Professionals Beware!
No Deliberate Indifference Required for This Claim to Find You

Violent and Agitated Inmates: A Review of Management and a Call for Research

Work Ethics: Where Do They Come From and Do You Possess Them?
The National Commission on Correctional Health Care and the Certified Correctional Health Professionals Board of Trustees are pleased to announce

**CCHP CERTIFICATION FOR REGISTERED NURSES**

- Specialty certification for nurses working in the correctional setting
- Recognizing the work you do and the difference you make
- Exclusively for nurses already CCHP certified
- From the most widely accepted correctional health care certification program

Certification in correctional nursing makes a difference—to the patients whose care is provided by certified correctional nurses, to employers who must staff their facilities with skilled and experienced correctional nurses, and to the individual nurse who attains the CCHP-RN© credential.

**Certification Makes a Difference – Do You?**

For more information or to obtain an application, visit our Web site at www.ncchc.org/cchprn. You may also contact us at cchp@ncchc.org or 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.
California Prisons to Adopt NCCHC Standards

The road to reform of the California prison health care system has been long and difficult. But now the turnaround is in full swing, and even greater improvements are on the horizon: The California Department of Corrections and Rehabilitation intends to bring 90% of CDCR’s health care programs in substantial compliance with NCCHC standards by June 30, 2015.

This objective is part of the five-year strategic plan issued by CDCR Secretary Matthew Cates this summer. The plan has four goals with 26 objectives that are seen as key for organizational process improvement. Goal 3 is to “employ best practices in correctional custody, care, and rehabilitation,” and national correctional standards are a key performance indicator for this goal.

Although the goal has several objectives that touch upon different areas of prison operations, the objective for health care relies on NCCHC’s Standards for Health Services. According to the document, “The courts have historically depended upon different areas of prison operations, the objective for health care relies on NCCHC’s Standards for Health Services. CDCR will adopt National Commission on Correctional Health Care standards to evaluate its performance and demonstrate compliance with national quality of care standards.”

In fact, many of the prisons’ policies are already based on the NCCHC standards, and this objective will move them significantly further in that direction.

CDCR is one of the largest prison systems in the United States, with 33 adult institutions, five juvenile justice facilities and several other types of facilities. It is responsible for overseeing 168,000 adult inmates and 1,400 juvenile offenders, and has approximately 66,000 employees. The strategic plan can be viewed online at www.cdcr.ca.gov/About_CDCR/index.html.

Finally! The First Med-Mal Insurance for Corrections

Correctional health professionals have unique risk management needs, and now there’s a special insurance program designed just for them. The Academy of Correctional Health Professionals has partnered with NSU Healthcare, a division of National Specialty Underwriters, to sponsor a professional and general liability insurance program.

NSU will offer very broad medical malpractice insurance coverage with specialized risk management resources for all employers of correctional health professionals. In recognition of the value of accreditation, participants who work in accredited facilities will receive premium credits or discounts. They also will have access to a valuable array of risk management services, such as online tools and resources to help prevent medical staff errors and patient injuries, plus recommended resources, self-assessment tools, a video lending library, newsletters and e-news alerts.

“This is an excellent program,” says Academy chair-elect Ralf Salke, BSN, CCHP-P, vice president of operations for Correctional Medical Services. “We believe it is the first program geared to fit the needs of correctional health professionals and it is truly unique in the U.S. medical malpractice insurance market. It recognizes the quality of NCCHC accredited facilities and the professionalism of Academy members, providing professional liability risk management services that will help reduce risk, prevent claims and improve the operation of facilities and companies serving this field.”

The program will be officially unveiled in October at the National Conference on Correctional Health Care in Las Vegas. Visit the Academy in exhibit hall booth 134 to learn more. Information and a link will also be available at the Academy Web site, www.correctionalhealth.org.

Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 12</td>
<td>Accreditation committee meeting</td>
</tr>
<tr>
<td>February 19</td>
<td>CCHP exam, multiple regional sites</td>
</tr>
<tr>
<td>May 21-24</td>
<td>Updates in Correctional Health Care conference, Phoenix</td>
</tr>
<tr>
<td>May 22</td>
<td>CCHP exam, Phoenix</td>
</tr>
<tr>
<td>July 8-9</td>
<td>Medical Director Boot Camp, Las Vegas</td>
</tr>
<tr>
<td>July 10-11</td>
<td>CCHP exam, Las Vegas</td>
</tr>
<tr>
<td>July 10-11</td>
<td>Correctional Mental Health Seminar, Las Vegas</td>
</tr>
</tbody>
</table>

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

In Other News...

Juvenile Standards. The updated manual is complete, with publication expected in early 2011. NCCHC’s juvenile health committee modeled the updates after the 2008 Standards for Health Services for adult facilities but took into account issues unique to juvenile settings and populations, aided by valuable input from the field.

OTP Accreditation Assistance. NCCHC has received a renewal of a three-year grant from the Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment related to NCCHC accreditation of opioid treatment programs. The funding helps to reduce the costs of education and surveys for OTP programs seeking accreditation.

Call for Reviewers. As the Journal of Correctional Health Care grows in stature, especially now that it is indexed on Medline, we are receiving a flood of manuscripts. And they all need peer review! If you have expertise to share, contact JCHC editor John Miles, who will give you the rundown on what it involves: journal@ncchc.org.
Evidence-Based Practice Can Transform Care

by Robert L. Trestman, PhD, MD

The past 20 years of rapid growth in the populations of America’s jails and prisons have reshaped the landscape of correctional health and health care. While there are many appropriate debates about the public benefits and costs of incarceration on such a scale, incarceration is a reality that provides an opportunity to change health care and health-related behavior with immediate and long-term benefit to the individuals affected.

The public health burden that jails and prisons bear is enormous. A disproportionate number of incarcerated individuals are medically and/or psychiatrically compromised. Many have substance misuse diagnoses. Many have histories of traumatic brain injury. Many have poorly controlled chronic diseases. This situation is an opportunity for us as health professionals to make a profound difference in the lives of individuals during incarceration.

