Evidence-Based Nursing Practice
The Time Is Right!

Holistic Health Care Offers Promise of Positive Outcomes

DOC-University Pharmacy Project

National Conference Preview
National Conference on Correctional Health Care

October 17–21, 2009 • Orlando

Building Health Care Systems That Work

Just as architecture holds the power to reshape the horizon, knowledge holds the power to transform health care. The National Conference gives you the blueprints to understand, develop and implement cost-effective, evidence-based systems of care. Packed with lectures, panels, workshops, posters, exhibits and networking, this meeting will give you the knowledge and skills to reshape not only your institution’s health services, but also the well-being of your patients and the community at large.

For more information, email info@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 the leading national organizations representing the fields of health, law and corrections.

Features
3 CDC Issues H1N1 Influenza Guidelines for Corrections
6 National Conference Preview
7 Legal Affairs: Beware of the Specialist’s Recommendations
10 Evidence-Based Nursing Practice: The Time Is Right!
14 Holistic Care Offers Promise of Positive Health Outcomes
16 DOC-University Rx Project Yields Big Savings—and Award—in Rhode Island
18 Force Feeding for Hunger Strikes

Departments
2 NCCHC News
4 News Watch
8 Clinical News Brief: Earlier ART Yields Better Outcomes
21 Journal Preview: Brief Negotiation Interviewing Lowers HIV Risk, Increases Testing
22 Spotlight on the Standards: Medication Services
23 Juvenile Voice: Nutritional Issues
24 CCHP Page
25 Field Notes
27 Classified Ads and Ad Index
28 Standards Q&A

BOARD OF DIRECTORS
Joseph V. Penn, MD, CCHP (Chair)
American Academy of Child & Adolescent Psychiatry
Nina Dozoretz, RHIA, CCHP (Chair-Elect)
American Health Information Management Association
Robert E. Morris, MD, CCHP (Immediate Past Chair)
Society for Adolescent Medicine
Thomas J. Fagan, PhD (Secretary)
American Psychological Association
Nancy B. White, LPC (Treasurer)
American Counseling Association
Edward A. Harrison, CCHP (President)
National Commission on Correctional Health Care
Carl C. Bell, MD, CCHP
National Medical Association
Patricia Blair, JD
American Bar Association
Kleantie Caruso, MSN, CCHP
American Nurses Association
Robert Cohen, MD
American Public Health Association
Eileen Couture, DO, CCHP
American College of Emergency Physicians
Charles A. Fasano
John Howard Association
Kevin Fiscella, MD
American Society of Addiction Medicine
Robert J. Gogats, MA
National Association of County & City Health Officials
Robert L. Hilton, RPh, CCHP
American Pharmacists Association
Renee Kenna, BSN, CCHP
American Correctional Health Services Association
Douglas A. Mack, MD, CCHP
American Association of Public Health Physicians
Nicholas S. Makrides, DMD
American Dental Association
Edwin I. Megargee, PhD, CCHP
International Association for Correctional and Forensic Psychology
Charles A. Meyer, Jr., MD, CCHP-A
American Academy of Psychiatry & the Law
Eugene A. Migliaccio, DoPH
American College of Healthcare Executives
Ronald C. Moomaw, DO
American College of Neuropsychiatrists
Peter C. Obie, PA-C, CCHP
American Academy of Physician Assistants
Peter E. Perroncello, MS, CCHP
American Jail Association
George J. Pramstaller, DD, CCHP
American Osteopathic Association
Patricia N. Reams, MD, CCHP
American Academy of Pediatrics
Judith Robbins, LCSW, CCHP-A
National Association of Social Workers
Sheriff B.J. Roberts
National Sheriffs’ Association
David W. Roush, PhD
National Juvenile Detention Association
Jayne Russell, MD, CCHP-A
Academy of Correctional Health Professionals
Ronald M. Shanksy, MD
Society of Correctional Physicians
Alvin J. Thompson, MD
American Medical Association
Ana Viamonte Ros, MD
Association of State and Territorial Health Officials
Barbara A. Wakeen, RD, CCHP
American Dietetic Association
Henry C. Weinstein, MD
American Psychiatric Association
Ronald Wilborg, MBA
National Association of Counties
Representative Appointment Pending
National District Attorneys Association

Copyright 2009 National Commission on Correctional Health Care. Statements of fact and opinion are the responsibility of the authors alone and do not necessarily reflect the opinions of this publication, NCCHC or its supporting organizations. NCCHC assumes no responsibility for products or services advertised. We invite letters of support or criticism or correction of facts, which will be printed as space allows. Articles without designated authorship may be reprinted in whole or in part provided attribution is given to NCCHC.

Send correspondence to editor Jaime Shinikus
NCCHC, 1145 W. Diversey Pkwy, Chicago, IL. 60614
Phone: 773-880-1460, Fax: 773-880-2424
E-mail: editor@ncchc.org, Web: www.ncchc.org
Survey Findings Will Help to Bridge Gaps in Pandemic Flu Assistance

As always, NCCHC is at the forefront in helping correctional facilities to provide high quality health care services. A current concern for many facilities is how to properly prepare for and respond to an influenza pandemic. Of great importance is collaboration with county and state health departments, which should have the resources to help correctional facilities before and during such an event.

As part of a nationwide effort to improve those relationships, NCCHC recently conducted a survey in cooperation with the National Association of County and City Health Officials and the Association of State and Territorial Health Officials (both are NCCHC supporting organizations). We sent an e-mail survey to the health administrators of all NCCHC-accredited facilities asking about health department help in preparing for and responding to a possible H1N1 flu outbreak, as well as satisfaction with the level of support they received.

The results will be tabulated in July. The findings, which we will share with our constituents, will enable NACCHO and ASTHO to guide their own members in working more effectively with correctional facilities.

Professionals Find Value in NCCHC Education

Even in these dicey economic times, savvy correctional health professionals—and the administrators who approve their budgets—know a good deal when they see one. That’s why they came out in droves to the Updates in Correctional Health Care conference in April. It didn’t hurt that the meeting was held in fabulous Las Vegas! But the real reason for the strong attendance, which was on par with the previous year, was because of its intentional focus on presentations designed to help you meet the fiscal and human resources challenges of these times. With 55 sessions on a broad range of topics and plenty of quality time for networking, this meeting was a sure bet!

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.

Facilities Look to NCCHC for Help

When things go awry, correctional facilities—even those that are not accredited—turn to NCCHC for assistance. For example, in Wisconsin, two deaths at a county jail prompted the sheriff to bring in NCCHC for an independent consultation. Our report detailed 27 recommendations for improvement and the jail staff is now busy with implementation, starting with the “big issues,” such as increasing physician hours and improving communication between the county and the contract management firm that provides health services.

For those facilities that have undertaken the effort to meet the NCCHC health services standards and invite a team of surveyors to measure compliance, there is a strong sense of pride and accomplishment in becoming accredited. In Virginia, the Albemarle-Charlottesville Regional Jail recently received initial accreditation. Although the jail’s health officials say that, for the most part, they only had to “tweak” their policies, the efforts bring great benefits on many fronts. Overall, it reflects positively on the facility, said superintendent Col. Ronald Matthews. It also shows the inmates that the jail cares about their well-being, and it improves staff morale.

Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 26</td>
<td>Accreditation committee meeting</td>
</tr>
<tr>
<td>July 10-11</td>
<td>Medical Director Boot Camp, Seattle</td>
</tr>
<tr>
<td>July 12-13</td>
<td>Correctional Mental Health Seminar, Seattle</td>
</tr>
<tr>
<td>August 22</td>
<td>CCHP examination, multiple regional sites</td>
</tr>
<tr>
<td>October 17-21</td>
<td>National Conference on Correctional Health Care, Orlando</td>
</tr>
<tr>
<td>November 20</td>
<td>Accreditation committee meeting</td>
</tr>
</tbody>
</table>

For the complete list of CCHP exams, including the regional exam sites see www.ncchc.org/cchp.

NCCHC Supports Global Principles for Socially Responsible Associations & Nonprofits

NCCHC has always been committed to operating in a socially responsible manner. Now, we’ve made that commitment in writing. NCCHC is proud to be a signatory of the Global Principles for Socially Responsible Associations & Nonprofits. A goal of the Global Summit for Social Responsibility convened in 2008 by the American Society of Association Executives and the Center for Association Leadership, the principles promote sustainable development and good corporate citizenship among members of the association community. They are based on universally accepted principles established by the United Nations Global Compact. The Global Principles also help create a network of associations, nonprofits, industry partners and other associates to provide a forum for learning and exchange of ideas and best practices. Learn more at www.asaecenter.org/Forms/SocialResponsibilityPrinciples.
CDC Issues H1N1 Influenza Guidance for Corrections and Detention Facilities

Guidance for correctional facilities on novel influenza A virus (H1N1, initially known as swine flu) was issued May 24 by the Centers for Disease Control and Prevention. The recommendations aim to ensure continuation of essential public health services and protection of the health and safety of inmates, staff and visitors. The document is labeled “interim” to highlight the fact that recommendations may need to be revised as more information becomes available.

Corrections-specific guidance was deemed necessary because of the “special risks and considerations” that these institutions pose. For instance, options for isolation or removal of ill inmates are limited. Also, it is essential to maintain an adequate workforce on site at all times.

The guidance focuses on general preventive measures, reducing the risk of introducing the virus into the facility, rapid detection of infected persons, and management and isolation of identified cases. A summary of key points that pertain to corrections follows. A number of recommendations refer to other CDC guidance documents, all of which are posted at the CDC’s H1N1 Web site.

Risk Reduction
• Visitors who had an influenza-like illness (ILI) in the previous 7 days or who still have symptoms 7 days after the illness began should not be permitted to enter the facility. Inmates and potential visitors should be informed of this. Staff with ILI should stay home (or be sent home if they develop symptoms on site) and remain at home for 7 days or until 24 hours after symptoms resolve, whichever is longer.
• If ILI is present, cancel internal group gatherings and stagger group meals and other activities to provide more personal space between individuals. Consider temporarily suspending or modifying visitation programs.

Rapid Detection of Cases
• Instruct inmates and staff to report symptoms of ILI to the facility health care professional at the first sign of illness. Evaluate incoming inmates and isolate those who display symptoms of ILI. (See the CDC’s interim guidance on identifying and caring for patients with H1N1 infection.)
• Conduct testing of some persons with ILI to determine what viruses are circulating at the institution.

Management and Isolation of Cases
• Health care staff should follow CDC guidance on infection control for the care of patients with confirmed or suspected H1N1 virus infection.
• Refer to CDC interim guidance on the use of face masks and respirators to reduce H1N1 virus transmission.
• Influenza antiviral chemoprophylaxis may be given to inmates and health care staff in accordance with current recommendations to reduce transmission. (See separate guidance document on use of antiviral agents.)
• Actively monitor the number, severity and location of cases of ILI.
• Separate inmates with ILI from others by placing them in individual cells when possible. Consider separating cellmates of sick inmates for 48 hours for observation.
• Provide care of inmates with ILI, including scheduled temperature checks and access to increased fluids, and antiviral treatment when indicated. (See guidance on antiviral agents.) Also provide tissue, a plastic bag for disposal of used tissues and alcohol-based hand sanitizers.
• Restrict movements of inmates with ILI within the facility and restrict inmates from leaving or transferring between facilities during the 7 days after onset of symptoms or until 24 hours after symptoms resolve, whichever is longer, unless necessary for medical care, infection control or lack of isolation space.
• If multiple inmates become ill with the H1N1 virus, establish an area specifically for these patients. Do not have them circulating in other parts of the facility. Designate staff to care for these patients only, and limit these staff members’ movement to different parts of the facility. (See Using Antiviral Medications to Control Influenza Outbreaks in Institutions.)
• Personal items (e.g., linens, dishes) of those who are sick do not need to be cleaned separately, but they should not be shared without thorough washing. Linens should be washed using laundry soap and tumble dry on a hot setting. Persons who handle laundry should avoid “hugging” it before washing it, and should wash their hands with soap and water or alcohol-based hand sanitizer immediately after handling it.
• Assess and treat as appropriate soon-to-be released inmates with ILI or other flu symptoms and make direct linkages to community resources to ensure proper isolation and access to medical care.
• Health care providers should identify and address the special health needs of persons at high risk for complications from infection with H1N1 virus. These include the groups typically at high risk for seasonal flu complications, such as the elderly, pregnant women, patients with chronic medical conditions and those who are immunocompromised. (See guidance specific to these populations.)

