EpiCrim 101
Why Epidemiological Criminology Matters to Health Professionals

The Litmus Test of EHR Performance
Staff Mentor Programs
Self-Injurious Behavior
One of the largest gatherings of professionals in correctional health care, Updates 2010 will share innovative developments, practices and research findings in a broad range of topics. With an emphasis on the intertwining roles of public health and correctional health, the presentations will focus on interventions that lead to reduced illness rates, financial savings, improved public safety and better use of health care resources.

For more information visit www.ncchc.org
e-mail conference@ncchc.org
or call 773-880-1460
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.
Position Statements and Clinical Guidelines
NCCHC’s Policy and Standards Committee has been busy writing and revising position statements. At this year’s fall meetings, the following statements were finalized by the committee and adopted by the board of directors:
• Administrative Management of HIV in Correctional Institutions (revision)
• Health Services Research in Correctional Settings (new)
• Transgender Health Care in Correctional Settings (new)

The position statements are available online in the Resources section at www.ncchc.org. The statement on transgender health care appears on page 8 of this magazine.

In addition, the committee has adopted a new, streamlined format for the Clinical Guidelines for Correctional Settings. All guidelines are under review and will be reissued as they are approved.

Pocket Guide on Schizophrenia
NCCHC is collaborating with Applied Clinical Education to produce an educational pocket guide titled “Caring for Individuals With Schizophrenia in Correctional Settings and Beyond.” Written by correctional psychiatry experts Andrew Angelino, MD, Jeffrey Metzner, MD, CCHP-A, and Henry Weinstein, MD, the guide includes a free posttest that offers one hour of continuing education credit for physicians, nurses and psychologists.

Content will address treatment guidelines specific to incarcerated patients, key issues in psychosocial and pharmacologic treatment, strategies for risk assessment and risk management, common barriers to adequate treatment and challenges with preparations for reentry to the community.

The guide is supported by an educational grant from Janssen, a Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc. It will be distributed in the first quarter of 2010.

Save the Date! April 24-27

Updates in Correctional Health Care Partners in Public Health
The intent of Updates 2010 is to share innovative developments, practices and research findings, thus enabling attendees to augment their knowledge and skills and to improve health care in their organizations. While covering a broad range of correctional health topics, the program will emphasize the intertwining roles of public health and correctional health.

Corrections presents a tremendous opportunity for interventions that lead to reduced illness rates, financial savings, improved public safety and better use of health care systems and resources. This meeting will focus on how to design and implement a comprehensive approach that includes early detection and assessment, health education, prevention, treatment and continuity of care.

Continuing education credit of up to 25 hours is available. Register by March 5 to receive an early-bird discount of $50!

Visit www.ncchc.org for details.

In Memoriam
Judith A. Stanley, MS, CCHP-A
NCCHC’s longtime director of accreditation passed away Nov. 17 in Chicago. Ms. Stanley retired from the National Commission in April 2008, after nearly 11 years of service.

Ms. Stanley was born April 1, 1944, in Buffalo, NY. Before embarking on a career in correctional health care, she was a Sister of the Immaculate Heart of Mary Province in Buffalo. After obtaining a master’s degree in counseling psychology and rehabilitation counseling, she worked at several hospitals, psychiatric institutions and correctional facilities in New York.

As director of accreditation, Ms. Stanley handled myriad responsibilities with skill and grace, helping countless correctional health professionals and facilities, as well as accreditation surveyors, with her wise counsel and support. A collaborative, encouraging approach was her hallmark.

After retirement, Ms. Stanley became a consultant for the Cook County Juvenile Temporary Detention Center in Chicago. She also served on the board of the Academy of Correctional Health Professionals.
Five Steps Toward an Ethical Practice

by Robert B. Greifinger, MD

In 1976, in Estelle v. Gamble, the Supreme Court established the clear constitutional right to health care for prisoners. During the past 33 years, we have made great strides in improving access to care and patient outcomes.

But we work in a difficult environment, stressed by the flood of inmates, resource constraints and lack of public support to provide proper care to our patients. Our patients can be very taxing to understand. And sometimes, as in any relationship, harmony does not always reign with our colleagues in custody. But in our professional home, only nurturing can help influence the lives of those in our care. We are no longer guests at custody’s table. We are part of a professional family and we need to fulfill our professional duties to patient safety and to our professional responsibilities and principles.

At times, we face conflict between our ethical obligations and custody practices. As professionals, we have an ethical obligation to speak out on behalf of our patients. If we remain silent when our patients are harmed, we fail them and we fail our principles.

I’ve seen some shameful practices recently. I saw a video of an emergency response team takedown, with helmets, batons and Tasers, solely to take a blood pressure on a quiet, intellectually challenged man. The health care staff stood by, acquiescing. I also read a jail policy that prohibited the use of splints and elastic bandages because, the policy said, “Our population usually needs none of these items and usually uses them to hide contraband...[they] will try to get away with whatever we let them...”

We need to speak out when a patient is kept in four-point restraints for no penological purpose and the patient is dehydrated and not eating. We need to speak out against shackling women in labor. We need to speak out against unnecessary use of force, unnecessary electronic restraint and prolonged isolation for patients with uncontrolled mental illness, where medical intervention would be more effective without any adverse security consequences.

It is too easy to get lost in harshness. We must overcome cynicism about our ability to do good and to advance our patients’ interests. Here are some examples: I recently reviewed a juvenile detention facility that does not allow any injections, including vaccinations, based on the health staff’s conclusion that syringes would be abused. I saw several cases where inmates with pain, vomiting and dehydration were denied access to the emergency room because “they manipulate to get out of the jail.” Another patient, in labor for 26 hours, delivered in her cell because the health staff did not believe her reports of pain and bleeding.

Our job is to attend to our patients’ medical needs and, where appropriate, to help lighten their hardened habits and behaviors. As a young professional, I began my career with hope and wonder. I imagine that most of you did too. Together, we have to figure out ways to keep these feelings alive without having them submerged by harshness, vindictiveness or futility.

Action Steps

I see five action steps that will bring us closer to achieving ethical integrity and patient engagement:

1. We should use evidence-based guidelines and performance measurement, putting patient safety first.
2. We must advocate for programs that would be good for public health, such as providing condoms to prevent transmission of sexually transmitted infections and providing substitution therapy for opiate addiction. These are part of our ethical obligations and professional responsibilities.
3. Old habits die hard. We must promote intensive drug treatment so that our addicted patients need not return to prison.
4. We should use our heads and our hearts to reduce stereotypes and cynicism. We do this by engaging our patients with humility and respect. Felon or not, each patient is a unique human being who deserves our full attention. Most of you share my views. I challenge you to take your positive experiences and make them into teachable moments. Document them and promote them.
5. We cannot silently acquiesce to conditions of confinement that inflict harm or violate human rights, such as the use of isolation for the seriously mentally ill. Each of us should make a resolution to speak out on these occasions.

Robert B. Greifinger, MD, is a physician consultant and college professor based in New York. This column is an adaptation of his acceptance speech as recipient of NCCHC’s 2009 Award of Excellence in Communication. See page 4 to learn more about Greifinger and the award.

I was happy to see an article on hepatitis C and young adults (Juvenile Voice column, Summer 2009). I work as a community educator with a nonprofit group working to provide education, support and advocacy services to people living with liver disease. One of our programs is focused on reaching out to high-risk young people.

I am writing to describe an error in the article. The Evaluation and Management section says: “Many specialists will not treat...patients who continue to use illicit substances because their impaired judgment may result in noncompliance with a complicated intravenous treatment regimen that causes many side effects and requires rigorous follow up laboratory testing.” The current treatment for chronic HCV involves a subcutaneous injection of a medication called pegylated interferon and an oral medication called ribavirin. Happily, no intravenous injections are required.

Mary Van Bronkhorst, PA-C
Hepatitis Education Project, Seattle, Washington
Outstanding Honorees Celebrated at NCCHC’s 2009 National Conference

The National Commission’s annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud the 2009 recipients of these prestigious awards, which were presented Oct. 19 during the opening ceremony of the National Conference on Correctional Health Care, held in Orlando.

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

Dianne Rechtine, MD, CCHP-A
For distinguished service to the field of correctional health care

Even in “retirement,” Dr. Rechtine labors for the cause of quality health care in corrections, giving generously of her time and talents, which are prodigious. She remains a close ally not only of NCCHC, but also numerous other organizations striving for the same cause.

Dr. Rechtine honed her skills in primary care as well as administration by working in private practice for two decades. In 1986 she discovered the joys and challenges of correctional medicine when she joined the Florida Department of Corrections as a physician at a prison hospital. Her roles and responsibilities expanded greatly over the next 20 years, as she held numerous executive positions at various facilities and regional offices and the central office. During that period, Florida’s inmate population roughly tripled in number. In the midst of countless budget, staffing and other difficulties, Dr. Rechtine always stood as a staunch advocate for the betterment of inmate health care, and led numerous efforts to that end.

Furthermore, Dr. Rechtine has always pursued professional growth both for herself and others. Soon after joining the Florida DOC she became involved in organizations such as the American Correctional Health Services Association and the Florida Council on Crime and Delinquency. When the Society of Correctional Physicians and the Academy of Correctional Health Professionals were launched in 1992 and 2000, respectively, she was among their first members. Similarly, she attained the Certified Correctional Health Care Professional and the CCHP-Advanced credentials in the early days of those programs. She has been a physician surveyor for NCCHC’s accreditation program since 1994. In all of these pursuits she has not been a passive member but a doer, a giver, a mentor, a leader.

Today, Dr. Rechtine keeps an active schedule conducting site surveys and mentoring new physician surveyors.

She also shares her knowledge as a professor at Nova Southeastern University College of Osteopathic Medicine, where she nurtures future correctional physicians through a prison rotation for medical students. Another of her passions is to develop correctional physicians through a rigorous two-year fellowship.