Question: Are we making the best use of this opportunity? The honest answer is: We don’t know. Currently, we make use of many idiosyncratic interventions and use few evidence-based correctional health practices. In fairness, there are many impediments to doing so. Correctional settings are generally poorly funded, are often driven to respond to the pressures of crises and the daily demands of acute care, and there is all too often the milieu of a rigid, change-averse environment. Furthermore, while advances in health care delivery are developing in community settings, little of this has been adapted and tested for use in corrections. As we all know, correctional settings have many distinct differences that may render inappropriate or useless many of the practices developed in the community.

Adapting clinical guidelines to correctional settings is often daunting. Logically, through applied research, best practice and evidence-based practice in the community would be adapted for our settings. The outcomes would be measured and the knowledge disseminated. In practice, little is being done. Modest work supports individual practice advances but shared or common protocols are lacking.

Practicing the Very Best Care

Recognizing this global challenge, the National Institute of Corrections began an initiative several years ago named for its first director. The Norval Morris Project (http://nicic.gov/Norval) “develops processes for discovering and disseminating innovations, knowledge, and ideas that allow the fields of corrections and human services to enhance the services they provide to clients and communities.”

While this initiative applies to all issues custodial and programmatic, it presents a unique opportunity to drive health care improvement through the development, dissemination and implementation of evidence-based practice. This process of taking clinical advances to the real world of clinicians is called “translational” research.

It is challenging enough to do this work in community settings, let alone jails and prisons. Nevertheless, opportunities exist for us to apply this knowledge. The implications are broad and include objectively defining and measuring symptom severity, laboratory values and functional capacity at baseline and throughout treatment. It means basing treatment decisions on best or evidence-based protocols. It means modifying treatment for an individual on the basis of consistent, reliable and valid data. It means holding clinicians accountable to reliably following standards. And it means changing population treatment on the basis of overall group outcomes. In short, it means practicing the very best health care we can using applied research.

In mental health, opportunities include use of evidence-based guidelines to treat serious mental illness. It includes using objective measures for symptom severity and functional status. It implies tracking baseline status and change over time to determine whether our interventions are working. In medical care, major opportunities lie in chronic disease and risk reduction interventions. In diabetes, for example, following clinical guidelines and using baseline hemoglobin A1c, body mass index and other laboratory values along with appropriate changes in diet and lifestyle.

How do we transform the health care environment in corrections to develop and then integrate evidence-based practice? We can start by looking at the basics of our processes and collaborating with those who have the skills we need. We need to build, incrementally and thoughtfully, quality assurance programs (“Are we doing what our policies say we should be doing?”) to accustom our staff to think about outcomes in terms of data. This is consistent with NCCHC standards. The next step is to incorporate quality improvement (“How can we get better results?”) into everyday practice. This is the foundation for helping our staff to participate in improved health care quality.

By structuring our daily work to support evaluation and research, we empower ourselves to think broadly about what we are doing, and reinforce why we went into health care: to reduce suffering and to improve the lives of our patients. There are many political, operational and financial challenges. Yet by embracing this opportunity, we will transform correctional health into what may become a beacon of quality in public health and public health care delivery.

Robert L. Trestman, PhD, MD, is the executive director of Correctional Managed Health Care, Farmington, CT; a professor of medicine and psychiatry, University of Connecticut Health Center; and a member of the NIC’s Norval Morris Keystone Group.
The Academy Says: ‘Let’s Celebrate!’

The Academy of Correctional Health Professionals is not only a supporting organization of NCCHC but also a close partner. NCCHC is proud to have helped in its creation in 2000 and to have nurtured it in its formative years. Now, as the Academy celebrates its 10th anniversary, this professional membership group continues to grow both in size—currently at more than 3,000 members—and in the valuable benefits and resources that it offers.

“To mark this special occasion, it seemed fitting to develop a slogan—10 Years to Life: Make the Academy Part of Your Life,” says Susan Laffan, RN, CCHP-A, CCHP-RN, who chairs the Academy’s board of directors.

Laffan also serves on a new marketing committee formed in part to develop ways to celebrate and promote the anniversary. The committee’s other members are also on the board; they are Steven Helfand, PsyD, CCHP, Sue Lane, RN, CCHP; Rick Morse, MBA, CCHP; and Todd Schwartz, MBA, CCHP. Stay tuned for plenty of creative ideas from this team, including special activities during the National Conference on Correctional Health Care.

Your Professional Community: A Refresher

For the benefit of CorrectCare readers who are not familiar with this excellent organization, Laffan offers a primer.

The Academy of Correctional Health Professionals is a national, not-for-profit membership organization that provides educational and professional development resources to individuals working in this field. Its mission is to create a professional community for the advancement of correctional health care. Four goals have been established:

• Assist the professional development of members
• Promote education and information exchange within the correctional health care community
• Advance the science and ethical practice of correctional health care
• Advocate for correctional health care excellence.

The benefits of membership are many and include the following:

• Discounted rates for educational meetings
• Complimentary subscriptions to NCCHC’s magazine CorrectCare and its Journal of Correctional Health Care, the nation’s leading correctional health care publications
• Members-only discounts on all publications available from NCCHC
• Shared interest groups and other networking opportunities
• A members-only listing and access to an online membership directory as well as other exclusive Web-based features
• Various career services, including a job board and a mentor program targeted to individuals’ interests and needs

“As we reflect upon the past 10 years and look toward the future, we encourage all correctional health professionals to take pride in their specialty and to join in our unique community,” says Laffan.

To learn more about the Academy or to join, visit the Web at www.correctionalhealth.org.

Proclamation
National Correctional Health Professional Week
October 10-16, 2010

Correctional health professionals provide health care in some of the most challenging environments across the country, including adult jails and prisons, juvenile detention centers and a variety of alternative correctional environments. In recognition of their contributions, the Academy of Correctional Health Professionals proclaims October 10-16, 2010, as National Correctional Health Professional Week.

During this week, we honor correctional health care professionals striving to provide constitutionally mandated and community-based standards of care in correctional facilities. This work is done tirelessly despite the fact that the challenges of providing this care grow more complex each year. We also salute correctional health professionals engaged in research, program evaluation and the sharing of information and ideas with colleagues with the goal of finding more efficacious and cost-effective ways to manage the full range of health care needs in our settings.