Other Recommendations
Recommendations on general preventive measures and workforce protection are generic in that they would apply to any health care setting, discussing topics such as hygiene practices and vaccinations.

Finally, non-English speaking inmates should be given educational materials and information that they can understand. If possible, provide a translator when evaluating and treating persons with symptoms. The CDC H1N1 Web site offers materials in Spanish and other languages.
Newswatch

17% of New Jail Inmates Have Serious Mental Illness
A study of more than 20,000 people entering jail found that nearly 17% of have serious mental illness, says a recent report from the Council of State Governments and Policy Research Associates. Serious mental illness was found among 31% of women and 14.5% of males, a “particularly troubling” finding given the growth in the female jail population and the lack of research on the reasons for this overrepresentation. Overall, these estimates are three to six times higher than in the general population, and indicate that as many as 2 million bookings of people with serious mental illnesses may occur each year. The study is the most accurate accounting on the subject in more than 20 years. Source: http://consensusproject.org/updates/features/preannouncement

PBS Highlights Woes of Releasees With Mental Illness
In 2005, the PBS series Frontline aired “The New Asylums,” a riveting documentary on mental illness in Ohio’s prisons (and winner of NCCHC’s 2005 Award of Excellence in Communication). In a follow-up, the same two filmmakers have produced “The Released,” which examines what happens to the seriously mentally ill when they leave prison and why their recidivism rates are so high. According to program information, more than 350,000 prisoners with mental illnesses will be released to the community this year. Typically, they are given a bus ticket, $75 and two weeks worth of medication. Within 18 months, nearly two-thirds are rearrested. The program, which aired April 28, may be viewed online, along with supplemental material such as story updates, a profile of a successful model for residential treatment in the community and a discussion board with dozens of thoughtful comments. Learn more: www.pbs.org/wgbh/pages/frontline/released

Hepatitis A, B Rates Down Sharply; Hep C Plateaus
Recommendations for childhood vaccination against HAV and HBV appear to have dramatically reduced infections, with rates in 2007 the lowest ever recorded, according to a report from the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Acute hepatitis A incidence declined 92% from 1995 to 2007, from 12.0 to 1.0 case per 100,000 population. Acute hepatitis B incidence declined 82% from 1990 to 2007, from 8.5 cases 1.5 cases per 100,000 population. Declines occurred in all age groups but were greatest among children younger than 15. Higher rates of HBV remain in adults, particularly males aged 30-44, reflecting the need to vaccinate adults at risk for HBV.

Following a peak in 1992, incidence of acute hepatitis C declined, primarily among injection-drug users and possibly because of changes in IDU behavior and practices. Since 2003, however, rates have plateaued. In 2007, as in previous years, the majority of HCV cases occurred among adults, and injection-drug use was the most common risk factor.

The report states that ongoing HBV vaccination programs and increased vaccination of adults with risk factors will eventually eliminate domestic HBV transmission. Further prevention of HBV and HCV relies on identifying and preventing transmission in hospital and other health care settings. HCV prevention also relies on identifying and counseling uninfected persons at risk about ways to protect themselves. Public health management of persons with chronic HBV or HCV infection will help prevent transmission to susceptible persons, and their medical management will reduce secondary effects of chronic liver disease. Source: MMWR Surveillance Summaries, May 22; www.cdc.gov/mmwr/mmwr_ss.html
Meeting Challenges

Colorado-based Correctional Health Partners (CHP) is proud to announce that it has increased its services to include the Oregon Department of Corrections. CHP is a clinically enhanced TPA with the expertise to effectively address and manage the unique challenges inherent in the delivery of healthcare services to correctional facilities. Our proven cost-containment systems have successfully increased the efficiency, managed the costs, and allowed for the highest quality of care for our clients.

“The strong working relationship we have with CHP is unmatched in my experience with contract agencies. Their staff is highly skilled, motivated, and experienced in managing a healthcare system. They are consummate professionals who demonstrate their commitment to us and ultimately the taxpayers. It is a true partnership in managing healthcare for the offender population.”

– Joan Shoemaker
Director of Clinical Services, Colorado Department of Corrections

We Deliver:
- Innovative cost containment services
- Claims processing
- Prior authorization and utilization management
- Reporting and analysis
- Provider network development
- Care management and coordination
- Pharmacy management, including formulary development
- Quality improvement

Delivering Quality Outcomes

Discover how Correctional Health Partners can support you in balancing clinical demand with available resources in your correctional system. Contact us today, and allow us to demonstrate how our expertise in developing services, skills, and collaborative relationships can bring substantial value to you.

Call toll-free 1.866.932.7185
or visit us on the web at www.CHPnow.com
Building Health Care Systems That Work

Today, cost-effective, evidence-based systems are the building blocks for transformation of correctional health care. The National Conference gives you the blueprints to understand, develop, implement and improve such systems. In this high-intensity environment—packed with lectures, panels, workshops, posters, exhibits and networking—you will gain the knowledge and skills to reshape not only your institution’s health services, but also the well-being of your patients and the community at large.

For even greater benefit, attend the preconference seminars to reinforce the foundations of your knowledge. The conference proper begins Sunday evening with the Exhibit Hall Opening Reception, where colleagues mingle and take a first look at the wealth of products and services on display.

The Coronado Springs Resort evokes the legendary cultures of Mexico and the Southwest amid Mayan architectural flourishes. Amenities include a large outdoor pool (with water slides and waterfalls), whirlpool, children’s pool, full-service restaurant, food court, health club, laundry facilities, business center and game room. Also enjoy complimentary transportation to Walt Disney World sites.

SESSIONS WITH SUBSTANCE

Immerse yourself in 3 days of programming and over 100 educational sessions, each designed to provide current information on subjects important to our field. Here’s a sampling:

- Assuring Nursing Skills Through Competency Development
- Beyond Diagnosis: The Soul of the Psychopath
- Chronic Pain: Getting to the Heart of the Matter
- Effective Corrections Crisis Intervention Training
- Essentials of Correctional Juvenile Health Care
- Excited Delirium and Sudden In-Custody Death
- Management of Hypertension and Diabetes
- Managing the Difficult Patient
- MRSA: The Superbug of Corrections
- Pandemic Preparedness Plans
- Seizures: Effective Treatment and Cost Management
- Write It Right: Reduce Your Lawsuit Risk by Improving Your Documentation

CONTINUING EDUCATION

Up to 32 hours of CE credit may be earned in each category below. This maximum number includes credits offered at preconference seminars. See the Preliminary Program or conference Web site for details.

- CCHP
- Nurse
- Physician
- Psychologist
- Social Worker
- General

FOR MORE INFORMATION

Visit the National Conference Web site for detailed information, including registration fees and policies, a schedule of sessions, the Preliminary Program and online registration. Or call us to request Preliminary Program by mail.

www.ncchc.org  773-880-1460
A review of the cases in this area reveals that the courts struggle with reconciling how a correctional physician can refuse to implement the recommendations of the specialist to whom the correctional physician turned for help in the first place. The judges look for evidence that a physician may have “deliberately ignored the express orders” of a specialist for “reasons unrelated to the medical needs of the prisoner.”

In such a circumstance, the courts generally do not decide that the correctional physician was deliberately indifferent in choosing not to follow the specialist’s advice. Instead, the courts simply determine that there is enough of a question that the issue should be left for a jury to resolve. As described by one court, “An inference of deliberate indifference may arise when prison officials refuse to follow an outside specialist’s orders or recommendations.”

The case of Gil v. Reed is perhaps the leading decision in this area. In Gil, the inmate suffered from a rectal prolapse and was referred by the prison physician to a surgeon specialist. Surgery was performed and the inmate’s surgeon specialist specifically instructed the prison medical staff not to provide certain pain relievers because of their constipating effect. Nonetheless, on three occasions after receiving these instructions, the prison physician ordered the inmate to be given the very medication that the specialist had warned against. This was done even though nonconstipating alternative pain relievers were available.

Under these circumstances, the Gil court could not make sense of the prison physician’s refusal to follow the specialist’s instruction and ruled that a jury should decide if the prison physician acted with deliberate indifference.

Conscious Decision or Blanket Denial?

In addressing inmate claims that a correctional physician was deliberately indifferent by refusing to follow a specialist’s recommendations, the courts try to assess whether the refusal reflected a conscious decision to try a different course of medical treatment or a simple blanket denial. The former is not sufficient to establish deliberate indifference, while the latter may show that the physician “knew of and disregarded an excessive risk to inmate safety.”

Provided that the decision reflects “a course of treatment based on the prevailing standards in the field,” the courts

continued on page 8
Earlier ART Yields Better Outcomes

HIV-infected adults in a “resource-limited” setting are more likely to survive if they start antiretroviral therapy before their immune systems are severely compromised, according to a randomized clinical trial in Haiti. In an interim review, an independent data and safety monitoring board found overwhelming statistically significant evidence that starting ART at CD4+ T cell counts between 200 and 350 cells/mm3 improves survival compared with deferring treatment until the count drops below 200 cells/mm3. The trial sponsor, the National Institute of Allergy and Infectious Diseases (part of the National Institutes of Health), heeded the board’s recommendation to end the trial immediately. Study participants who have fewer than 350 CD4+ T cells/mm3 will be offered ART.

The clinical trial began in 2005 and enrolled 816 adults with early HIV disease and CD4+ T cell counts from 200 to 350 cells/mm3. Half of the participants began ART within two weeks of enrollment; for the others treatment began when their counts dropped below 200 cells/mm3 or they were diagnosed with AIDS. This deferred treatment is the standard of care in Haiti and in keeping with World Health Organization guidelines. The first-line treatment regimen consisted of zidovudine, lamivudine and efavirenz.

At the time of the interim review, the standard of care group had nearly 4 times as many deaths as the early treatment group (23 vs. 6, respectively). Also, participants who began the study without TB infection were twice as likely to develop TB in the standard of care group (36) compared to the early treatment group (18).

The investigators say this finding may change the standard of care in dozens of countries where ART is initiated only when CD4+ T cell counts drop below 200 cells/mm3. In the United States, the Department of Health and Human Services has established a count of 350 CD4+ T cells/mm3 as an indication for initiation of therapy. However, the study finding also underscores the importance of identifying HIV infections earlier and starting ART earlier.


Specialist (continued from page 7)

may still defer to the correctional physician’s judgment. As one court explained, “What we have here is not deliberate indifference to a serious medical need, but a deliberate decision by a doctor to treat a medical need in a particular manner.”

In one case, for example, the court sustained a correctional physician’s decision to provide an inmate with some, but not all, of the specialist-recommended medications. The physician’s decision was based on his belief that some of the recommended medications were duplicative of others. Similarly, in another case, the court upheld a correctional physician’s decision to forgo a specialist’s recommendation to obtain an MRI. Here, the physician relied on his own multiple clinical examinations of the inmate, and the findings of an x-ray, as guiding his course of treatment.

ELECTING TO FORGO THE RECOMMENDATIONS OF A SPECIALIST PRESENTS LIABILITY RISKS AND SHOULD BE DONE ONLY AFTER CAREFUL CONSIDERATION. INMATES OFTEN FEEL THAT THEY ARE LEGALLY ENTITLED TO A SPECIALIST’S RECOMMENDATIONS EVEN THOUGH APPROPRIATE ALTERNATIVES ARE AVAILABLE. TO HELP REDUCE ANY POTENTIAL EXPOSURE, A CORRECTIONAL PHYSICIAN OPTING NOT TO IMPLEMENT A SPECIALIST’S RECOMMENDATION SHOULD DOCUMENT THE BASIS FOR HIS MEDICAL JUDGMENT AND OUTLINE THE ALTERNATIVE COURSE OF TREATMENT THAT WILL BE PROVIDED.