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

Robert B. Greifinger, MD
For a body of published works that have advanced the field of correctional health care

Any close observer of correctional health care has encountered the citation Greifinger, R.B. With 25 years of experience in this field, Dr. Greifinger is a renowned expert in health systems, quality improvement and policy. Fortunately for the field at large, he has long been committed to sharing his knowledge in writing. Although the scope of his research and published work is broad, common themes are evident. Together, this body of work has significantly influenced how correctional health care is perceived, how it functions and how efforts are made to improve it. Three works of particular importance are noted here.

A seminal work was “Correctional Health Care: A Public Health Opportunity,” published in 1993 in the Annals of Internal Medicine. Coauthored by Jordan Glaser, MD, this perspective column drew attention to the high prevalence of disease among inmates and the important public health role that criminal justice systems could play in treating these conditions both behind bars and upon release. The authors argued that correctional health programs need to adhere to national standards such as those of NCCHC, and must be “brought into the mainstream of clinical medicine and public health.”

A similar focus informed Dr. Greifinger’s work as principal investigator and editor for NCCHC’s landmark study on the Health Status of Soon-to-Be-Released Inmates. Funded by the National Institute of Justice, the three-year project culminated in a 2002 report to Congress. The research documented that tens of thousands of inmates are released every year with undiagnosed or untreated physical and mental illnesses, and that treatment in correctional facilities would be cost-effective to society. The detailed recommendations guide policy and quality improvement efforts to this day.
Dr. Greifinger again directed a large group of respected contributors as chief editor of Public Health Behind Bars: From Prisons to Communities (2007). The book examines the burden of illness in the prison population, the impact on public health as prisoners are released, systemic barriers to care and how care can be coordinated between correctional and community providers, with a proposed shift to primary care. Recommendations point to health care that is humane for inmates and beneficial to the communities they reenter.

Today, the forward thinking long championed by Dr. Greifinger has become conventional wisdom, and countless initiatives have been undertaken in keeping with his sage advice.

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

**Broward County Sheriff’s Office, Florida**
The five jail facilities that operate within the Broward Sheriff’s Office work together so seamlessly in health care delivery that it was natural to view them as a whole in granting the Facility of the Year Award. The selection committee was impressed with how well the staff consistently demonstrates professionalism, excellent coordination of health services across facilities and a commitment to continuity of services.

BSO operates three jails and two satellite facilities. In total, the system has an average daily population of about 5,200 and processes more than 66,000 admissions per year, making it the 12th largest local jail system in the United States.

To manage the health needs of this large volume of inmates, the first step is screening and triage that occurs at several stages before and during the booking process. Inmates identified with chronic conditions are immediately assessed by a nurse who also reviews the records. Twice each day a courier transfers paperwork, such as lab results, consult reports and ordered medications, between facilities.

There is much more to praise about the jail system and its health services, but perhaps the BSO motto says it best: “We are always ready for company.”

**NCCHC Program of the Year Award**
This award recognizes programs of excellence among the thousands provided by accredited prisons, jails and juvenile facilities.

**Special Needs Pod, Washington County Jail, Oregon**
Certain segments of the inmate population—those especially vulnerable to abuse or having certain mental disorders—simply don’t do well in general jail housing. To protect these inmates, in 2005 the Washington County Jail explored the use of a “special needs” housing pod. One year later, assessment of the program showed such positive outcomes that it was made permanent. A big bonus: The program used existing resources and required no additional funding, staffing or structural changes to the facility.

The target population includes inmates with major mental health disorders, developmental disabilities, history of head trauma, marked emotional liability and history of suicide attempt, as well as those who have certain physical limitations and those who are very young or old. Candidates are identified during intake screening, the classification process and mental health triage.

One-year findings included the following:
- Medication pass is streamlined and now takes half the time it did before.
- Certain inmates progressed from poor functioning to thriving in the new environment, and many report feeling less depressed and more productive.
- The number of inmates seen by the mental health team increased by 111%, and the number seen by nursing staff by 45%.
- Psychiatric medication usage decreased overall, and among those patients on such regimens, medication compliance increased by 20%.
- Facilitywide incident and disciplinary reports decreased by 50% in the first year and have remained at that level.
- Despite housing many highly challenging inmates, the unit is reported to be one of the quietest, cleanest and best cared for pods.
- Discharge planning and coordination with community providers is now more efficient.

Officers who work in Pod 5 volunteer and are trained for the assignment and work closely with treatment staff. Again, a motto may tell the story best: “We are not here to simply help the inmate survive; we are here to help them thrive.”

**Fall 2009 • CorrectCare**
Retraction of Findings on N95 Respirators and H1N1
Researchers who previously reported study findings that N95 respirators were better than surgical masks at preventing the spread of the H1N1 virus retracted their findings at the annual meeting of the Infectious Diseases Society of America. The reanalysis was prompted by questions from peer reviewers. A second study by different researchers had found no difference between the two types of masks. Both IDSA and the Society for Healthcare Epidemiology of America have argued that N95 respirators are not the best way to guard against H1N1 infection and may have detrimental effects in terms of costs, patient care and side effects for those who use them. The retracted findings are believed to be the basis of recommendations supporting N95 mask usage from the Institute of Medicine and the Centers for Disease Control and Prevention. Source: www.medpagetoday.com/MeetingCoverage/IDSA/16745

Response to Mental Health Crises
The federal Substance Abuse and Mental Health Services Administration has issued practice guidelines for responding to mental health crises. People with serious mental illness or emotional disorder often experience recurrent, significant crises due to the combined impact of numerous factors. Although the report does not focus solely on correctional settings, it notes that mental illness is three to four times higher among state prison and local jail inmates compared to the general population, and that these inmates are at least twice as likely to be injured while behind bars compared to inmates without mental illness. In the juvenile justice system, about three fourths of youth report mental health problems and one in five has a serious mental disorder. Developed by a diverse expert panel, the guidelines define appropriate responses to mental health crises. A goal is to replace the typical “reactive and cyclical approach” to mental health crises with one that aims to reduce the likelihood of future emergencies and produces better outcomes. Source: http://mentalhealth.samhsa.gov

Georgia Prisons Going Tobacco-Free
The Georgia Department of Corrections will soon join 10 other states in banning tobacco use entirely. Smoking has not been allowed inside the prisons since 1995, but it is allowed outdoors. The ban, which applies to staff as well as inmates, is being rolled out in phases, starting with three facilities on Jan. 1. It will be in effect at all 37 prisons by Dec. 1, 2010. A statement issued by the GDC notes the objectives of “a healthier Georgia” and containing rising health care costs for inmates, probationers and staff. Smoking cessation aids will be offered to staff and inmates. The agency recently surveyed county sheriffs and jailers in the state and found that most are already tobacco-free. Source: Atlanta-Journal Constitution, “State to ban smoking at all prisons,” Nov. 9, 2009, www.ajc.com

Contraception Services for Incarcerated Women
A recent study of correctional health professionals who work with incarcerated women concludes that reproductive needs are overlooked in these settings. With 286 people responding, 70% reported some degree of contraception counseling for women at their facilities, but only 11% provided routine counseling prior to release. Also, 70% said their institution had no formal policy on contraception. However, 38% of these clinicians do provide birth control methods, most commonly oral contraceptive pills. Source: www.contraceptionjournal.org, December 2009
To ensure the health, safety and welfare of inmates, staff and visitors during emergencies, an effective emergency response is paramount. Emergency planning requires an appropriate health staff response and coordination with community emergency services when necessary.

Standard A-07 Emergency Response Plan requires that the health aspects of the plan include, at a minimum, the following elements: health staff responsibilities, triage procedures, predetermination of the site for care, phone numbers and procedures for calling health staff and the community emergency response system (e.g., hospitals and ambulances), patient evacuation procedures and backups for each of the plan’s elements. The plan must be approved by the responsible health authority and facility administrator.

Having security representatives and community response agencies participate in planning and implementing mass disaster and man-down drills is certainly beneficial and is encouraged. Your local health department may also be a helpful resource in developing an emergency response plan.

**Mass Disaster Drill**

Mass disaster drills are a critical component of every correctional facility’s emergency response plan. At least one mass disaster drill should be conducted annually so that over a three-year period each shift has participated (Compliance Indicator 2). It is not necessary for all shifts to participate each year.

NCCHC defines a mass disaster drill as a simulated emergency involving multiple casualties that require triage by health staff. It frequently involves a natural disaster (tornado, flood, earthquake), an internal disaster (riot, arson, kitchen explosion) or an external nonnatural disaster (mass arrests, bomb threat, power outage).

This year, correctional facilities across the country have been faced with outbreaks of novel influenza A (H1N1) virus. These outbreaks present an opportunity for health staff to implement the health aspects of the facility’s emergency response plan. The exposure control plan also comes into play as the health staff strive to contain (or practice to contain) these outbreaks because of the actions taken to eliminate exposures to pathogens and minimize transmission of communicable disease among inmates (see standard B-01 Infection Control Program).

However, it is likely that multiple individuals will have symptoms of illness at the same time, which would require health staff to triage large numbers of patients in groups. The mass casualty aspect of an influenza outbreak enables staff to apply H1N1 virus drills and actual events to the mass disaster drill requirement. (Helpful information on responding to an H1N1 outbreak is available from the Centers for Disease Control and Prevention; find Interim Guidance for Correctional and Detention Facilities on Novel Influenza A [H1N1] Virus online at www.cdc.gov/h1n1flu/guidance.)

**Man-Down Drill**

The health emergency man-down drill also enables health staff to practice aspects of the emergency response plan. NCCHC defines such a drill as a simulated emergency affecting one individual who needs immediate medical intervention. It involves life-threatening situations commonly experienced in correctional settings, for example, an inmate collapsing on the basketball court or sustaining a severe burn in the kitchen. This drill should be practiced once a year on each shift where health staff are regularly assigned (Compliance Indicator 3).

Compliance Indicator 5 states that if full-time health staff are not assigned to a particular shift, that shift is exempt for drills, and if there are no full-time health staff, drills are not required. It should be noted that this standard focuses on the preparation of health staff; therefore, an event occurring on a shift where no health staff are on duty and involving only security staff would not be eligible to meet the intent of the standard.