Teamwork and mutual support across disciplines can make all the difference for recruiting health care providers into this field, retaining staff and maintaining morale in these stressful environments. Thus, we salute those professionals who, on a regular basis, contribute to a culture of providing quality health care and fostering pride and professionalism in the workplace.

In 2010, facilities across the nation continue to contend with reductions in funds and services and, simultaneously, higher medical acuity and age of our patients. Correctional health professionals understand and honor their legal and ethical obligations to provide quality care to their inmate-patients.

During this week, the Academy of Correctional Health Professionals invites you to celebrate the ongoing efforts and achievements of correctional health professionals across the United States.

Help us celebrate by participating in the special activities taking place at the National Conference on Correctional Health Care in Las Vegas, including the Eighth Annual Academy Day (with an evening reception) on Monday, October 11, and the Academy Inspirational Breakfast on Wednesday, October 13.
In today’s economy, some correctional administrators are facing tough decisions that threaten to downsize or even eliminate mental health services. With the number of inmates in need of mental health care on the rise, finding ways to provide adequate mental health services on a limited budget is a common challenge.

NCCHC defines mental health services as the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological and social, to alleviate symptoms, attain appropriate functioning and prevent relapse. The Basic Mental Health Services standard (G-04 in the 2008 manuals for jails and prisons) is meant to ensure that inmates with mental health problems are able to maintain their best level of functioning. The immediate goal of treatment is to alleviate symptoms of serious mental disorders and to prevent relapse.

Group counseling should be available to patients who need such service. Groups could be offered by on-site mental health staff, program staff, or community volunteers or mental health agencies. Topics might address parenting, trauma, loss and grief, communication, stress management, wellness for patients with a specific disorder or many other subjects. Many patients can benefit from the support offered in groups; the realization that one is not alone can be instrumental in treatment. Group therapy encourages emotional development, personal responsibility and leadership skills. Note that the G-04 standard requires group counseling and psychosocial/psychoeducational programs in addition to individual counseling; treatment documentation and follow-up; crisis intervention services; psychotropic medication management; when indicated; and identification and referral of inmates with mental health needs (Compliance Indicator 2). These on-site outpatient services should be in place regardless of the facility type or size.

The standard’s discussion section provides additional guidance: Facilities housing significant numbers of mental health patients with longer lengths of stay are expected to offer more extensive programming, and facilities that provide for patients who require psychiatric hospitalization levels of care are expected to mirror treatment provided in community inpatient settings. This section also discusses acute mental health residential units for facilities that provide this level of care on site for patients who are psychotic, mentally unstable or seriously suicidal. Crisis intervention and provision of appropriate psychotropic medications are also expected for inmates with short lengths of stay and in facilities that transfer inmates with serious mental health problems to other facilities.

When commitment or transfer to an inpatient psychiatric setting is clinically indicated, required procedures should be followed and the transfer should be timely. Until the transfer, the patient should be safely housed and adequately monitored (Compliance Indicator 2).

Additional Standards

Other standards address mental health care, as well. Standard G-01 Chronic Disease Services includes major mental illnesses; therefore, the responsible physician should establish and annually approve clinical protocols consistent with national clinical practice guidelines for management of major mental illnesses (Compliance Indicator 1h). Also, standard G-02 Patients With Special Health Needs applies to patients with serious mental health needs such as psychotic disorders or mood disorders (e.g., manic-depressives), self-mutilators, the aggressive mentally ill, those with post-traumatic stress disorders and suicidal inmates.

Mental health treatment is more than prescribing medication: We want to give patients treatment goals with clear steps to achieve them. Treatment goals may include developing self-understanding, self-improvement and gaining skills to cope with and overcome disabilities associated with various mental disorders. Treatment plans should include the frequency of follow-up for medical evaluation; adjustment of treatment modality as clinically indicated; the type and frequency of diagnostic testing and therapeutic regimens; instructions for diet, exercise, adaptation to the correctional environment and medication; and clinical justifications for any deviation from the protocol (see G-01, Compliance Indicator 2). Treatment plans may also incorporate ways to address patients’ problems and enhance their strengths, involve patients in their development and include relapse prevention risk management strategies. Such strategies should describe signs and symptoms associated with relapse or recurring difficulties (e.g., auditory hallucinations), how the patient thinks a relapse can be averted and how best to help the patient manage crises.

The G-04 standard also requires that outpatients receiving basic mental health services should be seen as clinically indicated, but not less than every 90 days. Those with a chronic mental illness should be seen as prescribed in their individual treatment plans (Compliance Indicator 4).

Coordination of medical, mental health and substance abuse services remains an important component of the standard on basic mental health services. Communication among providers is critical to ensure that comorbid conditions are adequately addressed.

Despite the economy and competing priorities, mental health services must be available for all inmates who require them. But our responsibilities do not end there: Inmates with critical mental health needs must also receive discharge planning (see E-13). They need arrangements or referrals for follow-up services in the community and arrangements for a sufficient supply of medications upon discharge to last until they can be seen in the community.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation; Scott Chavez, PhD, MPA, CCPH-A, is NCCHC’s vice president and liaison to the policy and standards committee. Contact them at info@ncchc.org or 773-880-1460.
DOES YOUR TPA DO MORE THAN JUST PAY CLAIMS?

CORRECTIONAL HEALTH PARTNERS’ CLINICALLY ENHANCED TPA DELIVERS

+ Innovative cost reduction strategies for inmate healthcare
+ Prior authorization and utilization management
+ Pharmacy management, including formulary development
+ Provider network development and contracting
+ Care management and coordination
+ Claims processing, reporting, and analysis
+ Quality improvement
+ Staffing solutions

THE STRONG WORKING RELATIONSHIP WE HAVE WITH CHP IS UNMATCHED IN MY OBSERVATION OF CONTRACT AGENCIES. THEIR STAFF IS HIGHLY SKILLED, MOTIVATED, AND EXPERIENCED.

