCCHC is supporting a collaborative educational effort that aims to improve health outcomes of HIV patients in correctional settings. The program is chaired by John Bartlett, MD, professor of medicine, director of the infectious diseases division and director of the AIDS service at Johns Hopkins University School of Medicine. Faculty members include Bartlett, Rick Altice, David Wohl and Judith Feinberg.

The program is accredited by the JHU School of Medicine, Office of CME in cooperation with NCCHC; 5.75 AMA PRA Category 1 Credits™ are available. It is being implemented in cooperation with MedXcel, LLC, and MedCases, and was funded through an educational grant from Boehringer Ingelheim Pharmaceuticals.

To learn more, visit www.correctionscme.com.

**Program Overview**

- **Target audience:** This course is designed for physicians, physician assistants, nurses and nurse practitioners involved in the treatment of HIV/AIDS in correctional systems.
- **Live meeting format:** Didactic clinical presentations will begin at 9 a.m., followed by a workshop for participants that will include interactive, peer-to-peer discussions on patient cases. Additional presentations will follow a lunch break, and the course will conclude at 4:30 p.m. Attendees will receive a “Winning Behaviors™” patient education tool for use in their practice.
- **Enduring materials:** Accredited online interactive case-based simulations and a monograph will be available to attendees as well as other clinicians who could not attend.

**Activity Objectives**

At the conclusion of this activity, participants should be able to:

- Identify factors that influence the evolution of drug-resistant HIV-1 variants and explain how resistance mutations are generated or avoided, and how they can be conferred to others
- Describe the advantages and disadvantages of phenotypic, genotypic and virtual phenotypic assays for antiretroviral (ARV) resistance mutational identification when selecting appropriate regimens for naïve, as well as highly-experienced, patients
- Appraise the latest efficacy, safety and pharmacokinetic data of approved and investigational ARV agents (including the two new drug classes: integrase inhibitors and CCR5 antagonists)
- Assess the options for HAART in HIV patients with cardiovascular disease or other cardiometabolic risk factors such as diabetes and hypertension
- Describe pharmacologic and clinical significance of drug-drug interactions in HIV-infected patients with comorbidities that require statins, azoles, anti-TB drugs and others
- Recognize the relevance of mental health disorders and their treatment between male and female incarcerated HIV patients when initiating on HAART

- Discuss drug selection and patient education strategies to overcome unrealistic therapeutic options in correctional systems and to improve adherence among inmates
- Explain strategies to bridge the gap with community-based HIV providers to maintain continuity of care received while in prison
- Apply effective communication skills with multidisciplinary care providers and officers within the correctional setting to ensure appropriate diagnosis, minimize therapeutic interruption and increase adherence

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In this column, we talk with Geraldine Pearson, PhD, APRN, director of an innovative program created to ensure that the psychotropic medication needs for youth in Connecticut’s juvenile justice system are met as the youth transition back to the community.

JR: Finding aftercare for detainees on psychotropic medications is a concern in almost every jurisdiction. Can you tell us how HomeCare started?

GP: In spring 2003, the University of Connecticut Health Center’s department of psychiatry received a grant from the state. The HomeCare program was born out of that grant with the goal of developing outpatient child/adolescent psychiatric services in Connecticut’s federally qualified health clinics (FQHCs). These clinics would serve youngsters needing short-term medication management after leaving a juvenile detention center. In that way, HomeCare would be an essential bridge for children awaiting appointments with longer term providers.

Before joining HomeCare, I was a clinical nurse specialist in the children’s state psychiatric hospital and had just completed my PhD in nursing. I was drawn to HomeCare because of the challenge of developing a community-based system for our high-need juvenile justice population.

JR: How is your program staffed and organized?

GP: HomeCare operates with a renewable $404,000 grant from the State of Connecticut Department of Children and Families and the Judicial Branch, Court Support Services Division. The program has expanded over the last five years, with increasing hours in each FQHC. The FQHC bills Medicaid for HomeCare services.

The first HomeCare clinic opened in September 2003, four more sites were added gradually and a sixth will open shortly. We also have partnered with other local community health centers. All of these FQHCs contract with the UConn Health Center for HomeCare services.