**Critiques and Exercises**

Perhaps the most important aspect of conducting mass disaster and man-down drills and participating in actual events is the critique that occurs afterward. Critiques document activities including response time, names and titles of health staff, and the roles and responses of all participants. The critique should contain observations of appropriate and inappropriate staff response to the drill. The critique report should be shared with all health staff (Compliance Indicator 4). Staff who cannot attend the drill should later document their review of the critique.

Through the critique process, weaknesses in the disaster plan may be identified and solutions can be discussed and implemented to improve future emergency response. Sharing the critiques with all health staff enables everyone to benefit from the discussion and make improvements when indicated. Individual responsibilities may be clarified or changed, and often the need to purchase or repair equipment is discussed during a critique.

Tabletop exercises are discussions about health staff’s projected response to emergencies and can assist staff in planning for a drill. However, tabletop or classroom exercises themselves do not meet the intent of the standard.

Remember, even if an actual event does not involve injuries, as long as the event is critiqued, the intent of the standard is met.

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.
Position Statement: Transgender Health Care

Editor’s Note: The introduction below is truncated. For the complete text, please visit www.ncchc.org.

Transgender people face an array of risks to their health and well-being during incarceration, and are often targets of physical assault and emotional abuse. They are commonly placed in correctional facilities according to their genitals and/or sex assigned at birth, regardless of their gender presentation. The health risks of overlooking the particular needs of transgender inmates are so severe that acknowledgment of the problem and policies that assure appropriate and responsible provision of health care are needed.

Position Statement
Because prisons, jails, and juvenile justice facilities have a responsibility to ensure the physical and mental health and well-being of transgender people in their custody, correctional health staff should manage these inmates in a manner that respects the biomedical and psychological aspects of a gender identity disorder (GID) diagnosis. NCCHC recommends that the following principles guide correctional health professionals in addressing the needs of transgender inmates:

Health Management
1. The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards developed by professionals with expertise in transgender health (see www.path.org/publications_standards.cfm). Determination of treatment necessary for transgender patients should be on a case-by-case basis. Ideally, correctional health staff should be trained in transgender health care issues. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training in transgender issues.

2. Because inmate-patients may be under different stages of care prior to incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments for transgender people. Policies that make treatments available only to those who received them prior to incarceration or that limit GID treatment to psychotherapy should be avoided. Policies that attempt to “freeze” gender transition at the stage reached prior to incarceration are inappropriate and out of step with medical standards, and should be avoided.

3. Diagnosed transgender patients who received hormone therapy prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary. Transgender inmates who have not received hormone therapy prior to incarceration should be evaluated by a health care provider qualified in the area of transgender health to determine their treatment needs. When determined to be medically necessary for a particular inmate, hormone therapy should be initiated and sex reassignment surgery considered on a case-by-case basis. Regular laboratory monitoring should be conducted according to community medical standards.

4. Treatment for genital self-harm or for complications arising from prior surgery or from self-treatment should be provided when medically necessary.

5. Correctional health care providers should provide patient education materials to help transgender patients cope with their diagnosis and treatment.

6. Psychotherapy such as “reparative” therapy or attempts to alter gender identity should not be employed. Reparative therapy inappropriately portrays GID as a mental illness and not a medical condition.

Patient Safety
7. In matters of housing, recreation, and work assignments, custody staff should be aware that transgender people are common targets for violence. Accordingly, appropriate safety measures should be taken regardless of whether the person is placed in male or female housing areas.

Discharge Planning
8. Transgender inmates receiving hormone therapy should receive a sufficient supply upon release to last until a community provider assumes care. Referrals should be made to community-based organizations with sensitive and inclusive services for transgender people.

9. Correctional policies for management of transgender inmates should be developed and implemented in partnership with local transgender communities, particularly current and former inmates, and transgender service providers when possible.
Drug Interactions
Efavirenz: Efavirenz has been shown in vivo to increase CYP3A. Other compounds that are substrates of CYP3A may have increased concentrations when coadministered with efavirenz, in whom an increase in efavirenz concentrations has been observed. It is not known whether efavirenz inhibits CYP2D6, CYP2C19, and 3A4 isoforms of the cytochrome P450 system in vivo. The possible interaction of efavirenz with an opioid agonist may result in decreased opioid effects. The pharmacologic effects of tricyclic antidepressants,招牌

Emtricitabine and Tenofovir DF: Since emtricitabine and tenofovir are primarily eliminated by the kidney, concomitant use of ATRIPLA with drugs that reduce renal function or compete for active tubular secretion may increase serum concentrations of emtricitabine, tenofovir, and/or other renally eliminated drugs. Drugs that induce CYP3A activity (e.g., phenobarbital, rifampin, rifabutin) would be expected to increase the clearance of efavirenz.

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Calcium Channel Blockers: Studies in rats have shown that coadministration of EFV with calcium channel blockers results in decreased plasma concentrations when coadministered with efavirenz. In vitro studies have demonstrated that efavirenz inhibits CYP3A4, which is involved in the metabolism of diltiazem. Dosing at bedtime may improve the tolerability of these side effects. The potential interaction of EFV with other calcium channel blockers that are substrates of the CYP3A4 isozyme should be considered.

Antimycobacterials: Studies in rats have shown that coadministration of EFV with isoniazid results in decreased plasma concentrations when coadministered with efavirenz. In vitro studies have demonstrated that efavirenz inhibits CYP3A4, which is involved in the metabolism of diltiazem. Dosing at bedtime may improve the tolerability of these side effects. The potential interaction of EFV with other calcium channel blockers that are substrates of the CYP3A4 isozyme should be considered.

Antiretroviral Agents: Protease Inhibitors: Increases in early phase trough and peak concentrations of Saquinavir have been observed with the coadministration of EFV and ritonavir. Other protease inhibitors may have similar interactions. In vitro studies have demonstrated that efavirenz inhibits CYP3A4, which is involved in the metabolism of diltiazem. Dosing at bedtime may improve the tolerability of these side effects. The potential interaction of EFV with other calcium channel blockers that are substrates of the CYP3A4 isozyme should be considered.

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Antifungals: Studies in rats have shown that coadministration of EFV with fluconazole results in decreased plasma concentrations when coadministered with efavirenz. In vitro studies have demonstrated that efavirenz inhibits CYP3A4, which is involved in the metabolism of diltiazem. Dosing at bedtime may improve the tolerability of these side effects. The potential interaction of EFV with other calcium channel blockers that are substrates of the CYP3A4 isozyme should be considered.

Antiretroviral Agents: Protease Inhibitors: Increases in early phase trough and peak concentrations of Saquinavir have been observed with the coadministration of EFV and ritonavir. Other protease inhibitors may have similar interactions.

Psychiatric Symptoms: Efavirenz has been shown in vivo to increase CYP3A. Other compounds that are substrates of CYP3A may have increased concentrations when coadministered with efavirenz, in whom an increase in efavirenz concentrations has been observed. It is not known whether efavirenz inhibits CYP2D6, CYP2C19, and 3A4 isoforms of the cytochrome P450 system in vivo. The possible interaction of efavirenz with an opioid agonist may result in decreased opioid effects. The pharmacologic effects of tricyclic antidepressants, e.g., amitriptyline, nortriptyline, desipramine, imipramine increases in early phase trough and peak concentrations of Saquinavir have been observed with the coadministration of EFV and ritonavir. Other protease inhibitors may have similar interactions. In vitro studies have demonstrated that efavirenz inhibits CYP3A4, which is involved in the metabolism of diltiazem. Dosing at bedtime may improve the tolerability of these side effects. The potential interaction of EFV with other calcium channel blockers that are substrates of the CYP3A4 isozyme should be considered.
A new field called epidemiological criminology is being developed by both public health and criminal justice scholars. What utility does this new academic development have for health care practitioners? For people actually working in the field? This article will define EpiCrim and illustrate how it is useful for health care administrators, staff and clients by providing specific examples: 1) assistance with securing grants, 2) forming and facilitating interdisciplinary teams, 3) replacing and/or explaining redundant terminology, 4) exposing harmful criminal justice policy, 5) highlighting the correlates between disciplines and 6) identifying crime victims.

Both policy and practice evolve with changing administrative and legal mandates; this is especially true for health care policies involving “unwilling subjects” such as inmates. Policy is shaped in response to different historical realities, whether cultural, political or economic in nature. This list includes various short- and long-term public health and criminal justice demands that guide actual workplace practice. Consider, for example, how HIV/AIDS has changed the day-to-day practices of everyone in both health care and correctional jobs. Health issues that impact society, such as HIV/AIDS, have a magnified effect in correctional environments. Consequently, health issues are forcing modification of correctional policy and practice.

EpiCrim is presented as a bridging framework for better understanding the role of public health in criminal justice and vice versa. For generations, the theories and methods advocated by epidemiology have served a legitimate role in the study of disease processes and tracking. Criminal justice could very well apply the same theories and methods to track things such as the spread of specific types of crime (e.g., crystal meth in the Appalachian region, home invasions in Orlando).

This has been done before; in the 19th and early 20th centuries, the fusing of public health theory and methods to crime control was a common practice. Benjamin Rush, a 19th century physician, was instrumental in developing a theoretical model on crime. His conceptualization of crime as a “moral disease” informed crime control policy and the design of the American penitentiary system. And the first women’s prisons in England were heavily influenced by psychiatric notions of the criminality of women. The ideologies of doctors and psychologists in this era were extremely important in creating therapeutic regimes and shaping contemporary thinking on women in prison. After this early linkage of health and corrections, the two disciplines diverged. EpiCrim seeks to reaffirm these connections.

**Defining Terms**

Criminology refers to the systematic study of the nature, extent, cause and control of law-breaking behavior, while criminal justice refers to the crime control practices, philos-
ophies and policies used by police, courts and corrections. Criminology is more concerned with theory (policy) while criminal justice is more concerned with practice.