– JOAN SHOEMAKER, DIRECTOR OF CLINICAL SERVICES, COLORADO DEPARTMENT OF CORRECTIONS

CALL TOLL FREE 1.866.932.7185 OR VISIT CHPDELIVERS.COM
BETTER SCHEDULE, MORE CHOICES
Immerse yourself in 3 full days of educational programming with over 100 sessions, including these outstanding examples:

• The Brown Bag Booking: Which Medication Do I Choose?
• Challenges in Implementing Proposed PREA Standards
• Chronic Disease Self-Management Promotion Groups in the New Jersey Prison System
• Delusions, Hallucinations or Little Green Men: Detection of Malingered Psychosis
• Essentials of Correctional Juvenile Health Care
• Navigating the Legal Landscape Affecting Correctional Health Care Management
• Neurological Evaluation Review for Nursing
• Outpatient Utilization Review Process That Uses Multiple Elements
• Refocusing Energy to Achieve Results: Four Key Management Skills
• Reproductive Health Issues for Incarcerated Women: Challenges and Solutions
• What's Your Conflict Management Style?... And How to Use It Effectively
• When an Inmate Death Leads to Litigation

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

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

THE WINNING FORMULA!
With sessions featuring the latest research, cost-effective methods and interactive discussions, the week will engage and empower all who attend. The National Conference provides a unique opportunity to learn, network and share, with more than 100 symposia, workshops, panels and roundtable discussions on a wide variety of topics.

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

TAKE THE DRIVER'S SEAT
Today it is essential to use your skills and resources most effectively. This important conference is designed to help you meet the myriad challenges facing our field. Here’s why you should attend:

• Discover the latest tools and techniques for making health services delivery more cost-effective
• Learn how other organizations have implemented successful programs for improving the efficiency of clinical processes
• Develop strategies for meeting national standards in the midst of budget cuts and staffing shortages
• Gain insights from eminent dignitaries at keynote presentations
• Update your skills while earning continuing education credit
• Network with colleagues, from top decision makers to in-the-trenches staff, to learn how they are handling the problems that you face every day
• Explore problem-solving products & services in the exhibit hall

THE RIO ALL-SUITE HOTEL
Imagine the luxury of a world-class resort combined with the connectivity of an office and the comforts of home. At the Rio, every room is a suite, with more than 600 square feet of luxurious space including a separate dressing area, couch, 32-inch TV, table with chairs, in-suite refrigerator and much more. After an exciting time in the huge casino, visitors can relax at the spa or one of the four pools. The Rio is also home to some of the best shows and fabulous dining for all palates. The hotel overlooks the breathtaking Las Vegas Strip and surrounding mountains, and offers free shuttle service to the Strip.

3700 W. Flamingo Rd., Las Vegas, NV 89103
Reservations: 888-746-6955

CONFERENCE LEARNING OBJECTIVES
- Demonstrate an understanding of correctional health care issues, including quality of care, access to care, financial management and workforce development
- Identify major health care, research and policy issues facing incarcerated individuals, including infectious diseases, mental illness, substance abuse and special needs (e.g., women’s issues, juvenile health, geriatrics, disability)
- Demonstrate increased understanding of skills necessary to better manage common medical, dental and psychological problems found in correctional settings
- Describe legal, ethical and administrative issues and develop solutions for the correctional setting

FOR MORE INFORMATION . . . Visit the National Conference Web site for detailed information, including registration fees and policies, a schedule of sessions, the Preliminary Program and online registration. Or call us to request a Preliminary Program by mail. www.ncchc.org • 773-880-1460
In 1976, the U.S. Supreme Court did correctional professionals quite a favor; in the famous case of Estelle v. Gamble, the court created a heightened standard of conduct known as deliberate indifference. Everyday negligence was no longer sufficient. If an inmate wanted to get past a motion challenging his pleadings, he had to show the provider knew of a substantial risk of serious harm and acted unreasonably despite this information.

Thereafter, while pro se prisoner suits remained a nuisance, providers were not kept awake at night worrying about having every treatment decision examined after the fact by a jury. Since prisoners could not meet the strict requirements for bringing state law medical malpractice cases, they were left with trying to get around the deliberate indifference standard on Section 1983 constitution claims.

Enter a new type of claim: retaliation.

Claims against correctional workers for retaliation are not subject to the heightened deliberate indifference requirement. Instead, in order to get to a jury, an inmate has to show three things: (1) he/she engaged in protected conduct of which the defendant knew, (2) he/she experienced some adverse action, and (3) some causal connection between the protected conduct and the adverse action.

Protected conduct in the correctional setting would include an inmate filing a grievance, formal complaint, lawsuit or similar document. Adverse consequences can be broad and range from a delay in treatment to a complete discontinuation of medication. Different courts construe a “causal connection” differently, but in general there has to be some argument that time period between the two events was fairly close.

That is all that is required. Once the inmate shows these three elements, the provider’s actual intention is irrelevant. To understand just how dangerous these claims are, read the following real-life example.

A Realistic Scenario

Envisioning a set of events leading a well-meaning professional to run headfirst into this legal doctrine is not difficult. Picture a psychiatrist scheduling a follow-up appointment with a difficult patient. After each visit, this patient files a formal grievance complaining about the doctor and the treatment decisions. Of course, each grievance is more absurd than the last. This same patient had sued mental health professionals twice at other facilities, with both suits dragging out for months into years.

Additionally and unsurprisingly, the psychiatrist’s calendar is packed. Each appointment slot is coveted and direly needed by each patient on her growing caseload. She would normally schedule the difficult patient for a follow-
up visit after four weeks. She dreads the grievance that is sure to follow the next visit and knows that each encounter increases the probability that she will be sued by this patient when he decides that he is angry enough.

So, she schedules his follow-up visit for eight weeks out. This gives everyone a month reprise from the circus that follows each visit and reduces the total number of visits she must conduct with the difficult patient over the course of his treatment. It also frees her schedule for one more visit with a patient who appreciates the treatment he receives.

Does this decision to move the visit back several weeks demonstrate deliberate indifference to the inmate's medical needs? Not unless the doctor knew waiting an extra month would cause serious harm. Was it retaliation? In almost all courts, absolutely.