Robert P. Vogt, JD, CCHP, is a partner in Weldon-Linne & Vogt, a Chicago-based law firm that defends health professionals and institutions in Illinois, Indiana and Wisconsin. Contact him at bvogt@wlveonline.com.
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 vivo studies have demonstrated that efavirenz inhibits CYP3A4 and induces CYP2D6. Coadministration of efavirenz with drugs primarily metabolized by these isoenzymes may result in altered plasma concentrations of the coadministered drug. Therefore, appropriate dose adjustments may be necessary for these drugs. Drugs that induce CYP3A activity (e.g., phenobarbital, rifampin, rifabutin) would be expected to increase the clearance of efavirenz resulting in lower plasma concentrations.

Emtricitabine and Tenofovir DF: Since emtricitabine and tenofovir are primarily eliminated by the kidneys, coadministration of efavirenz with tenofovir DF may reduce the tenofovir DF concentrations. There is insufficient data to support dosing recommendations for tenofovir DF, and it is not likely to significantly remove efavirenz from the blood.

Warnings and Precautions

ATRIPRA (efavirenz, emtricitabine, and tenofovir) is not recommended for use in individuals of reproductive potential because of the risk of transmission of HIV-1 to infants. Women should be advised to avoid pregnancy while taking ATRIPRA and to use effective contraception. Women should be informed that they may be tested for hepatitis B virus (HBV) before initiating antiretroviral therapy.

Geriatric Use: In clinical studies of efavirenz, emtricitabine, or tenofovir DF, it is not known whether either emtricitabine or tenofovir is effective in the elderly patients. Dosing recommendations for ATRIPRA is not recommended. There are insufficient data to support dosing recommendations for tenofovir DF, and it is not likely to significantly remove efavirenz from the blood.

Emtricitabine, Tenofovir DF: Other important drug interaction information for ATRIPRA is summarized below. The drug interactions described are based on studies conducted with efavirenz, emtricitabine or tenofovir DF as individual agents. Potential drug interactions require no special drug interactions have been conducted using ATRIPRA. The list includes potentially significant interactions, but are not all inclusive.

Established and/or OBSERVED Significance Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction

Antiretroviral agents: Protease Inhibitors - Coadministration of protease inhibitors with ATRIPRA is not recommended. Coadministration of atazanavir with efavirenz or tenofovir DF does not affect the antiviral activity of these drugs.

Antiretroviral agents: Integrase inhibitor - Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir with tenofovir DF does not affect the antiviral activity of these drugs.

Antiretroviral agents: Non-nucleoside reverse transcriptase inhibitors - Coadministration of efavirenz and tenofovir DF does not affect the antiviral activity of these drugs.

Antidepressants: Coadministration of efavirenz with efavirenz, emtricitabine, or tenofovir DF decreases plasma concentrations of efavirenz. The combined effect of efavirenz plus tenofovir and emtricitabine on clinical adverse effects is not known. Also, efavirenz has been shown to decrease tenofovir concentrations. There are insufficient data to support dosing recommendations for tenofovir DF, and it is not likely to significantly remove efavirenz from the blood.

Antipsychotics: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antipsychotics may reduce plasma concentrations of these antipsychotics (unpublished). Appropriate doses of fosamprenavir and ATRIPRA with respect to safety and efficacy have not been established. Coadministration of efavirenz with fosamprenavir 1.2 g and ritonavir 100 mg twice daily (300 mg of ritonavir is recommended when ATRIPRA is coadministered with fosamprenavir) resulted in a 33% increase in the ritonavir dose (unpublished). ATRIPRA is administered with fosamprenavir plus ritonavir twice daily. value; ritonavir concentration. The optimal dose of efavirenz with fosamprenavir needs to be determined.

Anti-infective agents: Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir and ritonavir increases efavirenz plasma concentrations.

Antimetabolites: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antimetabolites may be undertaken with caution and patients receiving this combination should be monitored closely for dose-dependent-associated adverse reactions. Dose-dependent is defined in patients who develop dose-dependent-associated adverse reactions. Suppression of CDA (e.g.) or pooled concentrations has been observed in patients receiving tenofovir DF with dolutegravir 400 mg daily. Atazanavir and lamivudine/tenofovir have been shown to increase tenofovir concentrations. ATRIPRA should be discontinued in patients who develop dose-dependent-associated adverse reactions. Coadministration of atazanavir with ATRIPRA is not recommended. There are insufficient data to support dosing recommendations for atazanavir, and it is not likely to significantly remove efavirenz from the blood.

Cyclosporine A: The effect of efavirenz, co-administered with cyclosporine, on ciclosporine concentrations is unknown. Dosing recommendations for ATRIPRA are not recommended.

Efavirenz, Emtricitabine and Tenofovir DF: Other important drug interaction information for ATRIPRA is summarized below. The drug interactions described are based on studies conducted with efavirenz, emtricitabine or tenofovir DF as individual agents. Potential drug interactions require no special drug interactions have been conducted using ATRIPRA. The list includes potentially significant interactions, but are not all inclusive.

Established and/or OBSERVED Significance Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction

Antiretroviral agents: Protease Inhibitors - Coadministration of protease inhibitors with ATRIPRA is not recommended. Coadministration of atazanavir with efavirenz or tenofovir DF does not affect the antiviral activity of these drugs.

Antiretroviral agents: Integrase inhibitor - Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir with tenofovir DF does not affect the antiviral activity of these drugs.

Antidepressants: Coadministration of efavirenz and tenofovir DF does not affect the antiviral activity of these drugs.

Antipsychotics: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antipsychotics may reduce plasma concentrations of these antipsychotics (unpublished). Appropriate doses of fosamprenavir and ATRIPRA with respect to safety and efficacy have not been established. Coadministration of efavirenz with fosamprenavir 1.2 g and ritonavir 100 mg twice daily (300 mg of ritonavir is recommended when ATRIPRA is coadministered with fosamprenavir) resulted in a 33% increase in the ritonavir dose (unpublished). ATRIPRA is administered with fosamprenavir plus ritonavir twice daily. value; ritonavir concentration. The optimal dose of efavirenz with fosamprenavir needs to be determined.

Anti-infective agents: Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir and ritonavir increases efavirenz plasma concentrations.

Antimetabolites: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antimetabolites may be undertaken with caution and patients receiving this combination should be monitored closely for dose-dependent-associated adverse reactions. Dose-dependent is defined in patients who develop dose-dependent-associated adverse reactions. Suppression of CDA (e.g.) or pooled concentrations has been observed in patients receiving tenofovir DF with dolutegravir 400 mg daily. Atazanavir and lamivudine/tenofovir have been shown to increase tenofovir concentrations. ATRIPRA should be discontinued in patients who develop dose-dependent-associated adverse reactions. Coadministration of atazanavir with ATRIPRA is not recommended. There are insufficient data to support dosing recommendations for atazanavir, and it is not likely to significantly remove efavirenz from the blood.

Cyclosporine A: The effect of efavirenz, co-administered with ciclosporine, on ciclosporine concentrations is unknown. Dosing recommendations for ATRIPRA are not recommended.

Efavirenz, Emtricitabine and Tenofovir DF: Other important drug interaction information for ATRIPRA is summarized below. The drug interactions described are based on studies conducted with efavirenz, emtricitabine or tenofovir DF as individual agents. Potential drug interactions require no special drug interactions have been conducted using ATRIPRA. The list includes potentially significant interactions, but are not all inclusive.

Established and/or OBSERVED Significance Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction

Antiretroviral agents: Protease Inhibitors - Coadministration of protease inhibitors with ATRIPRA is not recommended. Coadministration of atazanavir with efavirenz or tenofovir DF does not affect the antiviral activity of these drugs.

Antiretroviral agents: Integrase inhibitor - Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir with tenofovir DF does not affect the antiviral activity of these drugs.

Antidepressants: Coadministration of efavirenz and tenofovir DF does not affect the antiviral activity of these drugs.

Antipsychotics: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antipsychotics may reduce plasma concentrations of these antipsychotics (unpublished). Appropriate doses of fosamprenavir and ATRIPRA with respect to safety and efficacy have not been established. Coadministration of efavirenz with fosamprenavir 1.2 g and ritonavir 100 mg twice daily (300 mg of ritonavir is recommended when ATRIPRA is coadministered with fosamprenavir) resulted in a 33% increase in the ritonavir dose (unpublished). ATRIPRA is administered with fosamprenavir plus ritonavir twice daily. value; ritonavir concentration. The optimal dose of efavirenz with fosamprenavir needs to be determined.

Anti-infective agents: Coadministration of atazanavir with ATRIPRA is not recommended. Coadministration of atazanavir and ritonavir increases efavirenz plasma concentrations.

Antimetabolites: Coadministration of efavirenz, emtricitabine, or tenofovir DF with antimetabolites may be undertaken with caution and patients receiving this combination should be monitored closely for dose-dependent-associated adverse reactions. Dose-dependent is defined in patients who develop dose-dependent-associated adverse reactions. Suppression of CDA (e.g.) or pooled concentrations has been observed in patients receiving tenofovir DF with dolutegravir 400 mg daily. Atazanavir and lamivudine/tenofovir have been shown to increase tenofovir concentrations. ATRIPRA should be discontinued in patients who develop dose-dependent-associated adverse reactions. Coadministration of atazanavir with ATRIPRA is not recommended. There are insufficient data to support dosing recommendations for atazanavir, and it is not likely to significantly remove efavirenz from the blood.

Cyclosporine A: The effect of efavirenz, co-administered with ciclosporine, on ciclosporine concentrations is unknown. Dosing recommendations for ATRIPRA are not recommended.
Evidence-Based Nursing Practice
The Time Is Right!

by Lorry Schoenly, PhD, RN, CCHP

Judging from the response to a recent NCCHC conference session, interest is growing for application of evidence-based nursing practice (EBNP) in correctional health care. Speaker Susan Laffan, RN, CCHP-A, considers this a perfect time to apply the evidence-based approach to nursing care. “The trend toward evidence-based practice is growing in the nursing profession,” says Laffan, a consultant based in Toms River, NJ. “Our, clinical practice should rest on solid research evidence where possible.”

In fact, the origins of the modern nursing profession in the 1800s with Florence Nightingale included seeds of EBNP. In her 1861 landmark book, Notes on Nursing she states, “The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate improvement—which are of none—which are the evidence of neglect—and what kind of neglect.”

What Is EBNP?
Evidence-based nursing practice involves the use of the most credible and up-to-date research to guide patient care. This way of practicing stresses the use of protocols and procedures that are based on research and other objective information, rather than ritual, opinion or “the way we have always done it.” A 1992 survey of staff nurses regarding the sources of knowledge used to guide practice revealed that most relied on nursing school, workplace sources, physicians and intuition. Although enthusiastic about using research evidence as a basis for practice, nurses can be bewildered by how to do so.

EBNP brings many potential advantages, including more effective practice, greater confidence in decision-making and better patient outcomes. Sara Jo Brown, PhD, RN, author of Evidence-Based Nursing: The Research-Practice Connection, a nursing textbook, sees a bright future for nursing practice built on a strong foundation of credible evidence.

“Nursing is science and art—sort of like yin and yang that are complementary opposites within a greater whole,” Brown says. “Many nurses have strong nursing art knowledge and skills but have not incorporated the use of science into their practice. Effective practice needs both.” The correctional nursing specialty can undoubtedly help inmates achieve better health outcomes by turning more often to research evidence as a basis for practice.

Key Steps to EBNP
Practicing nurses need not conduct an actual research study to determine effective interventions. Fortunately, that is neither desirable nor advocated by EBNP specialists. Instead, EBNP focuses on using the wide array of published research to determine application to practice. Here are the key steps to the practice of evidence-based nursing.
• Identify a specific patient problem or situation that is in need of a better approach
• Systematically search for research evidence that could be used to address the issue
• Appraise the validity of the research evidence, and its relevance and applicability to your population and setting
• Integrate the research evidence with site information that might influence management of the issue
• Thoughtfully implement the evidence-based practice decision
• Evaluate the outcome of the decision

**Locating and Assessing Evidence**

The isolated nature of correctional nursing practice once made it difficult to find clinical research. Without easy access to a medical library or hospital resources, correctional nurses could be frustrated in attempts to locate answers to clinical challenges. In the last decade, however, the advent of the Internet, with its an increasing variety of search engines and online resources, has eliminated barriers to acquiring information. Now there are many Internet sites dedicated to serving as health care data repositories, with some specific to nursing.