Public health is devoted to the prevention and eradication of diseases that may infect communities. Epidemiology is, above all else, a methodology. It is the study of variables and factors that affect health. Epidemiology has traditionally served as the foundation for public health interventions. Epidemiology could be considered policy while public health is practice.

In our view, epidemiology/public health and criminology/criminal justice issues are closely related and often inseparable. EpiCrim is the merging of these disciplines. EpiCrim involves the study of anything that affects the health of a society, be it crime, flu epidemics, global warming, human trafficking or HIV/AIDS. Consider the following examples that illustrate how health care professionals may benefit from EpiCrim.

Hepatitis C, tuberculosis, aging prison populations and substance abuse are just a few of the health issues that are straining and subsequently altering correctional policy and practice worldwide. By necessity, public health is becoming highly important as a funding source, for technical expertise, for medical staffing and for policy making within correctional institutions. Numerous research reports and funding trends have documented this health-mandated change. The Federal Bureau of Investigation has even used public health analogies.

Furthermore, most destructive crime-related behaviors have strong ties to mental and physical health problems. For example, driving under the influence of intoxicating substances is a destructive behavior that affects the mental and physical capabilities of the driver. Interventions aimed at reducing this dangerous trend should consider mental and physical factors contributing to the use of intoxicating substances. Then a combination of criminological and public health factors may shed light on the reasons behind the reasons for drunk driving.

**How EpiCrim Benefits Health Professionals**

**Example 1: Securing Grants**

Because it is difficult to separate the criminal justice and public health behavioral correlates, the interdisciplinary nature of many funded research projects should come as no surprise. In fact, the National Institutes of Health’s “Roadmap Initiative” encompasses not only the biomedical sciences, but also their relationship to the epidemiological, behavioral and social sciences. What percentage of your funding is grant-related or agency-dependent? Having a new, solid and exciting theoretical basis for grant proposals greatly strengthens their odds of being funded.

**Example 2: Interdisciplinary Collaboration**

EpiCrim encourages a paradigm under which disciplinary boundaries are blurred or even eradicated. While other scholars have made linkages between health and criminology, we seek to clarify and expand on what they have observed. HIV/AIDS and other health maladies have been examined by interdisciplinary teams combining public health, medicine and criminology for over 20 years. However, most prior connections have dealt with specific problems. EpiCrim is by nature interdisciplinary and so allows correctional and health care workers a common ground as opposed to the traditional custody vs. health care conflicts. This blending of disciplines should reduce the inherent conflicts.

**Example 3: Sharing Terminology**

Health care professionals and criminal justice workers often focus on the same issues and use similar approaches, but they view things through different lenses and use different lexicons. For example, when criminal justice professionals talk about addressing the “root causes” of crime, they mean the same thing as “primary care” to health professionals. Likewise, “tertiary care” is analogous to specialized community policing units. Each discipline can learn from each other and increase its capacity by recognizing the commonality in approaches, methods and techniques.

In illustration, factors that increase epidemics such as HIV/AIDS are entwined with factors contributing to sexual exploitation of women and girls. Violence toward women affects their physical, sexual and reproductive health. Substance abuse is likely to diminish inhibitions, driving users to commit crimes such as rape, intimate partner violence and child abuse. An EpiCrim approach identifies these interconnected factors and encourages development of “primary care” strategies to prevent the root causes.

**Example 4: Exposing Harmful Policy**

Some criminal justice policies may actually harm public health care efforts. One convincing argument is that current law and law enforcement strategy promulgate, rather than reduce, drug abuse in America. These policies implicitly, and unknowingly, incorporate elements of public health and criminological theory. By making these linkages explicit, an EpiCrim approach may reveal to policy makers that many criminals may benefit more from less criminal justice intervention. This approach would also be useful in reassessing counterintuitive policies such as prohibitions against needle-exchange programs and condoms in prison.

Similarly, the prosecution of human traffickers through criminal justice channels only is not likely to reduce the occurrence of this crime. In South Africa, women and girls are more often trafficked by family members than by organized gangs. Reasons for this include children left behind by parents who have died of HIV/AIDS-related diseases, unemployment of primary caregivers, lack of finances to sustain large families and absolute poverty. Prosecuting traffickers through criminal justice processes may be the least likely means to prevent this crime.

**Example 5: Highlighting Correlates**

As disciplines such as criminology, psychology, public health and sociology became more specialized, scientists began looking within their own fields and few external methods and approaches were used to help explain

*continued on page 12*
behavioral change and deviance. As a result, contemporary practice is that crime causation and health behaviors are discussed only from a particular ideological perspective or academic discipline.

However, the correlates to crime and the correlates to health disparities are identical (e.g., poverty, minority status, lack of education, family history, neighborhood characteristics, geography and other psychosocial indicators). These correlates, as well as their related study designs, prevention strategies and consequences, are often taken for granted by scholars, students and practitioners who presume to understand these relationships. To date, no one has explicitly linked the two disciplines. More specifically, this unifying ideal has not been operationally defined in a way that allows serious contemplation, comparison, analysis and integration from diverse theoretical positions.

Example 6: Identifying Victims
Correctional health care workers are in a unique and favorable position to recognize victims of crimes that the police and prosecutors may overlook. Our research into human trafficking in South Africa and Florida has found several victims who were arrested. Recently, two young women were arrested in Orlando for prostitution. Their attorney discovered that they had come to the United States to be with “boyfriends” they met online and were now living in a van, their passports and children withheld, and being forced to perform sex acts. The traffickers told the victims not to seek law enforcement help since the police will simply arrest or deport them. Correctional health care professionals may be able to identify and assist these types of victims.

Future Needs
Intersections between criminal justice and public health theories, methods and approaches serve as models that can help to explain the dynamic relationships between these two seemingly different fields of study. As the criminal justice system can define criminal behavior, so too can systems of public health define epidemiological disease processes, which can lead to full-blown epidemics. EpiCrim links theories, methods and statistical models of public health to that of their criminal justice counterpart.

Much remains to be accomplished, however. Despite growing awareness and interest, EpiCrim needs greater clarification and explication. More importantly, it needs to start being useful for those outside the ivory towers of academia. In our vision, health care professionals may be among the first to make use of EpiCrim.

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To learn more about epidemiological criminology, visit the Web at www.EpiCrim.com.
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The Litmus Test of Electronic Health Record Performance

by Joseph E. Paris, PhD, MD, CCHP-A

The push to “go electronic” gets stronger with each passing year. Although only a minority of prisons and jails has converted to an electronic health record system, the number of conversions is growing. As an NCCHC surveyor of over two decades, I have been exposed to more than a dozen EHRs nationwide in facilities of different population sizes. As a surveyor I did not intend to gauge EHR efficiency, data completeness or general performance, but the need to survey computerized health records and logs did bring me into close contact with these systems.

Drawing from my experience with diverse, commercially available as well as home-grown correctional EHR systems, I was able to formulate a plan to quickly gather relevant clinical information. For surveys involving EHRs, I requested a staff person to be assigned to me for the whole survey, with the understanding that the assignment would fall on someone familiar with the EHR structure and thus capable of speedy review.

I reviewed weaknesses of certain individual EHRs in a previous issue of CorrectCare, pointing to workflow disruptions during conversion, inability to display multiple pages simultaneously, lack of tidy printed layouts, inability to flag and initial outside consultant reports, lack of a system to collect inmate signatures for consents or items received and general difficulty reading previous progress notes due to monotony of the layout.

This time, I will comment on common weaknesses of EHR systems when handling log-type or collective data belonging to all of the patients at a correctional institution.

It should be understood that I am convinced that EHRs are the way of the future and I do not advocate use of paper-based health records indefinitely. It is my hope that some of the lessons I learned reviewing correctional EHRs will be of value to correctional health authorities considering the purchase of a new EHR system.

Data Tracking Logs

Correctional staff using paper records know that logs are needed to track some essential functions of their health care units. Logs in common use include intake screening, health assessments, sick call, consultations, chronic care, PPDs, annual and other physicals, labs, X-rays, grievances and the performance of age-dependent routine health care maintenance functions such as mammograms, Pap smears, stool hemoccults and the like.

Paper logs work well in institutions with fewer than 500 inmates and with low turnover, like most state prisons. Paper logs become unwieldy for large institutions, especially if turnover is brisk, as happens in most jails. In these, paper logs quickly become cluttered with “yellowed out” names of inmates no longer in the system. Interestingly, many a correctional system with paper records has evolved some home-grown computerized system for tracking some of the functions above listed. These are not integrated, however, and do not lead to the development of a unified EHR.

When surveying a correctional institution for accreditation, I usually ask the questions below regardless of whether EHRs or paper records are in use. These questions reveal essential aspects of the functioning of the health care system in effect.

As a side benefit, the same questions, which I term “litmus test,” can be used to gauge the functionality of a proposed EHR system before committing to its purchase.

Key Questions

The litmus test questions deal with sick call, consultation, chronic care, PPD, physicals, lab, X-ray, grievances and the performance of age-dependent routine health care maintenance functions, as noted above. I will request that the following be printed for my review:

- List of all new arrivals for the past three months, stating date and time of arrival, date and time of performance of intake screening, and date and time of the initial health assessment (intake physical). It is critical to be able to determine how much time has elapsed between intake and the essential health screening and assessment functions.
- For the past 30 days, the interval between logging an inmate’s sick-call request and the actual performance of the visit, along with figures disclosing how many sick-call requests did not result in a visit, and for what reason. For visits not taking place, print also the ultimate outcome, such as rescheduling, inmate release date and the like.
- For the past three months, the interval between consultation request and consultation performance, along with information regarding whether or not the consultation report was received and whether it was initialed by the institutional physician.
- List of all chronic care patients, sorted by chronic disease, plus a list of patients with two, three, four or more chronic conditions, listing all conditions. This enables me, or an internal reviewer, to rapidly ascertain the most com-
plex cases and review these health records. The assumption is that if care is acceptable for these difficult cases, then care for simpler cases is most likely up to par. These lists are also useful as a snapshot of the prevalence of conditions.