A child psychiatrist and a child/adolescent psychiatric APRN work together at these clinics. HomeCare is now staffed with two full-time and two part-time APRNs, two part-time child psychiatrists and an administrative assistant. All are UConn Health Center employees. We recently added a first-year child psychiatry fellow to our staff group.

As would be expected, the population we serve is psychiatrically and psychosocially complex, requiring a high level of case management. As a result, for every hour of direct care provided by APRN staff, another hour of indirect care is allotted to meet these case management and other indirect needs.

Early on, we saw that the FQHCs needed psychiatric services for their pediatric populations. With the funders’ approval, psychiatric evaluation and medication management are also offered to FQHC patients who are not judicially involved, although the first priority is still treating justice-involved youth. And, at times, the populations overlap. HomeCare’s patients also can use the FQHCs’ primary care and dental services. So everyone wins.

JR: How are children referred to HomeCare and how long do they stay with you?

GP: At first, referrals came only from juvenile probation officers, and they still make up most referrals. There is a great benefit in the partnership formed between HomeCare and juvenile probation as we work together to manage complicated clients.

Now, referrals also come from adult probation officers who oversee offenders under age 18, from DCF workers and from licensed clinical coordinators, who recently have been added to several probation offices in Connecticut.

The average length of involvement in HomeCare is about three months. The goal is always referral to a longer term provider and no one is discharged until that link occurs. Some youngsters do return to the program, including after re-arrest or residential placement, even years later.

JR: Do you have any outcome data regarding your program’s efforts to bridge care?

GP: An institutional review board-approved study is now analyzing the re-arrest pattern for youth who received a HomeCare intake versus children who did not follow through with the intake referral. The study is in process so results are pending.

JR: What advice would you give to professionals considering a program like HomeCare?

GP: They should feel free to contact me. We are preparing a manual for program operations and I hope to conduct compliance studies throughout the coming year.

FQHCs are located in every state. Those in Connecticut were eager to collaborate with UConn Health Center to provide psychiatric care, and I assume the same would be true in many states. The HomeCare program is a successful example of a university-affiliated public model of care. It shows what is possible in any jurisdiction — with a small grant and innovative thinking.

Geraldine Pearson, PhD, APRN, is an assistant professor at the University of Connecticut Medical School and the director of Connecticut’s HomeCare program. To reach her, e-mail pearsong@psychiatry.uconn.edu.

Judith Robbins, LCSW, JD, CCHP, represents the National Association of Social Workers on the NCCHC board of directors and chairs the 2008 juvenile health committee. She is the director of Yale Behavioral Health’s Juvenile Detention Mental Health Program in the Department of Psychiatry at Yale Medical School, New Haven, CT.

If you’d like to comment on juvenile correctional health topics, write to NCCHC’s juvenile health committee c/o Matissa Sammons at matissasammons@ncchc.org or by mail to NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614.
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To give readers a snapshot into the work lives of their colleagues, we asked a few CCHPs to describe a typical day on the job. Marie Carlin, MA, LCSW, CCHP, jotted down a wonderfully detailed diary of activities (slightly edited for length).

A clinical social worker at the Hartford (CT) Community Correctional Center since 1997 and a CCHP since 2002, Carlin juggles a workload that includes mental health intake assessments, case management and crisis intervention for inmates with severe mental illness, discharge planning for mental health clients and liaison with service providers in the community.

Commenting about the care provided in jails generally, she says, "I don't think most people realize the extent and quality of the mental health services we try to provide to inmates. Our staff is very professional and often able to offer excellent mental health care with very limited resources."