Unless the inmate demonstrated a serious need for a quick follow-up visit, moving the appointment back will not meet the heightened standard of deliberate indifference; however, for retaliation, a heightened standard does not exist. Here, the inmate had unquestionably engaged in constitutionally protected conduct—filing his formal grievance. Equally clear, the well-intentioned doctor took an adverse action against him by moving his appointment back from when it would normally be scheduled. Finally, there was a causal connection both in the timing of her decision and the reason: She wanted to avoid or simply delay the costly and wasteful grievances and lawsuits that were certain to follow. While arguably reasonable, the provider's actions exposed her to a retaliation claim.

A Closer Look at the Elements

Protected Conduct
The most basic form of protected conduct is filing a lawsuit. It is a constitutional right for all individuals to make use of the court system and file suits to recover damages they believe they deserve. Many inmates abuse this right and flood the legal system with baseless and costly suits that do nothing but burn valuable time and resources; nonetheless, that does not take way their right to file the suits. In fact, the nature or validity of the suit has no bearing whatsoever on the fact that filing the suit was protected conduct and therefore is not a defense to a retaliation claim.

Informal conduct can be protected, as well. The filing of formal and informal grievances is without question protected conduct. Even letters of complaint to the prison supervisors can constitute protected conduct.

Adverse Action
The action taken against the inmate must be severe enough to deter a person of ordinary firmness from repeating the protected conduct in question after the retaliation. The conduct cannot be adverse in name only. Simple matters such as chastisement or warnings would not suffice to show the prisoner was retaliated against.

In the example above, if the prisoner were aware that he was being treated less often than similarly situated patients due to his lawsuits and grievances, he may be deterred from filing the complaints as he had in the past. While this is unquestionably a desirable result, the process used to get there was improper.

Causal Link
The adverse action must be caused in some way by the protected conduct. Just because a prisoner filed a grievance or lawsuit and was then disciplined or denied some other request does not mean that he has a retaliation claim. The adverse action in question must be in response to some degree to the protected conduct. The protected activity does not need to be the only cause of the adverse action, just one of the causes.

The decision by our overworked psychiatrist to move the unfriendly patient down the schedule a bit was not motivated solely by the inmate's grievances and lawsuits. He was not in terrible condition, other inmates are in poor condition, as well, and her schedule was bursting at the seams. The lawsuits and grievances were part of her decision, though, and that is enough to be considered retaliation.

Possible Saving Grace: Knowledge and Injury Defenses
Thankfully, the providers are not left defenseless. There are some arguments that can defeat a retaliation claim, the two most important of which are knowledge and injury.

A provider cannot by definition retaliate against a patient if she does not have actual knowledge of the protected conduct. If the psychiatrist in the example had not known about the prior grievances and lawsuits, she could argue that her decision to extend the time between visits was not retaliation. Simply being named in a grievance is not sufficient; the person taking the adverse action has to know about the protected conduct.

Another useful defense is injury. An inmate can recover damages for retaliation only if there is some type of arguable injury. Some adverse actions are severe enough to serve as injuries by themselves. For instance, punishing an inmate with solitary confinement may be considered an injury of its own, but a month-long delay in psychiatric care may not cause an inmate any suffering at all. That is the inmate's burden to prove.

However, when the psychiatrist made the decision to move the date of the patient's follow-up visit, she took a serious risk. Any episode or symptoms that occur during that four-week period will give rise to a claim for retaliation.

Last Thought
The fact that the psychiatrist was at all times making the decisions she felt was best for all parties involved is not relevant. Were the inmate's claim that she provided substandard care, her efforts to make the right decision might shield her from liability. But in retaliation cases, the doctrine of deliberate indifference is unavailable. By virtue of her actions, the psychiatrist risked going to trial and an adverse outcome.

Deana Johnson, JD, is an attorney with Insley and Race, LLC, Atlanta, GA, and a frequent speaker at NCCHC conferences. Email her at djohnson@insleyrace.com. This article was adapted with permission from the Spring 2010 issue of CorrDocs, the Society of Correctional Physicians newsletter.
S
ince the 1998 Hartford Courant investigative report on deaths associated with seclusion and restraint, the use of these methods has come under stricter control by regulatory agencies. However, there is a shocking lack of data on the safety or danger of using seclusion or restraint. This article reviews gaps in scientific knowledge about the effective use of seclusion and restraint in correctional health settings, points to areas where studies may prove fruitful and indicates a model for improving care.

Restraining people is dangerous, both for the instigator and the interventor. In recent years, there has been progress in understanding how to manage agitated and violent behavior. Unfortunately, it is inconsistently practiced. This article outlines basic principles and methods of managing agitated behavior of healthy-appearing adult males in correctional medical and mental health settings. It excludes groups such as medically frail people, those under pharmacological treatment for chronic violent conditions, the elderly and those suspected to be chronically ill.

Currently, there are many ways of managing agitated and violent behavior. In order of generally accepted risk, they are de-escalation, seclusion, physical restraint, chemical restraint, nonballistic weapons and firearms. This article omits discussion of the latter two, and limits the term physical restraint to the use of standard four-point manual restraint systems used in medical settings.

Methods of Restraint and Seclusion

De-escalation
De-escalation is the use of talking to help calm an agitated person. Many methods exist, but unfortunately none have been empirically researched. Two are worth noting. Verbal Judo is used widely in law enforcement. This simple method has five steps: listening with empathy, giving a context, providing options, confirming noncooperation and acting. For situations where there is not likely to be an ongoing relationship with the agitated person, this method has been reported to be useful. Another method is Crucial Confrontation. Although empirical data is not given, the authors state they studied and interviewed 25,000 people over 20 years to develop the method. Designed for business and family situations, it is useful for corrections settings where an ongoing relationship with the agitated person exists. During my time as a corrections medical director I used both methods successfully while performing medical treatment in volatile situations.

Seclusion
Confining an agitated person to a quiet room can be an effective way to reduce agitated behavior. In one study of 263 episodes, the authors found that 83% demonstrated agitated behavior at the initiation of seclusion, but only 23% remained agitated upon release.

Seclusion can be voluntary (a time-out), verbally ordered or physically mandated. Although protocols vary, the Joint Commission and the Centers for Medicare and Medicaid Services have issued guidelines on the use of seclusion and restraint. The Joint Commission standard states that seclusion and restraint are used only to protect the immediate physical safety of people and not as a means of coercion or discipline; they are used only when other means are less effective; the least restrictive method of effective seclusion or restraint is used; and it is discontinued at the earliest possible time. NCOCHC standard I-01 Restraint and Seclusion makes a sharp distinction between medically necessary restraint and seclusion and restraints ordered by custody staff. Furthermore, it does not permit medical staff to participate in custody-ordered restraint except to monitor the health status of restrained people.