- For all chronic care patients (or a suitable size sample), print the dates for chronic clinic visits in the past year, noting whether or not these were timely (usually every three months).
- List of all inmates showing the date of last PPD test, whether or not they were tested timely and results of the PPD reading in mm.
- List of all inmates showing the date of performance of their last annual physical (or the date it should have been performed but was missed). The purpose is to see quickly whether physicals are up to date.
- List of inmates for whom the doctor ordered a blood test in the past 30 days, showing whether the test was done, missed or postponed for any reason. This is to identify potential systemic problems with follow-up when a test is ordered.
- List of names of inmates with HbA1c of 10% or higher (other analytes may be used, such as hemoglobin under 10 grams, TSH of zero, high HIV viral loads, high bilirubin and the like). The idea is to quickly select electronic charts of inmates with significant laboratory abnormalities and to discern whether these had been properly addressed by the health staff.
- List of inmates who had a chest X-ray in the past three months, with a comment as to whether or not the film had been performed and whether it was termed “abnormal” by the radiologist.
- List of inmates who filed a grievance about medical issues in the past three months, along with information on whether the grievance had been responded to within institutional timelines and whether it had been denied or granted to the inmate.
- List of names of inmates who became due for a mammogram, Pap smear, hemoccult testing and the like in the past three months, along with an explanation on whether or not the test was performed on time and whether the results were positive or negative.

Obviously, many of these requested lists would enable me to readily identify problems with follow-up, both in the timely performance of the activity and in subsequent care when indicated.

Hope for the Future

Of note, none of the correctional institutions I reviewed was able to produce all the information requested. A few systems were able to produce some data, and several were unable to respond affirmatively to any of the requests. It is my hope that this suggested list of desirable EHR characteristics will be factored in when considering an EHR purchase.

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The predecessor article to this one is titled “Going to Court With an EHR” and appeared in the Summer 2009 (Volume 23, Issue 3) issue of CorrectCare.
Create a Mentor Program and Watch Your Staff Flourish

By Susan Laffan, RN, CCHP-RN/A

The applicant’s resume is strong, the credentials and references check out, the attitude is upbeat and the security check is spotless. Hired! Now what? How do you ensure that your new correctional health staff member is ready to perform the assigned job responsibilities before actually taking on those responsibilities? Training.

Proper training is vital, and optimally it is not a single phase but rather a multiphase process. These phases include orientation, preceptor training and competency testing, as well as mentoring, which may be the most rewarding for the staff member.

This article presents some guidelines for initiating and operating a mentor program. But first, we will briefly discuss the other phases since they are the backbone to any staff member’s success. Studies show that retention of new staff members is higher if they feel they have received a comprehensive orientation and preceptor experience rather than being “thrown to the wolves.”

Corrections is a unique setting for health care providers. It is important that new staff understand not only the health services aspect of their jobs but also the inherent security issues. It is during orientation that rules, regulations, policies and procedures are discussed. Poor understanding of these issues has at times resulted in a staff member being locked out of a facility due to a security infringement.

New staff members must know their specific job responsibilities and scope of practice. Registered nurses, for example, must understand that they are responsible to know and are held accountable for the American Nurses Association’s general standards for RNs, as well as its specific standards and scope-of-practice guidance for corrections nursing. All health care providers are also responsible for adhering to state and local regulations, and, if their facility is accredited, for complying with accreditation standards (such as those of NCCHC). This knowledge can be attained through a preceptor phase.

After staff members are trained, it is important that they maintain their competency in specific job skills. Competency testing should be done upon hire and at least annually. For nurses, skills measured may include venipuncture, restraint application, urine pregnancy testing and the use of medical equipment such as a blood glucose meter, AED/defibrillator and oxygen. All competency testing must be documented and remain on file.

Astute managers are proactive, encouraging a nurturing and positive environment for their staff. This is where mentoring comes in. In return, staff members will take pride in their work, striving to improve their own job performance as well as the efficiency and quality of health services as a whole.

Mentoring may begin at any time during the other three phases. It entails matching an experienced professional with the new employee to help the employee achieve professional growth. This growth provides a sense of accomplishment and satisfaction, and may be necessary to move up the ladder toward a management position. An effective mentor program can be very rewarding for everyone involved.

Benefits of a Mentor Program

• Assists with recruitment and retention of talented, committed staff
• Promotes autonomy within the organization
• Fosters professional and personal growth
• Enhances networking within the organization and with others in the correctional health care field
• Improves patient care, leading to better patient outcomes and satisfaction
• Gives mentors a sense of appreciation, a powerful feeling in a setting where health professionals do not always feel appreciated
• Strengthens employer satisfaction and enhances the organizational culture

Preceptor vs. Mentor

The terms mentor and preceptor are often used interchangeably, yet their meanings are different. A good model definition of preceptor comes from Saint Elizabeth Regional Medical Center, Lincoln, NE, which has been recognized for excellence in nursing. There, new employees are paired with a preceptor who is responsible for “the didactic and clinical information necessary to perform a job.” The preceptor provides “appropriate experiences” for the employee on the job, daily updates about the employee’s progress and an evaluation after orientation is complete.

This close interaction is meant to ensure that the new employee is competent in the job responsibilities and tasks within his or her scope of practice and has practical experience in dealing with protocols and established routines.

A mentor, on the other hand, is a trusted counselor or an influential sponsor or supporter. The philosophy is that experienced mentors can foster professional growth in others by providing valuable information and advice on a wide variety of job-related matters and helping the mentee establish and achieve goals.

But mentoring is a dynamic, two-way process. At Saint Elizabeth, mentors are expected to “serve as teacher, guide or coach,” but the partnership provides both individuals with the opportunity to give and receive. It is meant to foster long-term relationships based on trust, respect, communication and support. A firm commitment to the process and a willingness to invest time and energy are essential for a successful relationship.
Roles and Responsibilities

Many correctional health professionals are passionate about their own careers and already see the value in aiding others in their careers. These individuals are ideal candidates for the role of mentor. Typical mentor responsibilities include the following:

- Serving as a role model
- Sharing the organizational values, vision and culture
- Building relationships based on trust
- Establishing objective, realistic, measurable goals with the mentee
- Monitoring efforts to achieve goals and giving timely, objective, specific feedback
- Sharing experiences with the mentee
- Explaining issues and barriers specific to correctional health care practice
- Advising on career-related topics such as advancement, publishing, teaching, enhancing visibility, networking and overcoming obstacles

Mentees often are new employees, current employees who were promoted to a new job or those taking on new job responsibilities. However, any staff member might desire a mentor. Regardless of the situation, the employee being mentored should strive for growth and development by:

- Seeking advice
- Sharing needs and goals with the mentor
- Actively listening to the mentor
- Striving for continuous learning
- Committing to the organization’s goals, values and vision

A good mentor should take initiative in the relationship, inviting the mentee to talk, suggesting topics and offering to give advice. A supportive mentor will not only acknowledge accomplishments but also make useful suggestions and offer constructive criticism. Trust is essential; the mentee must trust that anything discussed will be held in confidence. But remember: A mentor meeting is not the forum for complaining about staff, policies or operations.

Professional growth is a key goal of mentoring, so this will be a prominent theme in the partnership. Mentees should be encouraged to become involved in organizations such as the Academy of Correctional Health Professionals and the American Nurses Association and to attend local, state and national conventions. Another smart move is to participate in NCCHC’s Certified Correctional Health Professional program. If appropriate, advanced certification or specialty certification for RNs can be a next step.

To enhance visibility, networking and, ultimately, leadership, the mentor should encourage the mentee to volunteer for projects at work, to provide an educational in-service for employees or patients, or to publish an article pertaining to correctional health care.

Both participants, of course, must be respectful of each other’s time. It is likely that the mentor has more pressing time demands, so he or she must be explicit about limits. It helps to schedule dates and times to meet, and to keep each other apprised of other times that are good or not good for contacts.

Launching the Program

In each correctional facility, there undoubtedly are some individuals who would make great mentors, as well as many who would appreciate and benefit from being mentored. Interest in a proposed program can be generated by explaining what mentoring is, how it works and how it benefits each partner in the relationship and the organization as a whole. This can be done at a staff meeting, through the employee newsletter, in informational handouts and many other methods.

The mentors should be recruited first so they can work together to establish site-specific goals that suit the needs of staff. These goals could include attendance at conventions, conducting in-service trainings, writing for publications, encouraging work colleagues to join professional groups or to obtain professional certification and so forth.

With the mentor goals set, the next step is to recruit mentees. For new employees, this should occur as soon as they are hired, but all staff members should be invited to participate. In addition to the methods noted above, word of mouth is very effective. All mentees should be encouraged to tell their peers about the program.

Generally, mentors and mentees meet one-on-one. However, an initial or periodic group meetings may be valuable. Here the mentors can reinforce the program purpose, explain the goals they have set, lay out the ground rules, discuss expectations and answer questions.

After the program is set in motion, it is important to conduct routine evaluations to determine if it is achieving its goals, if it is meeting staff needs and if changes are necessary. Participant feedback is vital. This can be gathered via a questionnaire that asks, for example, whether the program was beneficial, how it can be improved and how to encourage others to participate. Evaluation findings should then guide refinement of the program.

It is not hard to establish a mentor program and the rewards are many. Correctional health care professionals owe it to each other, and to themselves, to promote quality health care and professional growth among colleagues. A good mentor can contribute immeasurably to the development of a colleague. The mentor will remember and value those contributions forever, and later will probably mentor somebody else.

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Self-Injurious Behavior: What Is It and How Do We Deal With It?

Intentional self-injury by inmates is a serious and costly problem in corrections. The phenomenon is the subject of an article in the January issue of the Journal of Correctional Health Care. Authors Fagan, Cox, Helfand and Aufderheide draw from a thorough literature review and their vast professional experience to examine the spectrum of self-injurious behaviors, define terms, describe problems in assessment and treatment, present treatment strategies and make recommendations for a national strategy to develop self-injury programming in correctional settings.