Thus, the Internet is a great first stop on the road to implementing EBNP. The table above lists some of the most fruitful sites. Of course, traditional sources such as university and medical libraries are also helpful, if available.

The fastest road to EBNP is locating evidence-based clinical guidelines already developed by a reliable entity. In this case, there is no need to go back to the original studies—it has already been done for you. The next most helpful is a published systematic research review. Here, the author has studied the array of research in a particular area and synthesized the information and often the degree of confidence in the findings. The last choice would be to review individual published studies. This, of course, requires a greater understanding of research principles to determine if the findings are applicable in your setting.

Many organizations that produce evidence-based guidelines rate the strength of the evidence in support of each of the recommendations that make up the guideline. The table at right is an abbreviated version of one of these rating systems. The strongest evidence classification for a recommendation is 1A and the weakest is 4.

**Where to Start**

Brown suggests starting with clinical issues that aren’t currently being handled well. “Nursing issues with patient groups that are high volume, consume a significant amount of time or are not achieving good outcomes are good places to start,” she says. These issues often are identified through the continuous quality improvement program. A quality deficit generates an opportunity to pursue better patient outcomes. The standard of care, the nursing interventions, should be based on available research.

**EBN Example: Pressure Ulcer Prevention**

Pressure ulcer prevention is an example of a thorny correctional nursing issue that could be improved by adopting evidence-based interventions. The first step is to identify the populations that are developing pressure ulcers in your setting. Then, search the literature for research evidence relevant to your population. Look first for evidence-based clinical practice guidelines produced by respected organizations.

---

**Agency for Healthcare Research and Quality (AHRQ) Levels of Evidence**

<table>
<thead>
<tr>
<th>Type of Evidence</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meta-analysis of multiple well-designed controlled studies</td>
<td>1A</td>
</tr>
<tr>
<td>Well-designed randomized controlled trials</td>
<td>1</td>
</tr>
<tr>
<td>Well-designed nonrandomized controlled trials (quasi-experimental studies)</td>
<td>2</td>
</tr>
<tr>
<td>Observational studies with controls</td>
<td>3</td>
</tr>
<tr>
<td>• Retrospective studies</td>
<td></td>
</tr>
<tr>
<td>• Interrupted time studies</td>
<td></td>
</tr>
<tr>
<td>• Case-control studies</td>
<td></td>
</tr>
<tr>
<td>• Cohort studies with controls</td>
<td></td>
</tr>
<tr>
<td>Observational studies without controls</td>
<td>4</td>
</tr>
<tr>
<td>• Cohort studies without controls</td>
<td></td>
</tr>
<tr>
<td>• Case series</td>
<td></td>
</tr>
</tbody>
</table>

---

*continued on page 12*
If you cannot find one, then look for a systematic research review about the issue. Carefully consider all of the keywords that might lead to information about pressure ulcer prevention and management. Search words could include wound care, pressure ulcer, decubitis and wound healing. The box at left outlines search findings from the Web sites listed on page 11.

With search results in hand, decide which guidelines or study review results are most applicable to your situation. Then, working with administrative and medical leadership, determine which practices to incorporate into site policy and procedure for pressure ulcer prevention and care.

Involvement of all clinical staff in the process encourages staff development and adoption of new practice. Finally, patient outcomes should be tracked over time.

This is just one example of the myriad of correctional nursing issues that could benefit from applying evidence available from research taking place in the nursing community. The time is right to enhance the quality of care for our inmate-patients through EBNP.

Lorry Schoenly, PhD, RN, CCHP, is a clinical education manager with Correctional Medical Services and is based in Pennsylvania. Contact her at lschoenly@cmsstl.com. She also hosts an Internet site dedicated to increasing awareness of correctional nursing practice: www.correctionalnurse.net. Follow her on Twitter: lorryschoenly.

**Pressure Ulcer Search Results**

**National Guideline Clearinghouse**
Current evidence-based pressure ulcer guidelines from...
- Hartford Institute for Geriatric Nursing
- Registered Nurses’ Association of Ontario
- National Collaborating Centre for Nursing Support
- Also older guidelines

**Cochrane Collaboration**
Research reviews on...
- Surface support for pressure ulcer prevention
- Repositioning for pressure ulcer prevention
- Wound cleansing for pressure ulcers
- Much more

**Joanna Briggs Institute**
Best practice guidelines in PDF format:
- Pressure Ulcers: Prevention of Pressure Related Damage
- Pressure Ulcers: Management of Pressure Related Tissue Damage

**Registered Nurses’ Association of Ontario**
RNAO Best Practice Guideline:
- Risk Assessment and Prevention of Pressure Ulcers

---

**Physicians**

**You have OPTIONS!**

**We have OPPORTUNITIES!**

Correctional Medical Services (CMS), is the nation’s largest private provider of contract healthcare services to correctional facilities. As a Professional Healthcare provider, You have options, We have opportunities!

We are currently seeking Physicians to fill the following positions:

**Medical Directors, Staff Physicians, Psychiatrists and Dentists**
in Delaware, Arkansas, Maine, Missouri, Indiana, Maryland and New Mexico.

**For more information please contact:**
Dee Thandi, Physician Recruiter
Phone: 800-893-2118 • Fax: 866-303-2728
Email: dthandi@cmsstl.com • EOE/AAP/DTR
Guard against MRSA.
In prison, the last thing you need is a break out.

Keep costly MRSA and staph infections at bay with Hibiclens® antiseptic skin cleanser

It can cost a correctional facility tens of thousands of dollars to treat and manage a single case of MRSA infection. Your best defense is to prevent cross-contamination. At a cost of just pennies per use, Hibiclens kills MRSA and other staph infections (in vitro). Infections can spread and wreak havoc in a facility. Hibiclens, as part of a daily hand washing routine, can reduce the risk of cross contamination. Hibiclens also combats C-DIFF, another usual suspect in prison infections. Hibiclens bonds instantly to the skin and continues to kill germs for up to 6 hours after use.

To learn how to prevent MRSA, call 1.800.843.8497 or go to www.hibigeebies.com/prison

Clean-up with the benefits:
- Hibiclens kills MRSA
- Fast acting, broad-spectrum antimicrobial activity
- Efficacy is not compromised by contact with organic matter like blood
- Market leader in skin antiseptic washes

Hibiclens®

Biogel®
Hibiclens®
BARRIER®

MÖLNLYcke® HEALTH CARE

©2009 Mölnlycke Health Care AB. All rights reserved. 1.800.843.8497 www.hibigeebies.com
Holistic Care Offers Promise of Positive Health Outcomes

by Heidi Bale, RN, CCHP, and Jane Grametbaur, RN, CCHP-A

In a society brought up with scientific medicine, holistic medicine is generally perceived as all smoke and mirrors. Although some types of holistic medicine, like acupuncture, have become more mainstream recently, many medical professionals regard holistic treatment as ineffective or downright dangerous.

Although often dismissed as quackery, holistic medicine has roots as far back in history as man has walked the earth. Before the great scientific discoveries of the past century, the ordinary man depended on the tribal priest or healer to provide relief from his ills.

The healer often used herbs, plants and spiritual methods to treat disease. Several botanicals that come to mind as effective today are the opium poppy, from which we derive morphine, and foxglove, which the ancient herbalist prescribed for cardiac problems and from which digitalis was later extracted.

As the only known antidote to poisoning caused by the death cap mushroom, which kills by destroying the liver, the herb milk thistle has great potential for use in treating liver damage caused by cirrhosis and hepatitis. European doctors frequently use milk thistle to treat patients with liver disease and numerous studies have shown it is effective. A number of other herbs and over-the-counter vitamins, such as those containing omega-3 fatty acids, may be of use in treating other chronic medical conditions such as arthritis.

The ancient Chinese believed sickness stemmed from the interruption of the flow of energy through the body and developed a system to clear the body of blockages. We know this form of energy healing as acupuncture. Some Chinese patients have major surgery with nothing but acupuncture for anesthesia. After surgery these patients simply get up and walk out of the operating room.

In India, meditation, a religious practice devised to help the practitioner become closer to God, has shown benefits for health. Patients who incorporate meditation into their daily activities become calmer and have better control in stressful situations. With time, practitioners can lower blood pressure and heart rate, diminishing the need for medication.

Several traditional Native American practices also may be useful as an adjunct with current medical treatment for cardiovascular disease. In addition, Native American community leaders have used medicine men and women and ancient traditions to treat drug addiction and alcoholism in at-risk youth. Some traditions and ceremonies, such as the sweat lodge ceremony, have shown promise in treatment of PTSD and drug and alcohol addiction.

Well-Suited to Corrections

Correctional medicine traditionally has focused on the conservative practice of scientific medicine, so it would seem that holistic medicine would have no place in the correctional setting. Yet, in many ways, it is perfectly tailored for use in correctional populations.

Inmates suffer from varying degrees of anxiety due to the circumstances of their incarceration and to the stress of living in a correctional setting. Communal housing, disruption of sleep and daily routines, as well as loss of control in day-to-day decisions cause stress, behavioral outbursts and exacerbation of health problems.

Holistic medicine focuses on the treatment of the individual as a whole, encompassing care for not only the physical symptoms of illness but also the mental and spiritual symptoms. Meditation, relaxation techniques, Reiki, tai chi, guided imagery and gardening are methods most commonly used in corrections today.

A Sampling of Programs

In 2003 and 2004, the San Diego County Sheriff’s Department instituted a program for psychiatric patients incarcerated in its facilities. The goals included identifying mental health inmates who did not require care by a psychiatrist, treating this population using holistic methods, reducing the number of patients who required treatment with mental health medications, increasing the efficacy of time spent with patients by psychiatrists and decreasing wait times for patients in need of psychiatric evaluation.

Specially trained registered nurses identified patients who met the criteria of sleep disturbance, anxiety, substance abuse concerns and depressive symptoms in patients not on psychotropic medications. These patients were referred to mental health clinicians who had completed special training. The patients also received handouts on improving sleep and reducing stress.

As reported in the July 2006 issue of the Journal of Correctional Health Care, a study to assess program outcomes found that approximately half of the inmates initially seen needed no further follow up after holistic treatment. A small group did require follow-up visits but were managed without medication. Approximately 30% of the group required referral to the psychiatrist.

Study findings also showed a significant decrease in the wait time to see a psychiatrist, as well as the time needed by the psychiatrist to evaluate the patient. The more efficient use of time by the psychiatrists allowed more time for the evaluation and care of acutely ill mental health patients.

A number of studies have examined the use of meditation in prisons and jails. One of the most recent was completed by a group from Old Dominion University in Virginia and published in the January 2009 issue of the Journal of Correctional Health Care. The researchers hypothesized that the use of meditation by inmate populations would be a cost-effective way for institutions to deal with problems from insomnia to conflict management. The primary focus of the study was to determine if participation in a structured meditation program would decrease medical symptoms, emotions and behaviors in a female population.
The study group received training in meditation practices by trained facilitators. Emphasis was placed on enhancing inner calm and learning to live in the moment, as well as discussion with other study group members and facilitators. Results showed that inmates who participated in meditation had fewer sleep problems, fewer problems with angry outbursts, and reduced feelings of stress and anxiety.

In San Francisco, the city and county jails implemented a meditation program through the San Francisco Zen Center for a number of years. This class lasted about 90 minutes, incorporating tai chi and yoga exercises to quiet the mind and body. This program was directed at women who were incarcerated for alcohol and drug crimes.

At the Hampshire County House of Correction in Massachusetts, inmates have been trained to practice Reiki on each other. Reiki is a Japanese technique for relaxation in which practitioners use their hands in positions over the patient’s body to sense energy centers, or “chi.” With intuition and training, the practitioners unblock trapped energy, thereby releasing stress, easing withdrawal symptoms and smoothing out emotions. Students are taught to practice Reiki on themselves before mastering higher levels and tending to other inmates.