Physical Restraint
Physical restraint can be a dangerous practice, yet there is little literature concerning the rate of injury in correctional settings. Unfortunately, even death in restraint is not a separately reportable incident, and there is debate on how to classify it: accidental, homicidal, natural or undetermined.

In medical settings, physical restraint has been thought to cause death through asphyxiation, aspiration, cardiac arrest and other reasons. However, the data for injury or death in these settings is equally scant. But there is indirect evidence that an alarming problem exists. In 1994, the New York State Commission on Quality of Care reported 111 patient deaths in the preceding 10-year period in the medical setting that were related to restraint use. Also, the Joint Commission now collects data and has recorded 76 incidents of injury or death between 2004 and 2008.

Similar data for correctional settings could not be located but the potential magnitude of the problem is suggested by the following statistics. The Criminal Justice Statistics Center reported that in the 10-year period from 1994 through 2003, the State of California had 428 accidental deaths in custody. In the period between 1990 and 2004, the State of Maryland reported 45 accidental deaths in custody for which the cause of death remains unexplained. Finally, the U.S. Bureau of Justice Statistics reported that between 2001 and 2006, there were 377 deaths from either accidental or unknown causes. While most of these deaths may have been not related to restraint use, it is concerning that the data does not appear to be available.

Injuries related to the placement and use of restraints in correctional settings is likewise unknown. However, exertional rhabdomyolysis, pulmonary embolism and persistent emotional anxiety states have been attributed at least in part to the use of physical restraint and are consistent with the known mechanisms of these conditions. The safety or danger must be considered in the context of the rate of complications of alternate methods of management, which unfortunately, are also largely unknown.
Pharmacological Restraint

One alternative to physical restraint is pharmacological restraint. But it, too, can be dangerous. A variety of methods and medications can be used. Medications can be given orally (PO), intravenously (IV) or intramuscularly (IM).

Oral medications are painless to administer, but require cooperation of the person receiving them and take much longer to have therapeutic effect. For example, one commonly used agent, haloperidol, is effective 20 to 40 minutes after IM administration but takes three to six hours when given orally. However, oral medications have the advantage of not bringing a sharp needle into a volatile situation. IV administration has the most rapid onset, but gaining intravenous access can be difficult in uncooperative patients.

IM injections have an advantage over IV techniques in that they are easier to give and can be administered without the patient’s permission. However, they are painful and may cause complications such as cellulitis, abscess, phlebitis and hematoma (which, fortunately, are uncommon). The combination of rapid onset of action, ease of administration and the ability to give the medication to an uncooperative person make IM injection the route of choice in most patients with agitated behavior.

Another important set of risks is the side-effect profile of the drug given. Medications currently used are antipsychotics and benzodiazepines. Haloperidol is a typical antipsychotic drug. Its cardiovascular side effects include tachycardia, alteration in blood pressure and potentially fatal cardiac arrhythmia. Its central nervous system side effects include extrapyramidal symptoms, exacerbation of psychosis and neuroleptic malignant syndromes. Lorazepam is a typical benzodiazepine drug. Its side effect profile includes amnesia, weakness, unsteadiness, paradoxical disinhibition and potentially fatal apnea.

Newer antipsychotics such as olanzapine and ziprasidone have been used to alleviate acute agitation states. Both have few or no extrapyramidal side effects. Olanzapine does not carry a significant risk of cardiac arrhythmia in short-term use, but can cause diabetes with chronic use. Ziprasidone reaches peak therapeutic effect in as little as 30 minutes, but is associated with prolonged QTc syndrome, which may cause fatal cardiac arrhythmia. Both medications are much more expensive than haloperidol.

Few medications other than those named above have been studied in agitated behavior. This could be a useful area of study. Several agents used for procedural sedation in adults and children have rapid onset, short duration of action and limited side effects. For example, midohexital is a short-acting barbiturate that can be given intramuscularly with a rapid onset of action, typically less than 10 minutes. Its duration of action is less than 30 minutes when given to children for CT scans. Its use for IM injection in adults has yet to be studied. Midazolam has been shown to be much faster in onset than haloperidol or lorazepam (18 minutes vs. 28 to 32), and the time to arousal was also significantly faster, 82 minutes vs. 127 and 217. Various beta-blockers have been studied in the use of long-term therapy for violence disorders. Given the ability of these drugs to reduce tachycardia, blood pressure and other symptoms of arousal and agitated states, they may be useful in reducing agitated behavior acutely. This has yet to be studied.

Unintended Consequences?

The 1998 investigative series on restraint and seclusion raised public awareness of the problem and, in the intervening years, U.S. regulatory agencies have placed tighter control on the use of these methods. These regulations center on documenting the justification for restraint and intense monitoring of the restrained person in medical and psychiatric settings. This has prompted some institutions to develop policies of zero seclusion and restraint. This appears to be a laudable goal, and efforts to reduce the unnecessary use of restraints should be encouraged.

Unfortunately, resulting staff injury rates are rarely reported. In a letter to the editor, one program participant noted that while his directors reduced the use of restraints by 60%, the staff injury rate increase by 30%. Another problem is that agitated behavior can be the presenting symptom for a variety of potentially serious illnesses, including infection, metabolic disorders, endocrine disorders, trauma, pain, toxicologic disorders, structural brain abnormalities and psychiatric disorders. Even de-escalation may not be benign. I have seen cases where patients appeared to respond to de-escalation techniques, only to discover that they were actually getting too ill to mount further physical response.

Incarceration settings have a complex and volatile mix of detainees with a variety of medical, emotional and social illnesses. Most commonly accepted methods of managing violence in this setting have never been empirically tested. The publicity of death and poor outcomes associated with physical restraints has led to a trend toward limiting their use. Without adequate data, it is impossible to know if we have solved a problem or simply hidden it better.