These emotionally charged acts trigger complex responses and effects that challenge health staff and custodial staff alike. Staff time spent managing these cases is considerable and often fraught with frustration and indecision. Complicating matters, there is no standard nomenclature nor classification system for self-injurious behavior. With a spectrum that ranges from suicide attempts to serious physical harm to threats of such behavior and even to more accepted acts such as body piercing and branding, there is confusion about what constitutes self-injurious behavior as well as what to call it. Nor is there consensus about what motivates an individual to engage in such behavior and the intended consequences, including whether it is necessarily linked with an intent to commit suicide.

In their article, Fagan and his colleagues adopt a definition proposed by Mangnall and Yurkovich in 2008: “A direct behavior that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment.” Even so, they note, death can be an unintended consequence of such behavior. Furthermore, past research does show a strong link with other types of mental health problems, including substance addictions.

It is important that mental health clinicians begin by determining intent when assessing an inmate who self-injures. The answer will disclose the seriousness of the self-injury and guide an informed treatment strategy.

Assessment
A careful risk assessment will focus on the antecedents and intended consequences of the self-injurious behavior. For assessing suicidal intent, the risk factors in correctional settings are fairly well-established. Fagan et al. outline 15 factors presented in a 1999 Surgeon General’s report, pointing out salient differences between jails and prisons.

Other elements of suicide assessment include examining the current suicidal ideation and evaluating short-term acute-risk predictors. Another step is to identify, along with the inmate, safety needs and protective factors to reduce suicide risk. Finally, when suicidal intent is present, an appropriate treatment plan is needed to address urgent needs and reduce future risk.

Unlike suicide risk, there is not yet a well-defined and accepted set of risk factors for self-injurious behavior among inmates. Research studies have found different and even conflicting results concerning variables related to gender, age and criminal history. Thus, to date there is no clear consensus on a protocol for assessment of self-injury risk.

Treating Self-Injurious Behaviors
Likewise, there are no standard treatment protocols for self-injury. Given the inherent challenges to treatment in correctional settings, Fagan et al. propose collaborative management strategies based on principles of behavioral psychology. A collaborative approach is essential to prevent the disputes and negativity that often arise when mental health and correctional staff have differing views of and reactions to the inmate behavior (for example, “mad” vs. “bad”). The proposed treatment model also includes behavioral consultation and specific strategies that will help both

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staff and inmates to develop more adaptive coping skills. Management of these inmates requires flexibility in both the application of correctional directives and treatment strategies, and calls for mental health professionals to provide behavioral consultation to other staff on mental health needs and the disciplinary process. All staff should be educated that chronic self-injury has numerous causes and requires reasoned, planned individual interventions.

Each distinct act of self-injury should be evaluated for motivation, intent, lethality and context. The repetitive self-injurer with nonlethal intent then can receive specific management strategies. A key strategy is to develop, with inmate input, a behavior management plan. Broadly defined, this is a planned set of interventions or treatment that uses positive reinforcers and/or restrictions to increase desired behaviors. The JCHC article presents a detailed discussion of these plans.

The final element of treatment discussed is psychiatric referral. When less restrictive interventions are not effective in allowing the inmate to assume adequate self-control, psychiatric restraint may be indicated. There is no definitive evidence that psychopharmacological treatments are helpful except in emergencies.

**Foundations of an Effective Program**

Effective programs to identify, assess and treat suicidal and self-injurious behavior are essential and must be founded on principles such as risk, need and responsivity. Three principles are offered to guide such programs.

**Innovation.** The corrections industry is continually adjusting to changes in public opinion and budget constraints. Innovative and alternative strategies may be necessary to ensure the integrity of the program.

**Education.** An educational initiative should be undertaken that conceptualizes self-injurious behaviors in corrections as a public safety/public health issue. For example, these behaviors may result in security risks, or they may become endemic, increase in severity or result in death.

**Leadership.** Mental health staff must understand and appreciate their leadership role in the self-injury prevention and treatment program. Accordingly, they must establish credibility with other involved correctional staff through competence, communication and collaboration.

**Recommendations for a National Strategy**

Beyond self-injury programming at the parochial level, opportunities exist to improve methodology for comprehending these complex and high-risk incidents, and to formulate a consensual and coherent strategy for prevention. To this end, the JCHC article presents eight goals.

**Goal 1.** Promote awareness that self-injury in correctional settings is a public safety/public health problem that is preventable. Develop a listserv where professionals can communicate about these issues. Establish national forums that focus on self-injury programming and that bring together stakeholders to increase awareness. Greater awareness linked with dispelling myths will reduce the stigma associated with self-injurious behaviors.

**Goal 2.** Develop broad-based support for self-injury prevention programming. Include the correctional leadership, professional groups and other advocacy groups. Partnerships among key groups will help build momentum and provide continuity and legitimacy. Solicit funding from governmental grants and charitable foundations.

**Goal 3.** Develop evidence-based programming for the identification, assessment and treatment of the full range of self-injurious behaviors. Develop a standardized assessment instrument (such as the Multidimensional Risk Assessment Form) that identifies both risk and protective factors and is normed on a correctional population. Develop treatment algorithms and postintervention protocols with outcome measures to evaluate effectiveness.

**Goal 4.** Promote efforts to reduce access to means and methods of self-injury. Design educational material for staff about how self-injuries occur with serial self-injuring inmates. Include security and health care staff in monitoring and controlling objects used for potential self-injury. Develop standardized practices for controlling access.

**Goal 5.** Provide training for recognition of at-risk behavior and delivery of effective treatment. Standardize training for staff who come into contact with serial self-injuring inmates. Define minimum learning objectives for these staff and tailor the training to their assigned responsibilities.

**Goal 6.** Develop and promote effective clinical and professional practice. Use the 24 core competencies for mental health professionals from the training curriculum Assessing and Managing Suicide Risk (developed by the Suicide Prevention Resource Center and the American Association of Suicidology). Promoting effective clinical practices in the assessment and treatment of all forms of self-injury will improve the probability of successful outcomes. Use of protective factors is also important in reducing risk.

**Goal 7.** Standardize the nomenclature used to describe the spectrum of self-injury phenomena. Developing language and defining terms will help in interdisciplinary communication, accuracy in reporting and research.

**Goal 8.** Promote and support research on self-injurious behaviors in correctional settings. To date, little is known about how to modify certain risk factors associated with self-injurious behaviors without suicidal intent. Developing a database to collect information that can be analyzed and interpreted is critical for program viability.

This summary was written by CorrectCare editor Jaime Shimkus. The authors of the original article are Thomas Fagan, PhD, Nova Southeastern University, Fort Lauderdale, FL; Judith Cox, MA, CCHP; JFC Consultation Services, Clifton Park, NY; Steven Helfand, PsyD, CCHP, Correctional Managed Health Care, University of Connecticut Health Center, Farmington; and Dean Aufderheide, PhD, Florida Department of Corrections, Tallahassee.
TRUVADA is a once-a-day backbone for combination therapy in adults with HIV-1.

**In correctional facilities**

**Treat HIV confidently with TRUVADA**

- Demonstrated efficacy and tolerability profile through 3 years in Study 9342
- The only DHHS-preferred dual-NRTI backbone
- Chosen as the NRTI backbone with leading PIs

**Important 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.

**Adverse reactions**

- The most common (incidence ≥ 10%, any severity) and/or treatment-emergent (Grades 2–4, occurring in ≥ 25% of patients) adverse reactions occurring in Study 934 through 144 weeks include diarrhea, nausea, fatigue, sinusitis, upper respiratory tract infections, nasopharyngitis, headache, dizziness, depression, insomnia, abnormal dreams, and rash.
- 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.

**Warnings and precautions**

- New onset or worsening renal impairment
- Lactic acidosis and severe hepatomegaly with steatosis: observed in patients receiving nucleoside analogs, including VIREAD, a component of TRUVADA, in combination with other antiretrovirals.
- Treatment modification: creatinine clearance (CrCl) 30–49 mL/min: 1 tablet every 48 hours. CrCl ≤ 30 mL/min or hemodialysis: do not use TRUVADA.
- Dose adjustment is necessary for patients with mild renal impairment (CrCl 50–80 mL/min).

**Drug interactions**

- Didanosine (ddI): tenofovir disoproxil fumarate increases ddI concentrations. Consider dose reductions or discontinuation of ddI if warranted.
- Tenofovir DF (TFV): coadministration decreases ATZ concentrations and increases tenofovir concentrations. Use ATZ with TRUVADA only with ritonavir, monitor for evidence of tenofovir-associated adverse reactions.

**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.

Please see brief summary of full Prescribing Information on following page, including boxed WARNING information about lactic acidosis, severe hepatomegaly with steatosis, and exacerbations of hepatitis B upon discontinuation of therapy.
INDICATIONS AND USAGE

TRUVADA should not be coadministered with ATRIPLA® (emtricitabine 200 mg and efavirenz 600 mg) or TIBIDRO® (tenofovir disoproxil fumarate 300 mg and emtricitabine 200 mg). TRUVADA should not be coadministered with VIREAD® (tenofovir disoproxil fumarate) or VICTRELIS® (adefovir dipivoxil). TRUVADA should not be coadministered with lamivudine-containing products or other nucleoside reverse transcriptase inhibitors (NRTIs).

Dosage Adjustment for Patients with Altered Creatinine Clearance

Dosing recommendations for patients with renal impairment are given in Table 1.

<table>
<thead>
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Contraindications

Lactic Acidosis/Severe Hepatotoxicity with Steatosis: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues including emtricitabine and tenofovir disoproxil fumarate.