**Morning**

- **7:00** Collect charts for the day from medical records office
- **7:10** Read and answer e-mail: a social worker in the public defender's office alerting jail staff of a seriously mentally ill inmate coming in who might be a danger to himself and others; my supervisor informing me that I was accepted to attend a cross-training reentry meeting; jail reentry staff notifying me that my client is being referred for a program and asking if I want to be notified when it is determined (yes, I do; he is being treated for psychiatric illness and will need a discharge summary and meds)
- **7:30** Review jail diversion referrals of inmates who came in last night to see if they have information about disposition or diversion plans with which I need to collaborate, or if any referrals require that I initiate discharge planning
- **7:40** Review staff referrals and inmate self-referrals for discharge planning and schedule appointments for them
- **7:45** Look up locations that need to be seen today
- **8:15** Discharge planning for two inmates. One is a 66-year-old Viet Nam veteran with serious medical problems, PTSD symptoms and a recent alcohol problem; this is his first time in jail and he wants help getting into a VA recovery program. We contacted the VA homeless coordinator and VA shelter program, requested discharge medications and gave him discharge instructions. If he returns from court, we will proceed with the application for the VA residential recovery program.
- **11:00** Fax medical insurance applications to the department of social services; complete and fax discharge summaries to community treaters
- **11:30** Discharge planning with two more inmates

**Afternoon**

- **12:00** Send secured e-mail to social worker in public defender's office providing information that may be useful in determining a disposition at court; contact our IT desk for help with a computer glitch
- **12:30** Review discharge list and check off completed discharges; make list of inmates to see tomorrow; list the inmate ID photos I need for medical insurance applications and fax it to our mental health secretary, who will get them for me
- **12:45** Discharge planning with three inmates. One is a 22-year-old male with serious cognitive deficits and charged with rape. Contact the court to provide information relevant to disposition; contact a community support group he attended to arrange for assistance with transitioning to the community
- **1:15** Read and answer e-mail from jail diversion staff, organize notes from discharge planners' recent meeting, propose to the nursing supervisor a system to keep track of discharge medications, providing part of the administrative policies and copies of forms for recording information
- **1:35** Review charts of potential discharge clients to assess accuracy of mental health scoring and determine which need to be scheduled and which need to have mental health scores lowered
- **2:00** End of my day at HCCC

And how does Carlin feel at the end of the day? “I do love my job!” she exclaims.
Upper Respiratory Infections: upper respiratory tract infection, laryngitis, laryngopharyngitis, nasopharyngitis, pharyngitis, respiratory tract infection, rhinitis, viral respiratory tract infection

Less Common Adverse Events

The following adverse events (defined as always serious by MedRA-Preferred (Critical) Terms) occurred in <2% of SELZENTRY-treated patients. These events have been included because of their seriousness and either increased frequency on SELZENTRY or are potential risks due to the mechanism of action. Events attributed to the patient's underlying HIV infection are not listed.

Cardiac Disorders: unstable angina, acute cardiac failure, coronary artery disease, coronary artery occlusion, myocardial infarction, myocardiitis

Hepatobiliary Disorders: hepatitis cirrhosis, hepatic failure, cholestatic jaundice

Infections and Infestations: Clostridium difficile colitis, viral meningitis, pneumonia, septic shock

Mucolipidosis and Connective Tissue Disorders: myositis, osteosclerosis, Marfanoid habitus, blood CK increased

Neoplasms benign, Malignant and Unspecified (including Cysts and Polyps): abdominal neoplasm, anal cancer, basal cell carcinoma, Bowen's disease, cholangiocarcinoma, lymphoma, metastases to liver, esophageal carcinoma, squamous cell carcinoma, squamous cell carcinoma of skin, tongue neoplasm (malignant stage unspecified)

Nervous System Disorders: cerebrovascular accident

Overuse of Medication

The following adverse events [defined as always serious by MedDRA-Preferred -(Critical)- Terms] occurred in <2% of patients receiving SELZENTRY:

Table 3 Maximum Shift in Laboratory Test Values (Without Regard to Baseline)

Table 3 shows the treatment-emergent Grade 3-4 laboratory abnormalities that occurred in >2% of patients receiving SELZENTRY.

OVERDOSAGE

The highest dose administered in clinical studies was 1200 mg. The dose limiting adverse event was postural hypotension, which was observed at 600 mg. While the recommended dose for SELZENTRY in patients receiving a CYP3A inducer without a CYP3A inhibitor is 600 mg twice daily, this dose is appropriate for patients on HIV-1 infection.

In patients with renal impairment, especially when CYP3A inhibitors are coadministered, patients with a creatinine clearance of less than 50 mL/min who receive maraviroc and a CYP3A inhibitor may be at an increased risk of adverse effects related to increased maraviroc concentrations, such as dizziness and postural hypotension. Thus, patients with a creatinine clearance of less than 50 mL/min should receive maraviroc and a CYP3A inhibitor only if the potential benefit is felt to outweigh the risk, and they should be monitored for adverse effects.