There is a lot to learn. How do custody officers rapidly identify patients who are agitated because they require medical attention? Which de-escalation techniques are most effective? Are nonballistic weapons safer than five-person tackle techniques? When do the risks of physical restraint outweigh the risks of chemical restraint? These are just a few of the important questions that need to be answered.

And once we learn, we need to act. There are effective models for managing complex medical problems. Advanced cardiac life support was so successful that it was replicated by the American College of Surgeons as advanced trauma life support and by the American Academy of Pediatrics as pediatric advanced life support. It is time to develop a system of care that involves people and organizations from law enforcement, psychology, social work and medicine to work together to develop effective, safe and humane treatment of people with agitated and violent behavior.

Scott Savage, DO, CCHP, is a correctional medicine expert, a fellow of the American College of Emergency Physicians and a frequent speaker at NCCHC conferences. He currently works as a flight surgeon for Wyle Integrated Science and Engineering Group, Houston, TX.
Work Ethics: Where Do They Come From and Do You Possess Them?

by Susan Laffan, RN, CCHP-A, CCHP-RN

The U.S. Department of Labor estimates that 80% of workers who lose their jobs do so not because of lack of occupational skills, but because of poor work ethics. Clearly, ethics is an important issue in the workplace. Ethics are intrinsic, they come from within. It is very hard to teach someone else about ethics unless these values are demonstrated on a daily basis. Yet in the realm of work ethics, definitions and guidelines do exist.

For example, the International Council of Nurses calls for the nurse to promote an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

Leaders in the business world have identified essential work ethics that should be practiced and enforced to achieve a viable and effective workplace. (And there’s no denying, health care is a business.) Griffin Technical College in Georgia offers a helpful list of 10 work ethic traits:

- Appearance
- Attendance
- Attitude
- Character
- Communication
- Cooperation
- Organizational skills
- Productivity
- Respect
- Teamwork

Let’s look at each of these traits in more detail to get a better understanding of why each is so important and to discuss issues specific to the nursing profession.

**Appearance** refers to appropriate dress, grooming, hygiene and etiquette. Organizational dress codes are developed to ensure that all employees understand the expectation of proper attire in that workplace. This may include the absence of artificial nails and excessive jewelry, and the wearing of approved uniforms, not T-shirts, sweater vests or low-cut shirts.

**Attendance** pertains not only to employees showing up for scheduled shifts, but also being punctual and ready to begin working when the shift begins. This trait also refers to completing all assigned tasks and duties on time within the shift. For nurses this can be hard to accomplish at times due to variable factors such as patient volume, acuity and unexpected events, yet we should strive to complete all assignments in a timely fashion.

**Attitude** is demonstrated both by a positive attitude and self-confidence. An employee’s attitude is projected to patients, families, visitors, peers and managers. Tone of voice and facial expressions can give others the impression that we have “an attitude” even when this is not what we mean to portray. A positive attitude is expected at all times. We must also have realistic expectations of ourselves and understand that setting unrealistic goals or expectations can result in a poor attitude.

**Character** involves displaying loyalty, honesty, dependability, trustworthiness, reliability and initiative. It also encompasses the ability to follow rules, policies and procedures. Even in this day and age of too many tasks and not enough staff, if you are working with those who possess these traits the job seems easier because you can rely on others. Patients must trust and rely on nurses to provide quality health care. Patients also depend on nurses to be loyal and honest in the delivery of services.

**Communication** includes appropriate verbal and nonverbal communication with coworkers and with patients. Communication can alleviate many confrontations or it can escalate a situation if not done appropriately. Communication in the workplace does not include using your cell phone or text messaging in patient care areas or at nursing stations. These actions can be perceived as “not caring” gestures by onlookers. Communication also refers to real-time charting. This is important so that other health care providers can provide continuity of care.

**Cooperation** is important as it fosters collaboration between employees and provides a sense of accomplishment of common goals. Cooperation with other departments is critical to keep an efficient flow of services.

**Productivity** requires active participation. All health care providers must work within their scope of practice, and nurses must not forget that patient care is ultimately their...
responsibility. If a task needs to be performed that is normally delegated to others, a nurse may step in to take care of it. If a problem is identified, it is better to troubleshoot solutions than to just complain about it. Productivity may also include obtaining required educational certifications, competencies and licenses within expiration deadlines, and seeking further educational experiences such as college courses, conferences or continuing education credits.

Organizational skills include prioritizing and managing tasks assigned within appropriate time frames. These skills also demonstrate flexibility in handling change, thereby reducing potential stress. This may be one of the hardest traits to grasp if one does not understand time management. Organizational skills may be the key to prevent a situation that feels overwhelming from becoming chaotic.

Respect includes appropriately dealing with cultural, social and racial diversity, and treating others as you would want to be treated. Respect also includes the areas of confidentiality and harassment. The privacy of others is to be maintained, and gossip between employees is never appropriate. This often causes friction between employees, which may be perceived as a hostile work environment.

Teamwork is the coordinated effort of employees to produce a desired result, anticipated goal or common end. It involves being cooperative, being willing to help others and taking the initiative to do so.

From Principle to Practice
Each of these traits is important individually, yet they all intermingle to create a whole work ethic. The key to many of these traits is the sense of ownership we feel in our job or career. If we feel “connected” we are more likely to demonstrate these work ethic traits. In daily living we take care of our possessions, and so too should we take ownership in our job or career.

Nurses have additional guidance we can draw from. The American Nurses Association’s code of ethics for nurses includes nine general topics. These deal with compassion and respect; commitment to the patient; patient advocacy; accountability for individual nursing practice; responsibility toward oneself, the health care environment and employment conditions; advancement of the profession; collaboration with other health professionals; and articulating nursing values and maintaining the integrity of the profession.

As trained nurses, we know these principles, but do we put them into practice? It is common nature to want to do your best in everything you do. This is true in the workplace. You may not have a conscious thought of all the goals you set in any given situation, yet they are there. As nurses, we set goals continually. For example, we may aim to deliver medication on time, to alleviate a patient’s pain, to place an IV on a patient who has poor venous access and to provide all treatment ordered by the end of the shift. These are laudable goals, but we need to also keep in mind the big picture as outlined by complete set of ethics traits for our profession. We should strive to bring out all of the positive traits we possess—and to develop those that are lacking—to strengthen our work ethics.