Administration of TRUVADA is contraindicated in patients with a history of lactic acidosis or severe hepatomegaly with steatosis, particularly in those with risk factors such as history of diabetes, obesity, or use of other nucleoside analogues and/or other antiretrovirals. Many of these cases have been in women. Opaque and prolonged nuclear reorganization of hepatocytes and/or characteristic vacuolar change should not be used to diagnose lactic acidosis in patients with known risk factors for lactic acidosis. Treatment with TRUVADA should be suspended in any patient who develops symptoms or signs consistent with lactic acidosis or severe hepatomegaly with steatosis. Such symptoms may include extreme tiredness, a deterioration in liver function tests or an increase in transaminases. Patients treated with TRUVADA who are at risk for lactic acidosis/severe hepatomegaly with steatosis should be monitored closely. Monitoring of laboratory tests should be performed in patients who are female, morbidly obese, or have a history of metabolic disorder.

Patients Coinfected with HIV-1 and HBV: It is recommended that all patients with HIV-1 and HBV be screened for evidence of coinfection before starting treatment with TRUVADA. People with evidence of coinfection should not be treated with TRUVADA. Patients who are coinfected with HIV-1 and HBV have not been treated with TRUVADA. In Study 934, 511 antiretroviral-naive adult patients with HIV-1 and HBV were treated with TRUVADA. In some patients receiving HBV treatment, HBV viral load decreased and liver enzymes increased. Patients who are coinfected with HIV-1 and HBV should be closely monitored with both clinical and laboratory follow-up for at least several months after initiating treatment with TRUVADA. It is recommended that patients coinfected with HIV-1 and HBV be monitored for symptoms and signs of hepatotoxicity.

Drug Interactions

Drug interactions have been identified during postmarketing use of VIREAD® (tenofovir disoproxil fumarate) and EMTRIVA® (emtricitabine). Drug interactions observed during postmarketing use of VIREAD® and EMTRIVA® are described below.

Laboratory Abnormalities: Laboratory abnormalities observed in this study generally consisted of those seen in other studies of VIREAD® and EMTRIVA®.

Serious and/or Life-Threatening Adverse Reactions

Hepatitis B Therapy: Hepatitis B therapy may be warranted for patients with HIV-1 infection in whom treatment with TRUVADA is anticipated. Patients coinfected with HBV and HIV-1 may have a higher risk of hepatitis B reactivation.

Antiretroviral Pregnancy Registry: To monitor fetal outcomes of pregnant women exposed to TRUVADA, the Antiretroviral Pregnancy Registry has been established. Healthcare providers are encouraged to register patients by calling 1-800-258-4263.

Pediatric Use: TRUVADA is not recommended for patients less than 18 years of age because it is not known whether the drug excretion characteristics are different in children from those in adults. TRUVADA is not recommended for use in children less than 18 years of age.

Teratogenic Effects: Pregnancy Category B: In animal reproduction studies, no drug-related increase in fetal anomalies was seen in rats or mice at doses up to 750 mg/kg/day (50 times the human systemic exposure at the therapeutic dose) in rats or 469 mg/kg/day (26 times the human systemic exposure at the therapeutic dose) in mice. While there is no evidence of impaired fertility or harm to the fetus due to tenofovir disoproxil fumarate therapy, studies in animals cannot predict what the effects of tenofovir disoproxil fumarate might be in humans. The incidence of fetal variations and skeletal anomalies in offspring of rats dosed with tenofovir disoproxil fumarate was not increased. TRUVADA is not recommended for patients less than 18 years of age.

Drug Interactions

Drug Interactions: Drug interactions observed during postmarketing use of VIREAD® and EMTRIVA® are described below.

DRUG INTERACTIONS

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Serious and/or Life-Threatening Adverse Reactions

Liver Disease: The risk of aggravating liver disease has been confirmed in clinical trials where tenofovir disoproxil fumarate was administered to patients with chronic hepatitis B or C as an adjunct to antiviral therapy. Tenofovir disoproxil fumarate should not be coadministered with lamivudine unless the patient is not responding to lamivudine or has developed a resistance-associated mutation.

Altogether, it is recommended that tenofovir disoproxil fumarate be used with care in patients with chronic hepatitis B or C who are currently flaring or who have not responded to antiviral therapy.

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Emergency Contraception in Maryland

In this column, Judith Robbins, LCSW, JD, CCHP-A, talks with a team of health professionals from the Maryland Department of Juvenile Services about an emergency contraception program in DJS facilities.

JR: What is emergency contraception?

DJS: EC is a safe, effective method to prevent unintended pregnancy after sexual intercourse. The most common type of EC is oral hormonal medication, often called the “morning after pill.” The most widely used product of this type is Plan B, which consists of 1.5 mg of levonorgestrel (available either as two 0.75 mg tablets taken together or a single pill) taken up to 120 hours (five days) after intercourse. Plan B works to prevent pregnancy by thickening cervical mucus, preventing ovulation and affecting sperm or ova movement through the uterus. Plan B does not harm an existing pregnancy nor cause an abortion.

Women may choose Plan B in many situations, such as sex without a condom, condom breakage, rape, unprotected sex with inconsistent use of hormonal birth control (or during the first month of hormonal birth control) and unprotected sex while impaired by drugs or alcohol.

Plan B is approved by the FDA for over-the-counter sales to those age 17 and older. For those younger than 17, it is available by prescription.

JR: Why did you start an EC program at your secure juvenile justice facilities?

DJS: In the United States, nearly 1 million teenagers become pregnant each year and approximately four out of five of those pregnancies are unwanted. Girls in the juvenile justice system are at an even greater risk due to inconsistent condom use, early sexual activity, prostitution, substance abuse, gang involvement, mental illness and histories of sexual or physical abuse.

Secure juvenile justice facilities have a prime opportunity to link youth to reproductive health services, including EC. The Maryland DJS recognized an opportunity to prevent unintended pregnancies and also wanted DJS girls to have access to the same services available in the community. The EC screening process also starts an important conversation about family planning options and sexual health in general.

JR: How does your EC program work?

DJS: The program is nurse directed and integrated into the nursing intake assessment. Upon admission, all girls are offered testing for pregnancy, HIV, syphilis, gonorrhea and chlamydia. We also obtain a reproductive health history that includes questions about the date of last sexual intercourse, contraception use and pregnancy concerns. If a youth has had possibly unprotected sexual intercourse in the past 120 hours and doesn’t want to become pregnant from that encounter, the EC protocol is initiated.

Among the forms we developed to facilitate EC administration are a fact sheet, consent form and protocol flow sheet. When youth qualify for EC, the nurse initiates discussion guided by the fact sheet. If the youth wants EC, the nurse proceeds to the protocol flow sheet, which outlines the process for determining eligibility, obtaining consent, getting a physician’s verbal order, administering EC and scheduling follow-up.

JR: How did you introduce the program and train the staff? Were there any challenges?

DJS: During the planning phase, we sought feedback from stakeholders including health care staff, facility superintendents and DJS legal counsel. We developed a comprehensive nurse training module that discussed background on EC, the protocol and documentation, potential ethical concerns and strategies for communicating with youth. The trainings included a PowerPoint lecture, interactive scenarios and case studies.

Initially, some nurses had misconceptions about EC, confusing it with “the abortion pill” or thinking it could harm existing pregnancies. Others felt that DJS youth would not be interested in EC. The training addressed these concerns. We assessed knowledge through pre- and post-training tests. Test scores improved dramatically from an average 62.9% before training to an average 98.6% after training.

JR: What have you learned through program evaluation?

DJS: Program evaluation strategies include chart reviews, observation of intake assessments, and nurse and youth surveys. Our goals are to ensure that EC materials are youth-friendly, that nurses feel comfortable counseling youth on these issues and that girls who receive EC get appropriate follow-up. Nurses have reported high efficacy in using the EC protocol. Our greatest challenge has been ensuring consistent screening within the 120-hour window.

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

At the Maryland DJS, Jennifer Maehr, MD, is the medical director and a board-certified pediatrician and adolescent medicine specialist. Jessica Burns, RN, MSN/MPH, is a nursing program consultant. Alison Smith, RN, BSN, is a Johns Hopkins University graduate student intern.

For additional resources, including the DJS EC protocol forms and references, please visit the CorrectCare archive at www.ncchc.org/pubs.
Leading by Example Comes Naturally for Trustee

After a relatively brief but high-impact career in the world of correctional health care, Thomas G. Lundquist, MD, MMM, has moved on to academia. But we need not lament his departure. Having been bitten by the correctional health bug, he intends to continue to help this field make measurable improvements in the realms of telemedicine, electronic health records and operational performance overall. Even better, perhaps, he can now take a larger role as an advocate for correctional health care in policy debates.

Lundquist came to this field in August 2004, when he joined Wexford Health Sources, Inc., a health services contract management firm, as chief medical officer. He brought with him seven years of experience as a physician executive in a variety of health care sectors and delivery models, with expertise in quality management and a proven track record in population health and disease management programs.

Progressive Leadership

During Lundquist’s five years at Wexford, his successes were many. With a sharp focus on leadership and quality, he established a medical leadership branch of the company, delineating expectations, roles and responsibilities at the corporate and regional levels. He greatly improved utilization management by using case management and disease management strategies that, not surprisingly, also improved clinical outcomes. He also implemented corporatewide clinical protocols.

Lundquist is an ardent believer that it is not only smart, from a business perspective, but essential for correctional health systems to embrace technology. Accordingly, he led efforts to implement telemedicine and telepsychiatry at the facilities his company worked with.

Those efforts paid off. “I have seen firsthand the improvement of care delivery due to these technologies, and I have seen literally tens of thousands of additional visits being brought to patients in need through the use of telemedicine,” Lundquist says.

Similarly, he argued for—and sometimes achieved—adoption of electronic health record systems at his clients’ facilities. This technology, too, is a vital driver of quality, he says. With the frequent need for interfacility inmate transfers, EHRs ensure that providers receive consistent access to complete patient information, and they reduce costly inefficiencies such as duplicative testing.