Hepatic Impairment

The pharmacokinetics of maraviroc have not been sufficiently studied in patients with hepatic impairment. Because maraviroc is metabolized by the liver, concentrations are likely to be increased in these patients.

Gender

Population pharmacokinetic analysis of pooled Phase 1/2a data indicated gender (female: n=76, 23.2% of the total population) does not affect maraviroc concentrations. Dosage adjustment based on gender is not necessary.

Race

Population pharmacokinetic analysis of pooled Phase 1/2a data indicated exposure was 26.5% higher in Asians (N=69) as compared to non-Asians (n=119). However, a study designed to evaluate pharmacokinetic differences between Caucasians (n=12) and Singaporeans (n=12) showed no difference between these two populations. Only 14 Black subjects were included in the population pharmacokinetic analysis. No dosage adjustment based on race is needed.

Pregnancy

The safety and efficacy of maraviroc have not been specifically studied in patients with renal impairment, therefore maraviroc should be used with caution in this population. In the absence of metabolic inhibitors, renal clearance accounts for approximately 25% of total clearance of maraviroc. Maraviroc concentrations may be increased in patients with renal impairment, especially when the CYP3A inhibitors are coadministered. Patients with a creatinine clearance of less than 50 mL/min who receive maraviroc and a CYP3A inhibitor may be at an increased risk of adverse effects related to increased maraviroc concentrations, such as dizziness and postural hypotension.

Thus, patients with a creatinine clearance of less than 50 mL/min should receive maraviroc and a CYP3A inhibitor only if the potential benefit is felt to outweigh the risk, and they should be monitored for adverse effects.

Pediatric Use

The safety and efficacy of maraviroc have not been specifically studied in patients with renal impairment, therefore maraviroc should be used with caution in this population. In the absence of metabolic inhibitors, renal clearance accounts for approximately 25% of total clearance of maraviroc. Maraviroc concentrations may be increased in patients with renal impairment, especially when the CYP3A inhibitors are coadministered. Patients with a creatinine clearance of less than 50 mL/min who receive maraviroc and a CYP3A inhibitor may be at an increased risk of adverse effects related to increased maraviroc concentrations, such as dizziness and postural hypotension.

Thus, patients with a creatinine clearance of less than 50 mL/min should receive maraviroc and a CYP3A inhibitor only if the potential benefit is felt to outweigh the risk, and they should be monitored for adverse effects.

Drug Interactions

The pharmacokinetics of maraviroc have not been sufficiently studied in patients with renal impairment, therefore maraviroc should be used with caution in this population. In the absence of metabolic inhibitors, renal clearance accounts for approximately 25% of total clearance of maraviroc. Maraviroc concentrations may be increased in patients with renal impairment, especially when the CYP3A inhibitors are coadministered. Patients with a creatinine clearance of less than 50 mL/min who receive maraviroc and a CYP3A inhibitor may be at an increased risk of adverse effects related to increased maraviroc concentrations, such as dizziness and postural hypotension.

Thus, patients with a creatinine clearance of less than 50 mL/min should receive maraviroc and a CYP3A inhibitor only if the potential benefit is felt to outweigh the risk, and they should be monitored for adverse effects.

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Academy of Correctional Health Professionals

CareerCenter Joins Vast Network
The Academy CareerCenter has joined the National Healthcare Career Network, a Web-based network of association-sponsored online career centers that share job listings, resumes and career development content. The Academy joined the network to improve services to members and advertisers. Already there’s been a marked increase in traffic with over 1,500 job openings listed on the Academy CareerCenter site.

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Board of Directors 2008 Election
Balloting will take place at the National Conference on Correctional Health Care in Chicago. Members in attendance will have the opportunity to vote for the candidates of their choice. A special voting area will be set up in the exhibit hall at the Academy’s booth. On-site voting will be conducted during exhibit hall breaks, Oct. 19-20. Members who cannot attend the conference may participate in the election by voting online Oct. 3-17.