In 2006, San Quentin State Prison in California established a gardening program for inmates through the Insight Prison Project, a not-for-profit organization that aims to provide unique rehabilitation programs for the prison. Participants were taught to cultivate plants and gardens on the grounds of the prison. As they learned to nurture flowers and vegetables, these men also learned to nurture positive responses to negative emotions and interactions. This program sought to plant responsibility, teamwork and appreciation through mindful gardening. Prison officials hope to expand this program, which now operates independently as the Insight Garden Project.

Insight Prison Project also offers a “mindful meditation” program. Increasingly popular in recent years, mindful meditation requires no special skills or training and instead simply focuses on being “in the present” and allowing the practitioner to let various thoughts surface while meditating. This form of meditation honors all belief systems and backgrounds and can be performed anywhere.

As more correctional facilities see the benefit of using holistic treatment as an adjunct to scientific practices, we can expect to see more innovative and creative solutions to medical and psychiatric issues. For instance, the San Bernardino County, CA, jail recently purchased a Wii play station by Nintendo for use in treatment of mental health patients.

“We added the Wii program to our mental health group sessions in an effort to engage more of our seriously mentally ill patients,” says health services administrator Kathy Wild, RN, MPA, CCHP. “We looked at the recent increase in the use of this equipment for nursing home residents and were impressed with the results. We do this group several times a week and include the mental health clinicians and our nurses during the sessions. This engages the patient with the staff. We are very impressed with the results we’ve seen so far. Inmates who rarely come out of their cells look forward to using the system and often are seen laughing and talking with staff during the course of the group.”

Significant Benefits

Whether it is through yoga, guided imagery (a form of guided meditation), tai chi, gardening or other means, the reduction of stress and anxiety is proven to reduce pain, improve sleep quality, calm emotions and produce a sense of well-being. This, in turn, decreases the need for expensive medications and reduces behavioral outbursts and assaults on staff. Given the escalating costs of health care and the difficulties in recruiting staff, the potential benefits of holistic care are significant.

With a little imagination and innovation, staff can blend holistic care with conventional medical treatment. The end result will benefit the patient and the health care system by decreasing exacerbations of chronic illness, teaching patients new methods of coping with pain and anxiety, and providing patients with self-care practices that will last a lifetime.

*Heidi Bale, RN, CCHP, is health services coordinator for the Washington State Department of Corrections, Raymond, WA. Jane Grametbaur, RN, CCHP-A, is the principal of Grametbaur & Associates Legal Nurse Consultants, Riverside, CA. To contact the authors about this article, send an e-mail to jgrametbaurRN@aol.com.*
S
aving an estimated $12 million over the course of a
seven-year program is sweet enough. It was the cherry
on top when the Pharmacy Benefit Management
Institute honored the collaboration that produced those
savings with its 2009 Rx Benefit Award, which recognizes
innovation in pharmacy management.

The initiative is a joint effort between the Rhode Island
Department of Corrections and the University of Rhode
Island’s College of Pharmacy.

In its award announcement, PBMI said the two entities “are
pioneering a new higher educa-
tion/state agency management
model.” This is the first time the
institute has honored a collabo-
ration involving a university or
college and a state agency.

Since its inception in 2002, the collaborative management
model has enabled RIDOC to
reduce medication waste by
nearly 75% and to hold the
trend line on expenditures
despite significant drug cost
inflation and increases in the
inmate population.

“Our 2009 award recipients have differentiat-
ted themselves from industry norms with
creative new approaches,” said
Dana Felthouse, president of
PBMI, which helps health care benefit executives work
with pharmacy benefit managers and other pharmacy
professionals to design prescription drug benefit programs.

“Another hallmark of the winners is a passion for collabora-
tion among stakeholders. The solutions are programs that
demonstrate success in improving pharmaceutical health
care, as well as curbing costs.”

Then and Now

The situation was not so rosy 10 years ago, when the
Department of Corrections operated an on-site pharmacy
staffed with state employees, says Joseph Marocco, MPA,
CCHP, RIDOC’s associate director of health care services. It
was difficult to recruit and retain staff for several reasons,
including a national shortage of pharmacists and correc-
tional salaries that did not match those in the community.
To try to keep up with the growing demands of a growing
inmate population, contract pharmacists were often used,
at a hefty cost.

To remedy those problems, in 2000 RIDOC decided to
outsource pharmacy services. Although that was a definite
improvement, the prison system’s health administrators
wanted to get a better handle on overall pharmacy man-
agement. “We wanted to make sure we were looking at the
whole picture: our formulary, who was on what meds and
why, cost analysis and cost-saving measures, plus reporting
on all of this,” Marocco explains.

Again they turned to outside expertise. After a competi-
tive bidding process, the agency awarded URI’s College of
Pharmacy a three-year, $454,000 contract in 2002 to man-
ge its pharmacy program using pharmacy benefit manage-
ment strategies. The new approach was a success, and the
two organizations are now in the midst of a
four-year, $682,000 con-
tract.

Today, pharmacy
services are managed
jointly by the College of
Pharmacy’s Healthcare
Utilization Management
Center and RIDOC
medical staff. The col-
lege provides an on-site
pharmacy manager and
extensive data analysis,
reporting, clinical sup-
port and management
resources. Pharmacy stu-
dents assist with much
of the data analysis.

Prescription fulfillment
done via contract with
CPS (Contract Pharmacy
Services Inc.) using an
electronic pharmacy order system.

The results speak for themselves. RIDOC’s daily popula-
average 3,800 inmates and annual admissions are
18,000 per year. Based on pharmaceutical trend data, the
system’s medication costs had been projected to be $13.7
million from 2003 through 2006, but its actual costs were
$8.8 million. Total overall savings have climbed to $12
million as the program has matured, according to E. Paul
Larrat, associate dean of the College of Pharmacy and
HUMC codirector, along with Rita Marcoux, an assistant
professor of pharmacy research.

This is an impressive feat given the growth in inmate
numbers, the changing demographics and health problems
among the patient population, and rising drug prices, says
Marocco.

Rx for Quality

RIDOC relies on the college pharmacy experts and students
for medication quality review, says medical director Michael
Poshkus, MD, CCHP. This includes help with quality assur-
ance programs and review of medication use as well as any
medication errors that may occur.

Poshkus appreciates having pharmacy experts to consult
“whenever we have a question about ordering medica-

Displaying the 2009 Rx Benefit Award are Matt Coty, URI pharmacy
student, and Rita Marcoux, URI assistant professor of pharmacy
research. Also present (L-R): student Brian Touhey; Michael Poshkus,
RIDOC medical director; E. Paul Larrat, associate dean, URI College
of Pharmacy; Joseph Marocco, RIDOC associate director of health
care services; and Larry Myerson, the URI on-site pharmacy
manager. (photo credit: URI/Michael Salerno)
tions and what would be the most cost-effective means to provide pharmaceuticals to our patient population.” He also values the work of the students. “Their projects involve reviewing our utilization of different drugs and helping us come up with protocols that allow us to better utilize medications for our populations.”

Marocco adds that the program has improved his department’s relationship with the state Board of Pharmacy by helping the board understand the complexities of correctional pharmacy care. “It’s not a nursing home; it’s not a hospital; it’s not an ambulatory care center. It’s a little bit of everything.”

Larrat says it is unusual to apply pharmacy benefit management strategies to a group like RIDOC. “One of the things that has impressed me is the team atmosphere. We were very welcomed by the medical team a few years back. That’s helped with access to information and our ability to educate the staff about pharmaceutical care, which hopefully filters down to better care and treatment of the inmates.”

Fostering Future Pharmacists
Both Poshkus and Marocco praise the work of the URI pharmacy students and are pleased that the prison setting can serve as a teaching facility for them. Indeed, Marcoux says PBMI was “very excited that we are taking this opportunity to introduce students to a part of pharmacy that often, students are not aware of. They are gaining experience that prepares them for jobs that many organizations in the health care industry are seeking.”

Although the students who work on the project do sometimes visit the prison facilities, they spend most of their time on URI campus analyzing data and prescription trends. “I reviewed utilization of emergency prescriptions to see where we can maximize the effectiveness of the ordering system,” says Matt Coty, who graduated in May after completing his six-year doctor of pharmacy degree. He says the program is important because “everybody deserves appropriate medications, and they should be treated just as any other individual would be treated.”

Brian Touhey, who also graduated in May with a doctorate in pharmacy, says he would encourage other pharmacy students to make this one of their rotations. “Part of it was being on campus analyzing the numbers and then coming here to see it all come to fruition. This helped me not only with my clinical judgment, but my personal judgment as well... You have to use your professional judgment, your clinical judgment, put everything else aside and do your best for them.”

This article was written by CorrectCare editor Jaime Shimkus using information provided by the University of Rhode Island as well as by Joseph Marocco, MPA, CCCHP, RIDOC’s associate director of health care services.
Force Feeding for Hunger Strikes

by Marc F. Stern, MD, MPH

Whether you think it’s a step forward or backward, the Supreme Court of Washington State recently issued a ruling in a case that adds some clarity to how correctional health care physicians should deal with hunger strikers. The events in the case, McNabb v. Department of Corrections (2005) took place in 2004; the court heard the case in 2005 and handed down its ruling in 2007.

Mr. McNabb arrived in WDOC from jail after being sentenced for starting a fire in which family members were hurt. He had been on a hunger strike for five months and had lost around 90 pounds upon admission to WDOC; therefore, WDOC began force feeding the patient via nasogastric tube. Shortly after beginning force feeding, the patient volunteered to eat, but brought suit against WDOC claiming WDOC had violated his right to refuse treatment under his right to privacy. He asked the court to declare WDOC’s force-feeding policy unconstitutional.

The court concluded that WDOC was correct in force feeding Mr. McNabb in arriving at their decision (which can be viewed at www.courts.wa.gov/opinions/pdf/773599. no1.pdf), the court did not deny that Mr. McNabb has a right to refuse artificial nutrition. However, they felt that the state has a greater interest in force feeding him. Specifically, they wrote:

“...the court will weigh McNabb’s right to refuse artificial means of nutrition and hydration against the existence of five compelling state interests: (1) the maintenance of security and orderly administration within the prison system, (2) the preservation of life, (3) the protection of innocent third parties, (4) the prevention of suicide, and (5) the maintenance of the ethical integrity of the medical profession.”

This is the first time a court has used this particular set of litmus tests in this combination. However, the component tests are not new. Indeed, the first test is also known as the Turner Rule. In Turner v. Safley (1987), a case regarding an inmate’s right to marry, the U.S. Supreme Court found that the state’s interest outweighs the inmate’s interest when the state has a legitimate penologic interest to deny the inmate’s right. So, for example, if the state felt that the inmate’s hunger strike might spread to other inmates, impairing the state’s ability to maintain safety and order, then the Turner Rule would be satisfied. Incidentally, the risk of a hunger strike spreading is not just theoretical. In fact, it is what happened in New York DOCs when Mark David Chapman (sentenced in the death of John Lennon) stopped eating in protest. The second through fifth tests were borrowed from another Washington State case (Welfare of Colyer, 1983).

WDOC Policy Passes Muster

In its decision, the court referred frequently to WDOC’s force-feeding policy, including the fact that the policy was applicable to this situation and was properly executed by WDOC. Thus the policy itself has now been subject to judicial review and has survived. This may provide some guidance to other jurisdictions.

As of this writing, the 2007 policy in effect is essentially the same as the one reviewed by the court, except that it affords WDOC the authority to obtain clinical data from the patient against his/her will in order to monitor the patient after force feeding is initiated. Such data includes vital signs, blood tests and urine tests. An updated version of the policy, published in December 2008, extends that authority to the pre-force-feeding period when staff is trying to determine whether or not the patient’s condition is serious enough to begin force feeding. (The policy, no. 620.100, is posted at www.wdoc.wa.gov/policies.)

It is interesting to note that unlike the WDOC’s policy on involuntary medication administration for severe mental disease (which was upheld by the Supreme Court in the well-known case Washington DOC v. Harper, 1990), WDOC’s forced feeding policy does not include a due process component. The current court did not take issue with this. They noted and were satisfied that medical staff issued a written determination.