While describing his work at Wexford as one of the most enriching experiences in his career and praising the dedicated professionals on the front line, Lundquist also recounts some frustrations. In particular, he points to the lack of support for technology, population health management strategies and other key needs in correctional health care. He emphasizes that the blame does not lie with the correctional agencies themselves: “Much decision making about programmatic effort and investment is in the realm of public policy and needs to be addressed in that forum.”

Speaking Out

And that’s where Lundquist hopes to make a difference. Currently he is an adjunct faculty member at the H.J. Heinz College of Public Policy and Management at Carnegie Mellon University, Pittsburgh, where he teaches physician executives about issues such as health care quality, patient safety and leadership. But he is considering taking on a full-time faculty role at CMU.

“It would allow me to engage more unencumbered in the public policy debate about health care delivery and the business case for quality,” he explains. “It also would allow me to pursue grant-funded research focusing on improving health care delivery in corrections. I believe a much stronger connection between our nation’s public health efforts and correctional health care delivery must prevail.”

This philosophy meshes with Lundquist’s motivations for becoming certified through the CCHP program. “I believe that accreditation and certification are good ways to create common ground and to continually raise the bar on the quality of providers and organizations,” he says. “Becoming a CCHP has allowed me to lead by example and encourage others to never stop learning, no matter where you are in your career.”

This profile was written by Matissa Sammons, NCCHC’s certification coordinator. To reach her, e-mail cchp@ncchc.org.

<table>
<thead>
<tr>
<th>CCHP Exam Dates</th>
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<tbody>
<tr>
<td>February 20</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>March 11</td>
<td>Portland, OR</td>
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<tr>
<td>April 25</td>
<td>Nashville, TN</td>
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<tr>
<td>July 11</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>August 21</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>October 10</td>
<td>Las Vegas, NV</td>
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For more information about the application process or the exams, please visit www.ncchc.org/cchp.

We are seeking additional sites for the regional 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 Dental Association
Capt. Nicholas Makrides, DMD, MPH, the ADA’s representative on NCCHC’s board of directors, has proposed that the federal Healthy People 2020 initiative add an oral health objective for correctional facilities. In the past and in the proposed 2020 Healthy People oral health objectives, institutional populations have been omitted. Makrides says that because these populations have been omitted from large-scale national investigations on oral health, including the Surgeon General’s report “Oral Health in America” and the National Health and Nutrition Examination Surveys, there are no national data sets that describe the oral health of inmates. Makrides is a U.S. Public Health Service officer and chief dentist for the Federal Bureau of Prisons.

American Public Health Association
The APHA’s annual meeting in November in Philadelphia featured 40 presentations on correctional health care. Topics were quite diverse and included ethical dilemmas, immigrant detainees, medication assisted therapy, STD screening for female jail inmates, health disparities, inter-agency collaboration and much more. The call for abstracts for the 2010 meeting ends in mid-February.

American Bar Association
The ABA is undertaking a revision to its Criminal Justice Standards, the first major update in over 25 years. NCCHC was consulted on aspects related to correctional health care, and the final document will cross-reference NCCHC’s standards.

Academy of Correctional Health Professionals
The Academy will soon conduct a survey of its membership. This survey, which is done every five years, will inquire about members’ professional needs and interests, as well as demographic information. The results will help the board of directors to strengthen the Academy’s programs and services to better the needs of the membership. Please complete the survey when you receive it!

Correctional Health Professionals Week
The first-ever National Correctional Health Professionals Week occurred Oct. 18-24 in conjunction with the National Conference on Correctional Health Care. Meeting participants were excited about the celebratory week, which was conceived by the Academy of Correctional Health Professionals as a time “to honor professionals striving to provide constitutionally mandated and community-based standards of care” in correctional settings.

The GEO Group, Inc. is currently recruiting in California, Florida, Georgia, Louisiana, Mississippi, New York, North Carolina, Oklahoma, and Texas for opportunities in healthcare including:

Medical Directors, Physicians, Psychiatrists, Dentists, Nurse Practitioners, RN’s, LPN’s, Dental Assistants & Psychologists

For more information, please contact:
Nichole Vinci, Manager, National Recruitment
Toll Free: 1.866.301.4436 ext. 7537
Fax: 561.443.3839
E-mail: nvinci@thegeogroupinc.com
Apply Online: www.thegeogroupinc.com
Correctional Managed Health Care (CMHC) is a $102 million, 800 employee division of the University of Connecticut Health Center, contracted with the state’s Department of Correction to provide comprehensive health care to almost 20,000 inmates at 20 prisons and jails. CMHC has created this new position to assure the appropriateness of secondary and tertiary care given outside the prisons. Reporting to the Director of Medical Services, the Assistant Director will lead the review of requests for specialized services and will conduct real-time review of hospital services, seeking both cost savings and improved quality of care. The position will include a limited amount of direct patient care, as well as some supervision of personnel and programs within the DOC facilities.

This position requires a minimum of seven (7) years experience in both clinical care (with recent exposure to in-patient care) and professional leadership and administration, with a minimum of four (4) years as a practitioner and a minimum of three (3) years in a managerial role. Hospitalist experience a definite advantage. The incumbent must exercise a high level of skill in communication and negotiation with other professionals. The position requires a Connecticut license to practice medicine and surgery, and board certification in an American Board of Medicine and Surgery specialty, with a preference given for a primary care field, and for prior correctional experience. The position offers a competitive salary and generous State benefits.

For more information about this position, go to https://jobs.uconn.edu, or contact Alexandra Mazur Smith at (860) 679-5513 or Alsmith@exchange.uconn.edu.

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M/F/V/PwD
EMPLOYMENT

Join the Prison Health Services Team in servicing the Michigan Department of Corrections. Prison Health Services is currently hiring a State Medical Director for Michigan. Responsibilities include: Implementation and ongoing monitoring of the six clinical programs in the PHS Medical Management Model; Quality Improvement; Utilization Management; Disease Management; Credentialing; Training and Education; and Infection Control.

Preferred Education and Experience: Board Certified in Internal Medicine or Family Medicine; Current, unrestricted Michigan Medical License; Three to Five years of Experience in a Leadership Role within a Large Health Care Organization; Correctional Health Care Experience.

Compensation Package includes: Competitive Salary; Relocation Assistance; Paid Liability Insurance; Health/Dental/Life Insurance; Vacation/Holiday/Sick Leave; 401k Retirement Plan; Long and Short Term Disability Options; Employee Stock Purchase Plan; Tuition Reimbursement and CME.

Interested candidates should contact: Lindsey Knowlton via email: knowltlk@asgr.com; fax: 615-309-6512 or phone: 517-827-3149.
Standards Q & A

Expert Advice on NCCHC Standards

by Jennifer E. Kistler, MPH, and R. Scott Chavez, PhD, MPA, CCHP-A

No-Smoking Policy

**Q** Our state passed a law that prohibits smoking in all public spaces. Our facility is now smoke-free. Do we still need to have a policy?

**A** Yes. Standard F-03 Use of Tobacco requires that smoking is prohibited in all inside areas, and if the facility allows smoking outside, specific areas are designated. In addition, the standard requires that, at a minimum, the prevention and abatement program includes nicotine replacement products and written materials on prevention and abatement of tobacco use. The written materials should be available in areas accessible to all inmates (such as the clinic, library and housing). Since all applicable NCCHC standards should be addressed in policy, even if your facility is officially smoke-free, your policy still should address the standard’s compliance indicators.

Performance Reviews

**Q** I’m not very clear on the difference between a clinical performance enhancement review (C-02 Clinical Performance Enhancement) and an annual performance review. Can you please explain this?

**A** A clinical performance enhancement review is focused on the quality of the clinical care provided; a health professional’s work is reviewed by another professional of at least equal training in the same general discipline, such as the review of the facility’s physicians by the responsible physician. An annual performance review might address areas such as punctuality, teamwork, attitudes, goals, etc.; those types of reviews do not apply to this standard.

HSA Eligibility

**Q** Is it OK for our sergeant to be the health services administrator?

**A** Standard A-02 Responsible Health Authority states that a health administrator is a person who by virtue of education, experience or certification (e.g., MSN, MPH, MHA, FACHE, CCHP) is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for inmates. If the sergeant is a Certified Correctional Health Professional (CCHP) or has other relevant educational credentials, then by virtue of his or her education, experience or certification this position would be appropriate.

Pharmacy Inspections

**Q** Since we do not have a staff pharmacist, standard D-01 Pharmaceutical Operations says that a consulting pharmacist should be used for documented inspections and consultation on a regular basis, not less than quarterly. Does a pharmacist have to be the one to physically conduct the inspections, or can a pharmacy tech do the inspection as long as it is reviewed and signed off by a pharmacist?

**A** No. The intention of this standard is that a consulting pharmacist actually conducts the inspections. A situation where another type of staff member conducts the inspection and then has a pharmacist sign off would not be in compliance with the standard.

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.

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**Medical Director**

Florida Department of Corrections

The Florida Department of Corrections is seeking a Medical Director with administrative experience and proven leadership to oversee all clinical and administrative aspects of a $440 million health care delivery system for over 100,000 inmates. Board certification in primary care specialty required; 5 years post-licensure experience required; correctional experience desired. Florida license required pursuant to Chapter 458, Florida Statutes. This position is located at our Central Office in Tallahassee.

- Salary negotiable
- Generous State of Florida benefit package:
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Serious inquiries, please contact Jennifer Dudley by email at dudley.jennifer@mail.dc.state.fl.us, by phone at 850-410-4615 or apply online at https://peoplefirst.myflorida.com.
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every customer, every sample, every day

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• 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

www.spectradiagnostics.com

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Not if you contract with MHM. We commit considerable resources to attracting and retaining professionals for our correctional mental health programs. Drawing from an immense talent pool, our in-house recruiters assemble teams rapidly for each new contract. And we keep the positions filled—with a very low vacancy rate.

Providers stay with us and help us grow because they enjoy working for a company focused on mental health—especially one that invests in their careers. MHM now manages mental health programs in 250-plus correctional facilities nationwide. Our staffing approach has been so successful that we also provide medical staffing for select client agencies.

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