American Academy of Child and Adolescent Psychiatry
The AACAP has launched an online curriculum on substance use disorders. It is structured as an 11-lecture series that provides the latest knowledge on substance dependence, diagnosis and treatment. The AACAP created the curriculum in response to high demand for physician training in identifying and treating adolescent substance use. In a study published in the July issue of the Journal of the American Academy of Child and Adolescent Psychiatry, it was recommended that clinicians who work with adolescents receive training in substance use assessment during medical school or residency. The study also indicated that many pediatricians do not screen adolescents for substance use and even fewer feel comfortable conducting a comprehensive evaluation or providing referrals for treatment. The curriculum, which offers 5.5 hours of CME credit, is available at www.aacap.org/cs/onlinecme.

American Psychological Association
In response to reports of alleged involvement of a psychologist (not an APA member) in an abusive interrogation of a Guantanamo detainee, the APA has issued a statement of its position on such activities. “No psychologist—APA member or not—should be directly or indirectly involved in any form of detention or interrogation that could lead to psychological or physical harm to a detainee.” The association has identified 19 interrogation techniques that it prohibits, but notes that the list is not exhaustive. Techniques prohibited as in violation of professional standards include waterboarding, hooding, forced nudity and stress positions. The APA states that it will “pursue ethics investigations where evidence indicates that an APA member has violated our ethical standards.” View the statement and related documents at www.apa.org/releases/statement.html.

Society of Correctional Physicians
The Society has recently enhanced its Web site with two members-only features: a message board for information sharing and a directory of members. The directory enables SCP members to update their own contact information as well as look up their colleagues. Access requires log-in and password. The site also posts an archive of the SCP newsletter, CorrDocs, which is available to all visitors. To learn more about these features or to sign up for the message board, visit www.corrdocs.org.
procedures, education and training, discussion forums, and counseling or intervention strategies.

**Application of the Standard**

NCCHC’s standards have always promoted health care quality and now, in keeping with community standards of care, we are encouraging correctional facilities to be even more aware of, and target, preventable adverse events.

In terms of compliance, we interpret the Patient Safety standard in relation to other standards. For example, patient safety could be viewed as seriously jeopardized if correctional and health care administrators did not adequately resolve systemic problems related to quality (A-06), staffing levels (C-07) or suicide prevention (G-05). Collectively, such issues could point to a bigger problem of a culture that neglects patient safety.

On the other hand, NCCHC would look favorably on a system that identified a potential weakness that could jeopardize patient safety and took steps to correct it. Correctional facilities often face fiscal and personnel shortages. Adding medical errors to the mix only compounds the problems. When health care delivery systems fail and errors occur, this has a ripple effect, leading to financial woes, litigation, personnel shortages and poor health care outcomes.

NCCHC’s new Patient Safety standard reminds us that leadership should foster a culture of patient safety and error reporting and prioritize the steps taken by health care professionals each day to keep their patients from harm.

R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. To contact her, e-mail jenniferkistler@ncchc.org, call 773-880-1460 or write to NCCHC, 1145 W. Diversey Parkway, Chicago, IL 60614.

An archive of past Spotlight articles is available at the CorrectCare page at www.ncchc.org.

**For Further Reading . . .**

- In 1996, the Institute of Medicine launched an ongoing effort to assess and improve the nation’s quality of care. Two IOM reports—To Err Is Human (1999) and Crossing the Quality Chasm (2001)—made huge waves and have guided efforts across the nation to improve patient safety. Learn more at www.iom.edu/?id=21805.
- The two research studies cited in this article are as follows:
EMPLOYMENT

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Learn more at www.ChangingPrisonHealthCare.org. EOE.

 CALIFORNIA PRISON HEALTH CARE

Public Health Behind Bars: From Prisons to Communities. This book examines the burden of illness in the prison population, the impact on public health as prisoners are released and how to coordinate care between correctional and community providers. Over 40 practitioners, researchers and scholars in correctional health, mental health, law and public policy offer recommendations for care that is humane for inmates and beneficial to the communities they reenter. Edited by Robert Greifinger. Springer (2007), hardcover, 576 pp, $89.95. See table of contents at www.ncchc.org.