Unsettled Question

Whether increased authority on the part of correctional systems to force feed inmates is a good thing is not a settled question. That, certainly, is an ethical question for each of us to ponder. However, from a legal standpoint, at least, not all courts have agreed with the Washington State Supreme Court that prison walls separate citizens from their constitutional rights. At least three state courts have reached an opposite conclusion (California Supreme Court: Thor v. Superior Court, 1993; Georgia Supreme Court: Lane v. Prevatte, 1982; Florida appeals court: Singletary v. Costello, 1996; all cited in AELJ Monthly Law Journal: Jail & Prisoner Law Section, December 2007)

Finally, the reader should carefully note that all the cases discussed above concerned inmates who were otherwise in good physical health. In the case of a patient with a severe debilitating or terminal disease they would not, and should not, apply.

This article was reprinted with permission from the Winter 2009 issue of CorrDocs, the quarterly newsletter of the Society of Correctional Physicians. This version has been modified slightly to omit case reference details. CorrDocs is available at the SCP Web site, www.corrdocs.org.

Marc F. Stern, MD, MPH, is a correctional health care consultant. At the time this article was written, he was the assistant secretary for health services at the Washington State Department of Corrections. To contact him, send an e-mail to mfstern@u.washington.edu.
Treat HIV confidently with TRUVADA in correctional facilities

- Demonstrated efficacy and tolerability profile through 3 years in Study 9342
- TRUVADA is the only DHHS-preferred dual NRTI
- TRUVADA or its components have been chosen in long-term clinical trials with leading PIs1,4,9

Depend on TRUVADA to be your partner with PIs

Safety information: drug interactions have been observed between tenofovir 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 tenofovir-associated adverse reactions. TRUVADA should be discontinued in patients who develop tenofovir-associated adverse reactions.2

TRUVADA is a once a day backbone for combination therapy in adults with HIV-1

Indications and use1
TRUVADA, a combination of EMTRIVA® (emtricitabine) and VIREAD® (tenofovir disoproxil fumarate), is indicated in combination with other antiretroviral agents (such as non-nucleoside reverse transcriptase inhibitors or protease inhibitors) for the treatment of HIV-1 infection in adults. The following points should be considered when initiating therapy with TRUVADA for the treatment of HIV-1 infection:

- It is not recommended that TRUVADA be used as a component of a triple nucleoside regimen
- TRUVADA should not be coadministered with ATRPILA® (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg, EMTRIVA, VIREAD, or lamivudine-containing products)*
- In treatment-experienced patients, the use of TRUVADA should be guided by laboratory testing and treatment history

WARNINGS
Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues, including VIREAD, a component of TRUVADA, 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 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.

Dosage and administration
- Recommended dose: one tablet (containing 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate) once daily taken orally with or without food
- Dose recommended in renal impairment: creatinine clearance (CrCl) 30–49 mL/min. 1 tablet every 48 hours. CrCl <30 mL/min or hemodialysis: do not use TRUVADA.
- No dose adjustment is necessary for patients with mild renal impairment (CrCl 50–80 mL/min)

Warnings and precautions
- New onset or worsening renal impairment
- Emtricitabine and tenofovir are principally eliminated by the kidney. Renal impairment can include acute renal failure and Fanconi syndrome
- Assess CrCl before initiating treatment with TRUVADA. Routinely monitor CrCl and serum phosphorus in patients at risk
- Dosing interval adjustment of TRUVADA and close monitoring of renal function are recommended in all patients with CrCl 30–49 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
- Avoid administering TRUVADA with concurrent or recent use of nephrotoxic drugs
- Decreases in bone mineral density (BMD): consider monitoring BMD in patients with a history of pathologic fracture or who are at risk for osteopenia or osteoporosis
- Redistribution/accumulation of body fat: observed in patients receiving antiretroviral therapy
- Immune reconstitution syndrome: may necessitate further evaluation and treatment
- Triple nucleoside-only regimens: early virologic failure has been reported in HIV-infected patients. Monitor carefully and consider treatment modification

Adverse reactions
- The most common (incidence ≥10%, any severity) and/or treatment-emergent (Grade 2–4, occurring in ≥2% of patients) adverse reactions occurring in Study 9348 through 144 weeks include diarrhea, nausea, fatigue, sinusitis, upper respiratory tract infections, nasopharyngitis, headache, dizziness, depression, insomnia, abnormal dreams, and rash
- The following postmarketing adverse reactions may occur as a consequence of proximal renal tubulopathy: nephrotoxicity, electrolyte abnormalities, hypokalemia, muscular weakness, myopathy, hypophosphatemia
- Other adverse reactions that occurred in at least 5% of patients receiving EMTRIVA or VIREAD with other antiretroviral agents in clinical trials include anxiety, arthralgia, increased cough, dyspnea, fever, myalgia, pain, abdominal pain, back pain, pancreatitis, peripheral neuropathy (including peripheral sensory and neuropathy), pneumonia, and thirst

Drug interactions
- Didanosine (ddo): tenofovir disoproxil fumarate increases ddI concentrations. Consider dose reductions or discontinuations of ddI if warranted
- Atazanavir (ATV): coadministration decreases ATV concentrations and increases tenofovir concentrations. Use ATV with TRUVADA only with ritonavir; monitor for evidence of tenofovir-associated adverse reactions
- Lopinavir/ritonavir: coadministration increases tenofovir concentrations. Monitor for evidence of tenofovir-associated adverse reactions

Combines (cobicistat/tenofovir, Epivir® or Epivir-HBV® (emtricitabine), Excimer® (adefovir disoproxil fumarate), or Truvada® (emtricitabine/tenofovir disoproxil fumarate))

References:
Lactic Acidosis and Severe Hepatomegaly with Steatosis

Patients receiving tenofovir disoproxil fumarate (TDF) may be at increased risk of developing lactic acidosis and severe hepatomegaly with steatosis, which may necessitate discontinuation of therapy. In a large clinical trial involving 1,075 patients receiving TDF in combination with other antiretrovirals, a total of 11 patients (1%) developed lactic acidosis and severe hepatomegaly with steatosis. Patients with certain host factors or type of infection may be at greater risk. These events have been fatal in some cases. In one study, 7 out of 14 patients with this condition died or required transplantation.

CLINICAL STUDIES

Truvada was evaluated in a total of 8 clinical trials. Two were phase 3 trials (16-week studies) in treatment-experienced patients. Two trials were 24-week studies in antivirally-naive patients with advanced HIV-1 infection. One study (48 weeks) evaluated the combination of Truvada with other antiretroviral agents. Two were 48-week studies in antivirally-naive patients with mild-to-moderate renal impairment. One was a 24-week study evaluating the combination of Truvada with other antiretrovirals in antivirally-naive patients with mild-to-moderate renal impairment.

SIDE EFFECTS

Thrombocytopenia

In phase 3 clinical trials in treatment-naive patients, thrombocytopenia was identified in 0.4% (1/238) of patients during 24 weeks of therapy. The most commonly reported adverse reactions were diarrhea (4.1% vs 3.7%), nausea (2.8% vs 2.5%), infusion site reaction (2.6% vs 3.7%), headache (2.5% vs 2.8%), vomiting (2.5% vs 2.8%), and upper respiratory tract infections (2.5% vs 2.8%).

Drug Interactions

Biktarvy was evaluated in a total of 4 clinical trials. Two were phase 3 trials (16-week studies) in treatment-experienced patients. One trial was a 24-week study evaluating the combination of Biktarvy with other antiretrovirals in treatment-naive patients with mild-to-moderate renal impairment. One was a 24-week study evaluating the combination of Biktarvy with other antiretrovirals in treatment-naive patients with mild-to-moderate renal impairment.

WARNINGs AND PRECAUTIONs

Virologic failure: It is not expected that Biktarvy will prevent virologic failure when used in combination with antiretrovirals.
Study: Brief Negotiation Interviewing Lowers HIV Risk, Increases Testing

Researchers and public health practitioners recognize that incarceration provides a great opportunity to intervene with populations at high-risk for HIV and AIDS largely because of their drug-use behavior. However, at any given time, “twice as many offenders are under community supervision as are incarcerated, and the HIV prevention needs of probationers and parolees have been largely overlooked,” according to data cited in the latest issue of the Journal of Correctional Health Care.

Turning their attention to this “hidden population,” Sonia Alemagno, PhD, and colleagues sought to develop and test an intervention that addresses reduction of HIV risk and encourages HIV testing. But they wanted to go beyond the “education only” approaches, which often fail to change behavior, without going to the other extreme, “expensive and involved enhanced interventions.”

Instead, they explored a strategy known as motivational interviewing. With evidence of positive outcomes mounting in the literature, this approach “allows intervention staff to help clients express concerns about their health and self-examine motivation for change.” A newer, related model, brief negotiation interviewing, is being applied to “hectic settings” such as emergency rooms and courts. According to the authors, BNI is a computerized, self-directed intervention that combines a short structured interview with a brief counseling session. It is “not seen as actual treatment, but rather as a step in the process of connecting with the treatment system” and is meant to encourage testing and counseling and to promote specific behavioral changes.

A randomized clinical trial was conducted among participants recruited from a probation department and two substance abuse treatment agencies in Cleveland, OH. The study examined whether BNI could decrease HIV risks and increase testing for HIV in this population. A trained interviewer conducted individual, face-to-face interviews in a private setting at baseline and two months later. The interview questions focused on drug-use and sexual behaviors associated with HIV risk.

After the first interview, the 104 group members received the Treatment Alternatives to Street Crime (TASC) intervention: written educational materials on HIV, STDs, TB and hepatitis, plus a list of community providers who conduct testing and counseling. They also were given a bus pass and reminded of the follow-up interview.

The 108 experimental group members were invited to engage in a single 20-minute BNI session using a “talking” computer. Specific topics varied depending on whether the participant was an injection drug user or was at sexual risk, and focused on “good things” and “not so good things” about these behaviors. Personal-risk feedback was provided with objectivity, emphasizing personal choice and responsibility for change. Finally, participants were given a personal prevention checklist based on individual responses, along with a voucher for free HIV and STD testing and a bus pass. They were given additional information on HIV and were encouraged to discuss the intervention with their case manager, who could assist further with referrals.

At follow-up, 95% of participants in the experimental group and 75% in the control group were located and interviewed.

Results indicate that, overall, both programs produced positive results as indicated by the improvement in risky sexual behavior and attitudes toward behavior change. However, those who received the BNI component demonstrated increased AIDS awareness, had a significantly higher rate of HIV testing and were more likely to say that they wanted to make some changes to reduce their AIDS risk.

JCHC Volume 15, Issue 3

The Enduring Menace of MRSA: Incidence, Treatment, and Prevention in a County Jail — Grant E. Deger, MD, CCHP, and David W. Quick, DO, PhD

A Qualitative Exploration of HIV/AIDS Health Care Services in Indian Prisons — Sayantani Guin, MPH, MA

Resumption of Smoking After Release From a Tobacco-Free Correctional Facility — Thomas Lincoln, MD, Robert W. Tuthill, PhD, Cheryl A. Roberts, MPA, Sofia Kennedy, MPH, Theodore M. Hammett, PhD, Elizabeth Langmore-Avala, MA, DTR, and Thomas J. Conklin, MD

Alcohol, Marijuana, and Perceptions of Influence on Social and Sexual Behavior Among African American Adolescent Female Detainees — Lindsay Danielle du Plessis, MPH, Rhonda Conerly Holliday, PhD, Alyssa G. Robillard, PhD, and Ronald L. Braithwaite, PhD

Brief Motivational Intervention to Reduce HIV Risk and to Increase HIV Testing Among Offenders Under Community Supervision — Sonia A. Alemagno, PhD, Richard C. Stephens, PhD, Peggy Stephens, PhD, Peggy Shaffer-King, MA, and Patrick White, MA

Commentary: A Personal Retrospective: In the Eye of the Accreditation Storm (Part II) — Judith A. Stanley, MS, CCHP-A

NCCCHC Position Statement: Prevention of Juvenile Suicide in Correctional Settings

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

Members of the Academy of Correctional Health Professionals receive JCHC (hard copy and online) as a benefit of membership. To learn how to obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
D-02 Medication Services (essential)

Medication services are clinically appropriate and provided in a timely, safe, and sufficient manner.
—2008 Standards for Health Services for jails and prisons

In the 2008 Standards for Health Services, the standard on Medication Services (D-02) contains a new compliance indicator: Inmates entering the facility on prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications are provided as clinically indicated.

Newly admitted inmates who report taking medications currently or who bring medications with them are to continue their medication unless there is a clinical reason to alter or discontinue the medication. Note that the E-02 Receiving Screening standard states in Compliance Indicator 9 that “prescribed medications are reviewed and appropriately maintained according to the medication schedule the inmate was following before admission.”

Protocols should be in place so that the drugs are administered in a timely fashion as dictated by clinical need. Clinical need is the key factor; therefore, medications should be prescribed only when they are clinically indicated.

There are different options to ensure that inmates who are admitted on prescribed medication continue to receive necessary drugs. Perhaps the physician or on-call physician is contacted by health staff for a verbal order once they have verified the medication through the community prescribing clinician or pharmacy. Another option is authorizing nurses to give medications based on the community clinician’s valid order until the facility physician is able to see the inmate. Some facilities do allow the use of medication that is brought in if it is contained in the original pharmacy packaging, labeled as required and staff have verified the order with the community prescriber or pharmacist.

A physician, dentist or other legally authorized individual may determine that a prescribed treatment is no longer clinically indicated or that there is an alternative to a medication that the patient was taking before incarceration. It is good practice to explain to patients the clinical justification behind discontinuing or prescribing alternate medication so that they understand that health care decisions are made based on their health needs and not for any punitive reason.

Importance of Continuity

Continuity of care is an important concept in this standard as it intends to help prevent adverse patient outcomes. For instance, it may not be possible to maintain a therapeutic dose of medication unless medications are taken as prescribed. Inordinate delays in receiving clinically indicated prescription medication may result in significant morbidity or mortality. Adverse patient outcomes can also occur when there are frequent changes in medication orders, medication histories are not reviewed by the clinician or treating clinicians are unaware of each other’s prescribing practices.

We all understand the importance of patients continuing to take medication as prescribed for health conditions such as high blood pressure or diabetes. There are also many other prescription medications that could have adverse health consequences if abruptly discontinued or not taken in a timely manner; steroids, antidepressants, antibiotics, and others require strict regimens in order to remain effective or prevent side effects. The facility provider will evaluate the medical necessity of prescriptions for newly admitted inmates to ensure that there is continuity of care and that health needs are met.

Medication services should, of course, be clinically appropriate and provided in a timely, safe and sufficient manner commensurate with current community practice. Therefore, the responsible physician should establish the policies regarding all prescription medications administered or delivered in the facility.

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 Pkwy, Chicago, IL 60614. For an archive of Spotlight articles, visit the Resources section at www.ncchc.org.

Spotlight on the standards

by Jennifer E. Kistler, MPH

In the 2008 Standards for Health Services, the standard on Medication Services (D-02) contains a new compliance indicator: Inmates entering the facility on prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications are provided as clinically indicated.

Newly admitted inmates who report taking medications currently or who bring medications with them are to continue their medication unless there is a clinical reason to alter or discontinue the medication. Note that the E-02 Receiving Screening standard states in Compliance Indicator 9 that “prescribed medications are reviewed and appropriately maintained according to the medication schedule the inmate was following before admission.” Protocols should be in place so that the drugs are administered in a timely fashion as dictated by clinical need. Clinical need is the key factor; therefore, medications should be prescribed only when they are clinically indicated.

There are different options to ensure that inmates who are admitted on prescribed medication continue to receive necessary drugs. Perhaps the physician or on-call physician is contacted by health staff for a verbal order once they have verified the medication through the community prescribing clinician or pharmacy. Another option is authorizing nurses to give medications based on the community clinician’s valid order until the facility physician is able to see the inmate. Some facilities do allow the use of medication that is brought in if it is contained in the original pharmacy packaging, labeled as required and staff have verified the order with the community prescriber or pharmacist.

A physician, dentist or other legally authorized individual may determine that a prescribed treatment is no longer clinically indicated or that there is an alternative to a medication that the patient was taking before incarceration. It is good practice to explain to patients the clinical justification behind discontinuing or prescribing alternate medication so that they understand that health care decisions are made based on their health needs and not for any punitive reason.

Importance of Continuity

Continuity of care is an important concept in this standard as it intends to help prevent adverse patient outcomes. For instance, it may not be possible to maintain a therapeutic dose of medication unless medications are taken as prescribed. Inordinate delays in receiving clinically indicated prescription medication may result in significant morbidity or mortality. Adverse patient outcomes can also occur when there are frequent changes in medication orders, medication histories are not reviewed by the clinician or treating clinicians are unaware of each other’s prescribing practices.

We all understand the importance of patients continuing to take medication as prescribed for health conditions such as high blood pressure or diabetes. There are also many other prescription medications that could have adverse health consequences if abruptly discontinued or not taken in a timely manner; steroids, antidepressants, antibiotics, and others require strict regimens in order to remain effective or prevent side effects. The facility provider will evaluate the medical necessity of prescriptions for newly admitted inmates to ensure that there is continuity of care and that health needs are met.

Medication services should, of course, be clinically appropriate and provided in a timely, safe and sufficient manner commensurate with current community practice. Therefore, the responsible physician should establish the policies regarding all prescription medications administered or delivered in the facility.

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 Pkwy, Chicago, IL 60614. For an archive of Spotlight articles, visit the Resources section at www.ncchc.org.
In this column, Judith Robbins, LCSW, JD, CCHP-A, talks with nutrition consultant Barbara Wakeen, MA, RD, CCHP, about nutritional issues specific to juvenile detention populations.

JR: What are the special dietary needs of adolescents and how can corrections facilities meet these needs?

BW: Adolescents require more calories, calcium, phosphorus and iron than most adult age groups. The key is to provide a balanced diet of adequate nutrients and calories.

In my experience and based on what I’ve learned from other corrections dietitians, most juveniles are receiving more than 3,000 calories per day, including snacks. Some facilities offer double entrees at lunch and dinner meals.

Many juvenile facilities participate in the USDA Child Nutrition National School Lunch Program/School Breakfast Program. These programs require certain food groups and quantities to be offered, along with some nutrient restrictions such as types and amounts of fats. Participants are also entitled to purchase commodity food items, which can help food budgets. Whether or not facilities participate, I have found that their meals are usually visually very balanced—that is, fruits and/or vegetables and milk at all meals.

Likewise, juveniles housed in adult facilities are usually recognized as having special nutritional needs and are served the adult menus augmented with milk, fruit and one or two snacks per day.

Unfortunately, even though nutritionally balanced meals are offered, adolescents often have not been exposed to some of the food served or dislike it and choose not to eat it. Thus, it can be challenging to ensure adequate intakes.

JR: How can juvenile correctional facilities provide the most helpful guidance for kids with, or at risk of, obesity, diabetes and other conditions?

BW: Classes, handouts and one-on-one counseling are good ways to provide education. The subject matter can address nutrition basics, therapeutic diets, activity, etc. Ideally, a registered dietitian is available to offer education, but most often the medical department performs that task.

Incorporating daily physical activity and structured exercise can also yield positive results for some kids at risk.

Educational agencies (including correctional facilities) that participate in the Child Nutrition Program are required to establish a school wellness policy that applies to all juveniles, not just those at risk. This is somewhat akin to NCCHC standards in their proactive stance for health during and after incarceration. Information on the wellness policy requirements can be found at www.fns.usda.gov/tni/Healthy/wellness_policyrequirements.html.

JR: Registered dietitians are in short supply in many juvenile systems. When an RD is not on staff, how can professionals collaborate to improve dietary choices for kids?

BW: RDs write and approve menus based on state regulations, accreditation standards, facility policy and other guidelines (e.g., the USDA Child Nutrition Program) with which the facilities must comply. However, unless we are there to monitor, we cannot guarantee the outcomes.

Start by reviewing the various requirements noted above. Look at what is offered in commissaries and vending machines, if these are available to the juveniles. Look at trends in weight gain, food waste, health and behavioral issues. Meet with the food service director to address any problems you find. If there is cause for concern, this can validate the need for a visit or consult from the RD to assist in modifications for compliance or healthier menu options. Ultimately, the RD will have to approve any menu changes.

JR: Do you have any suggestions for maintaining healthy diets while managing tightening budgets?

BW: Although it’s not always popular with the kids, strive to omit or reduce “empty calories,” such as candy, cookies, cake, soda pop or other calorie-dense, low-nutrient foods.

JR: Most juvenile settings have a diverse population with very different food preferences. Do you have any advice about whether these preferences should be reflected in the menus?

BW: Most correctional facilities in the United States do not honor personal food preferences in terms of likes and dislikes. I am in agreement with this. That said, standard menu planning usually does factor in preferences according to population demographics. Some accreditation standards require food preference surveys. Facilities use this information to incorporate popular foods on cycle menus when possible or to omit unpopular foods. Meal participation and plate waste are also indicators of food popularity.

Foods usually popular with juveniles are incorporated into menus that offer a variety of other foods that may be less popular but are nutrient dense. This approach results in healthy menus that introduce new foods into the diet.

Barbara Wakeen, MA, RD, CCHP, is the principle of Correctional Nutrition Consultants, Ltd, based in North Canton, OH. She represents the American Dietetic Association on the NCCHC board of directors and serves on NCCHC’s juvenile health committee. She is the author of Nutrition and Foodservice Management in Correctional Facilities. Reach her at bwakeen@neo.rr.com.

Judith Robbins, LCSW, JD, CCHP-A, represents the National Association of Social Workers on the board and chairs the juvenile health committee. She directs the Juvenile Detention Mental Health Program of Yale Behavioral Health, Department of Psychiatry, Yale Medical School, New Haven, CT.

We welcome your comments on this column or other juvenile correctional health topics. Please write to us at editor@ncchc.org or CorrectCare, c/o NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614.
Step Up! Seeking Candidates for Board

Serving on the Certified Correctional Health Professional board of trustees is a great way to “give back” to this important program and the thousands of people who participate in it. But the benefits go both ways: It is also a wonderful opportunity for leaders in this field to continue their professional growth and build their network of like-minded colleagues.

If that piques your interest, step up! CCHPs in good standing are encouraged to seek nomination, or to nominate a fellow CCHP, to serve on the board of trustees. Elections are held every year to fill a three-year term. Comprised of 10 correctional health professionals, the board is charged with guiding the CCHP program and improving it as necessary to make it more responsive to the needs of the correctional health care community. Trustees are also responsible for developing, scoring and evaluating the various certification exams.

Upon acceptance of nomination, candidates will be asked to submit a short statement describing their ideas about the direction of the CCHP program. Elections will be conducted online later this summer. The new trustees will begin their term immediately after the annual board meeting in October.

To make a nomination, complete the form online at www.ncchc.org/cchp by July 31, 2009.

Another Batch of CCHPs Makes Its Mark!
The CCHP board of trustees and staff congratulate the 72 individuals who passed certification exams held in February and March and officially became CCHP effective in April. For a complete list of their names, affiliations and locations, please visit the CCHP News page online.

Becoming a Certified Correctional Health Professional is an important step toward increased knowledge, greater professional recognition and identification as a leader in the complex and ever-changing field of correctional health care. If you do not yet participate in the program but would like to know more, please visit the Web to read about the benefits of certification as well as the application and examination process, and to obtain an application. Or contact us at cchp@ncchc.org or 773-880-1460. We also present informational sessions at NCCHC conferences and seminars.

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 12</td>
<td>Seattle, WA</td>
</tr>
<tr>
<td>August 1</td>
<td>Bastrop, TXs</td>
</tr>
<tr>
<td>August 22</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>September 16</td>
<td>Sacramento, CA</td>
</tr>
<tr>
<td>September 19 &amp; 20</td>
<td>Centennial, CO</td>
</tr>
<tr>
<td>October 18</td>
<td>Orlando, FL</td>
</tr>
</tbody>
</table>

For more information about the application process or the exams, please visit www.ncchc.org/cchp.