Bates’ Pocket Guide to Physical Examination and History Taking, 5th Ed. The classic Bates approach in an outline format with exam techniques on the left and abnormalities and interpretations on the right. This edition features greater emphasis on patient interview techniques, a new chapter on older adults and new images of abnormalities, with 500+ color drawings and photographs. A PDA download has outlines of exam procedures and techniques. By Lynn Bickley & Peter Szilagyi. LWW (2005), softcover, 416 pp, $42.95

About CorrectCare™
CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

Subscriptions: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, 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 magazine is also posted at www.ncchc.org.

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 1 for contact information.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, contact Jaime Shimkus at editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

ADVERTISER INDEX
Abbott Laboratories – I Stand With Magic.............BRC, 5
Abbott Laboratories – Kaletra.................................IBC
Academy of Correctional Health Professionals.......20
Bristol-Myers Squibb – Sustiva..........................21-23
Bristol-Myers Squibb / Gilead – Atripla.............Insert, 15
California Prison Health Care Receivership Corp....34
Certified Correctional Health Professional (CCHP) ...36
Correctional Medical Services (CMS)..................34
Corrections Corporation of American (CCA).........35
Denture Dental......................................................4
Gilead Sciences – Truvada.................................25-26
Hibiclens.............................................................29
Journal of Correctional Health Care..................24
Maxor Correctional Pharmacy Services................6
MedCases..........................................................17, 33
Medi-Dose..........................................................9
The Mentally Disordered Inmate and the Law.......8
MHM Services...................................................BC
NCCHC Standards for Health Services..............3
Pfizer – Selzentry...............................................Insert, 31
Prison Health Services (PHS)..............................32
Wexford Health Sources....................................27
Zerowet Supershield ..........................................14
First Aid Training for Inmates

Q: We are considering offering basic first aid and CPR classes to our inmates. It is not our intention to use inmates in any capacity to provide routine care for other inmates, but rather, to provide those inmates who are interested with skills that may be of value in the event of an extreme emergency situation. What is NCCHC’s position on training inmates in basic health care issues? Would you consider this a violation of standard C-06?

A: C-06 Inmate Workers prohibits the use of inmates as health care workers. Since you have stated that you would not be using inmates in this capacity, there is no violation of the standard. NCCHC supports health education programs for inmates. As long as you do not intend to use inmates to provide ongoing care, there is no reason that they should not have an opportunity to learn CPR and basic first aid.

Examples of violations of this standard include inmate workers taking pulse and oximetry readings on patients waiting for sick call, checking abnormal blood pressure readings and changing bandages, or even taking supplies from the cabinet. Inmates translating sick call slips from English is a violation of patient confidentiality. These situations may place inmate workers in a position of power over their peers. It may be tempting to use inmate workers in health care delivery when staffing is an issue, but besides violating the NCCHC standard, doing so frequently violates state laws, invites litigation and brings discredit to the correctional health care field.

Infirmary RN Supervisor

Q: We operate an infirmary and have a supervising registered nurse on every shift. Is this what is intended by the standard?

A: In standard G-03 Infirmary Care, Compliance Indicator 4 requires that “a supervising registered nurse is on site at least once every 24 hours” (emphasis added). A supervising RN need not be present on every shift.

Periodic Health Assessments

Q: In standard E-12 Continuity of Care During Incarceration, periodic health assessments are mentioned in Compliance Indicator 7. Do all inmates require a periodic health assessment on an annual basis?

A: No, the standard does not require an annual health assessment. The responsible physician determines the frequency and content of periodic health assessments based on protocols promulgated by nationally recognized professional organizations. Periodic assessments are likely based on age, gender and risk factors. Certain elements of the assessment, such as mammogram or prostate exam, are repeated at appropriate frequencies.

Correction: 2008 Prison Standards, Oral Care

In the first printing of the 2008 Prison Standards, PE-06 Oral Care had two errors regarding time frames. An errata page (which has been sent to those who purchased the book) reads as follows:

- Compliance Indicator 1: Oral screening by the dentist or qualified health care professionals trained by the dentist is performed within 7 days of admission.
- Compliance Indicator 3: An oral examination is performed by a dentist within 30 days of admission.

R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. Send your question to info@ncchc.org or call 773-880-1460.
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Rodney Williams
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