Also, we are seeking additional sites for the August and future exams, as well as CCHPs to proctor the exams. If you would like to participate, contact the CCHP coordinator at 773-880-1460 or cchp@ncchc.org.
American Correctional Health Services Association
Jacqueline Moore, PhD, RN, CCHP-A, was honored with ACHSAS’s 2009 Distinguished Service Award. Presented during the association’s annual meeting in March, the award is given to individuals who have attained significant achievement or contribution to correctional health service and/or ACHSAS.

Now an independent consultant based in Colorado, Moore has had a long and illustrious career in the correctional health field. There are five criteria by which nominees are evaluated; many recipients excel in two or three, it was noted. Moore, however, was praised for “displaying excellence” in all five criteria. Among the specific achievements cited are the following:
1. Development of a model program: launching “a new concept of comprehensive contract health services in a jail”
2. Research: conducting doctoral research on factors related to the shortage of nurses working in corrections
3. Publications: writing and editing copious published works
4. Training and education: developing surveyor training when she was NCCHC’s accreditation director
5. Public relations and management: overall leadership and management expertise

American Medical Association
At its annual meeting in June, the AMA adopted a public health policy concerning the use of tasers by law enforcement agencies. According to a brief issued by the association, an AMA report finds that tasers, when used appropriately, can save lives during interventions that would have otherwise involved the use of deadly force. “While tasers can help law enforcement officers, proper use must be ensured through specific guidelines, rigorous training and an accountability system,” said AMA board member Joseph Annis, MD. “There should also be a standardized approach to the medical evaluation of subjects exposed to tasers.”

American Bar Association
The ABAs AIDS Coordinating Committee has issued “A National AIDS Strategy: Legal Perspectives.” The purpose is to highlight some of the legal issues, and the laws to address them, that remain unsettled concerning HIV/AIDS in America. Laws and legal services play a pivotal role in stemming the spread of HIV by reducing stigma and discrimination linked to the virus, according to the committee. This, in turn, encouraging greater HIV testing, which is critical to prevention. A number of policy recommendations pertain to correctional settings and populations. The report is posted at www.abanet.org/AIDS.
NCCHC’s National Conference is the must-attend event of the year for correctional health professionals, and now you can contribute to their experience. Nearly 2,000 high-level attendees from all sectors of this multidisciplinary field will convene in Orlando for education, networking and career development. They are the leaders—and emerging leaders—who make and influence purchase decisions, and they will be looking for information about products and services that can help them deliver quality care. The NCCHC exhibit hall is a hot spot for you to define your role in this specialty field. When you connect with these influential professionals, you also reach the facilities, departments and staff they work with every day.

Correctional health care is a vast marketplace. Some $7 billion per year is spent to provide government-mandated health care to the 2.3 million individuals housed in the nation’s jails, prisons and juvenile facilities. At the state level, correctional health care providers, medical directors, nurses and other allied health professionals and administrators. What’s more, you can pinpoint only those most interested in your offer with multiple selections, such as job title, work setting and demographics. No other marketing channel allows you such a targeted marketing opportunity.

Looking to recruit exceptional correctional health care professionals? Find your next lead with the National Commission on Correctional Health Care mailing list, a proven tool to reach over 30,000 physicians, nurses, mental health care providers, medical directors, nurses and other allied health professionals and administrators. What’s more, you can pinpoint only those most interested in your offer with multiple selections, such as job title, work setting and demographics. No other marketing channel allows you such a targeted marketing opportunity.

Where Will You Find Your Next Great Hire?

Did You Know?

- 77% of last year’s attendees visited the exhibit hall at least three times
- 95% said they found the exhibit hall worthwhile
- 78% said they visit to learn about products and services

Exhibitor Benefits

- 2 full conference registration passes per 10’ x 10’ booth
- Discounted registration for additional personnel (up to 5)
- 75-word listing in the final program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free listing in NCCHC’s online Buyers Guide
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Discounted advertising in the conference programs and CorrectCare
- Priority booth selection for the 2010 Updates conference

Sponsorship Opportunities

Enhance your presence and maximize marketing dollars through these outstanding opportunities.

- Premier programming: Sponsorship of educational sessions on hot topics demonstrates support of the correctional field and gives your company high-profile exposure.
- Final proceedings: The CD-ROM provides a lasting record of concurrent sessions, with abstracts, handouts and PowerPoints. The sponsor is acknowledged on the cover.
- Internet Cafe: Enjoy a high-tech presence by sponsoring the exhibit hall computer stations, where attendees gather to check e-mail and browse the Web.
- Exhibit Hall Reception/Luncheon/Breaks: These events enable attendees to meet with exhibitors and network with colleagues while enjoying refreshments.
- Other opportunities: Conference bags, lanyards, water bottles, badges and banners are all good ways to boost visibility. Have an idea we haven’t mentioned? Let us know!

Registration Information

The meeting site is Disney’s Coronado Springs Resort in Orlando, FL. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details or to reserve your space, please see the Exhibitor Prospectus, available at www.ncchc.org, or contact us at info@ncchc.org or 773-880-1460.
EMPLOYMENT

Come Join Our Winning Correctional Health Team, CFG Health Systems
CFG Health Systems, LLC (sister corp. of Center for Family Guidance, PC) is a physician-owned and operated behavioral healthcare organization providing a full range of mental health services. We offer many diverse career opportunities with excellent benefits and are currently looking to place professionals within several correctional facilities in New Jersey or Pennsylvania:
• Physicians (Psychiatry, General Medicine)
• Dentists (General Dentistry)
• Nurse Practitioners
• PhD/RNs/LPNs
Interested candidates please contact:
Physician/Dentists: Frank Zura, Coordinator, Phone: 856-797-4760, fzura@cfgpc.com
Nurses: Nancy Delapo, Director, Phone 856-797-4761, ndelapo@cfgpc.com

MARKETPLACE

10% discounts are offered for Academy members (single copies) and for bulk purchases of a single title. To order, or for an NCCHC catalog, visit www.ncchc.org or call 773-880-1460.

NCCHC Standards for Mental Health Services in Correctional Facilities. These standards support an accreditation program for mental health services that operate under an authority different from health services. They parallel the standards for health services in format and substance, but make more explicit what is required for adequate delivery of mental health services. General areas covered include patient care and treatment, clinical records, administration, personnel and legal issues. These standards can help facilities determine proper levels of care, organize systems more effectively and efficiently, and demonstrate that constitutional requirements are being met. Glossary + index. Softcover, $69.95

Corrections Nursing: Scope and Standards of Practice. Corrections RNs must practice in work settings and environments for which health care is not a primary mission, delivering adequate and humane care in an unbiased manner. They must be qualified to address an enormous range of patient needs. They must understand and apply the concepts of primary care services, employing skill sets of ambulatory care, community health, emergency, occupational health, public health and school nursing. This book articulates the essentials of this specialty, its activities and accountabilities. American Nurses Association (2007). Softcover, 95 pages, $18.95

ADVERTISER INDEX

Bristol-Myers Squibb / Gilead – Atripla..........Insert, 9
CCHP-Nursing..........................................................24
Correctional Health Partners (CHP).................5
Correctional Medical Services (CMS).............12
Dentrust Dental.........................................................4
Geo Group............................................................17
Gilead Sciences – Truvada.................................19-20
Hibiclens..............................................................13
InFocus Marketing.................................................26
MHM Services.........................................................BC
National Conference on Correctional Health Care-JFC
NCCHC Standards...............................................25
Prison Health Services (PHS)...........................22
Spectra Diagnostics................................................IBC
Wexford Health Sources...................................8

www.ncchc.org
Suicide Prevention Checks

Q We perform 15-minute checks on our potentially suicidal inmates. Is this practice in compliance with the G-05 Suicide Prevention Program standard?

A Potentially suicidal inmates are those who are not actively suicidal but express suicidal ideation and/or have a recent history of self-destructive behavior. These inmates should be observed at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes). It depends on what you mean by 15-minute checks: If the observation is occurring regularly every 15 minutes, this is not in compliance with the standard. The idea is to check on the potentially suicidal inmate at irregular intervals, with no more than 15 minutes in between each check (see Compliance Indicator 1d). Lastly, if the potentially suicidal inmate is placed in isolation, then constant observation is required.

Emergency Response Critiques

Q Recently, we had a fire in our facility and had to implement our emergency response plan and evacuate a housing unit. Can we use the critique of this incident toward meeting the A-07 Emergency Response Plan standard, even though there were no casualties?

A Yes. Actual emergencies, whether or not injuries were involved, can certainly be critiqued and shared with staff to meet the intent of this standard. (See the Discussion section in the standard.)

Clinical Mortality Review

Q Typically, we wait for the results of the autopsy in order to complete a clinical mortality review. This often takes 60 days or more. Is it acceptable to wait for the autopsy results before completing the clinical mortality review?

A Death reviews should be completed in a timely manner even if the autopsy results are not yet returned. According to standard A-10 Procedure in the Event of an Inmate Death, all deaths should be reviewed within 30 days (see Compliance Indicators). Reviews consist of an administrative review, a clinical mortality review and, if the death is by suicide, a psychological autopsy. The intention of this standard is to avoid preventable deaths; therefore, any corrective actions identified through this process should be implemented and monitored sooner rather than later and treating staff should be informed of the administrative review and clinical mortality review findings. Clinical mortality reviews can be appended with information from the medical autopsy report.

Tuberculosis Screening

Q I work in a jail and would like to know if we are required to complete a screening test for tuberculosis as part of the receiving screening.

A No, the E-02 Receiving Screening standard for jails does not require inmates to receive a tuberculosis test at the time of the receiving screening. Mainly this is because detainees often do not remain in the facility long enough to have the tuberculin skin test read. However, TB testing is required under the E-04 Initial Health Assessment standard (see Compliance Indicators 2e and 5e). We also recommend that a tuberculosis control plan be followed that is consistent with published guidelines from the Centers for Disease Control and Prevention. Please note that for prisons, a screening test for tuberculosis is required under the Receiving Screening standard (Compliance Indicator 10).

Health Assessments for Infirmary Orders

Q I was wondering if a history and physical is required as part of the infirmary admitting order, under the G-03 Infirmary Care standard?

A No. A patient may have just had a health assessment prior to being placed in the infirmary, so an additional history and physical would not be required. An infirmary order should include the admitting diagnosis, medication, diet, activity restrictions, diagnostic testing required, frequency of vital sign monitoring and other follow-up (Compliance Indicator 8a). Admission to and discharge from the infirmary should occur only on the order of a physician (or other clinician where permitted by virtue of his or her credentials and scope of practice).

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee.

If you have a question about the NCCHC standards, please write to info@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A questions, visit www.ncchc.org and go to the Resources section. There you will also find an archive of Spotlight on the Standards columns. These articles shed light on the nuances of various standards, explaining the rationale behind them, the intended outcomes, compliance concerns and the impact on the accreditation process.
At Spectra Diagnostics, we realize you deserve more than just test results from your clinical laboratory partner. That’s why we provide the focused, personalized support and flexibility you need to get the job done.

Count on Spectra Diagnostics for:
- Customer Liaison assigned to each facility for personalized, single-source support
- Reliable results and rapid turnaround times
- STAT testing services
- Extensive courier network
- Customized requisitions
- Access to results and reports via custom interfaces
- Comprehensive training tools

For more information, email us at spectra.diagnostics@fmc-na.com or call 888-726-9105
Busting Myths of Correctional Mental Health

All mental health treatment is the same

There’s a big difference between simply dispensing medicine for inmates and providing specialized mental health programming.

MHM has developed more than 50 treatment modules for inmate groups of varying needs and cognitive abilities, including those restricted to their cells. Clients credit these programs for calmer segregation units. Our behavior management expertise also helps reduce problems and exorbitant off-site costs.

Our training curriculum for correctional officers and staff helps them understand and identify the signs of mental illness. Morale improves and turnover decreases as staff learn to better manage inmates.

How do we know what works? Clients tell us. Plus, we proactively audit every program and share plans for improvement.

It’s a fact—for proven, powerful clinical programs, it’s time to see the specialist. Contact MHM today.

MHM Services, Inc
800.416.3649
www.mhm-services.com