This also works to the benefit of our organization as a whole. When there are many employees who possess strong work ethics, those who do not possess these qualities will quickly discover the expected standard and follow the good example that others set.

Susan Laffan, RN, CCHP-A, CCHP-RN, works in a New Jersey hospital emergency department and is co-owner of a business that provides infection control programs to municipal employees. She also works part-time as a correctional staff nurse and performs chart reviews for lawyers involved in correctional health care cases. Laffan is chair of the Academy of Correctional Health Professionals board of directors.

Work Ethics Self-Assessment
This self-assessment will help you discover the positive work ethic traits you already possess and those you might want to develop. If most of your answers are “yes,” you possess the traits that employers expect. If any answers are “no” perhaps it is time to reflect on those areas and set goals for improvement.

Appearance
☑️ Do you follow the workplace dress code?

Attendance
☑️ Do you miss work six or more times a year?
☑️ Are you ready to work at your scheduled shift?

Attitude
☑️ Do you display a positive outlook at work?

Character
☑️ Do your peers trust you in the workplace?

Communication
☑️ Do you follow the chain of command?
☑️ Do you give peers pertinent patient information?

Cooperation
☑️ Do you have common goals with peers on your shift?

Organizational Skills
☑️ Do you prioritize tasks and care for your shift?

Productivity
☑️ Do you complete all tasks/charting during your shift?

Respect
☑️ Do you respect peers?
☑️ Do you respect managerial staff?
☑️ Do you feel respected by others in the workplace?

Teamwork
☑️ Do you help others at work in completing tasks?
☑️ Do you feel others help you in completing tasks?
Correctional Nursing Practice: What You Need to Know (Part 3)

NCCHC’s Certified Correctional Health Professional program now offers specialty certification for RNs. The CCHP-RN certification is the formal recognition of the specialized knowledge, skills and experience deemed specific to the practice of nursing in a correctional setting. Whereas nursing licensure establishes legal authority for an individual to practice nursing, specialty certification reflects achievement of the special knowledge and skills needed for a particular practice area.

This column, written by members of the CCHP-RN task force, discusses various areas of correctional nursing practice covered in the CCHP-RN exam outline. This will assist nurses preparing to take the exam as well as explain the key concepts of the specialty for the novice correctional nurse. Learn more about the CCHP-RN program at www.ncchc.org/cchprn, where you can also view the entire test outline (see downloads).

Professional Development
A key area of correctional nursing professional development is collaboration. In correctional health care we have collaboration responsibilities not only with other care providers but also with our correctional staff colleagues. A valuable way to collaborate with correctional peers is through the establishment of a common purpose. Health care staff and custody officers work together within the enclosed community for mutual support and similar goals.

Correctional health expert Joseph Paris, MD, PhD, CCHP-A, suggests engaging in quality improvement efforts that would benefit both disciplines as a method to encourage collaboration (see his chapter on Interaction Between Correctional Staff and Health Care Providers in the Delivery of Medical Care in Clinical Practice in Correctional Medicine, 2nd Edition, by Michael Puisis, DO). Examples of good mutual projects might be reducing med line time or responding to medical emergencies. In addition, regularly scheduled communication points such as weekly or even daily briefings increase collaboration and communication.

Collaboration is more intense than mere involvement. Whereas involvement is sharing information about what is happening, collaboration is actually working together toward a common goal. Collaboration involves mutual decision making in a two-way exchange rather than merely assigning tasks or involving in actions. Collaboration uses a consensus approach rather than one-way communication.

When it comes to medical information, patient confidentiality must always be considered. According to NCCHC standard A-08 (Communication on Patients’ Health Needs), communication with custody staff should address “significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.” Provide the minimally necessary information needed to meet the safety need. For example, you might specify that a patient requires a lower bunk but not that he is epileptic, or that an inmate should not work in a job involving high temperatures, not that the inmate is mentally ill and receiving psychotropic medications. Enough rumors and assumptions make the rounds in a facility without adding to it.

Conditions that may require communication with custody to accommodate safety, housing or classification needs include chronic illness, dialysis, adolescents in adult facilities, communicable diseases, physical disability, pregnancy, frail elderly, terminal illness, mental illness, suicidality and developmental disability.

Professional development also includes consultation with other care providers. In this regard correctional nursing is similar to other practice settings, although there may be a larger group of disciplines to consider. Adherence to the team approach in all clinical processes is the ideal to strive for.

Conflicts can arise due to conflicting missions between custody and health care, as well as competing priorities among health care staff. The Department of the Navy has delineated the principles of conflict resolution as follows (see www.mediate.com/articles/navy.cfm for details):

• Think before reacting
• Listen actively
• Assure a fair process
• Attack the problem
• Accept responsibility
• Use direct communication
• Look for interests
• Focus on the future
• Options for mutual gain

Professional nursing practice requires continually upgrading knowledge, skills and abilities. Thus, other professional development areas to consider are peer review or competency evaluation of individual staff members, quality improvement efforts for clinical processes and accountability for continuing professional development such as maintaining licensure, remaining current with practice changes and proactively improving nursing skills.

Finally, professional development involves actively participating in the orientation and in-service activities for health care and custody staff. Corrections staff need to know their role in emergency medical situations, how to control infections in the facility and how to deal with common health issues like diabetes and hypertension, to name just a few.

Applying professional development principles to correctional nursing is a key component of the specialty. Those who pursue specialty certification must understand these principles and apply them in practice.

Lorry Schoenly, PhD, RN, CCHP-RN

Lorry Schoenly, PhD, RN, CCHP-RN, is a member of the CCHP-RN task force and coordinates this column. She is an independent consultant specializing in correctional health care and social media and is based in Pennsylvania. For correspondence about this column, write to editor@ncchc.org.
Treat HIV Confidently With TRUVADA

- Demonstrated efficacy and tolerability profile through 3 years in Study 934
- DHHS-preferred dual-NRTI backbone for more than 5 years
- Chosen partner with leading PIs

Depend on TRUVADA to be your NRTI backbone

Important Safety Information

- WARNINGS: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including VIREAD, a component of TRUVADA, in combination with other antiretrovirals.
- TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of TRUVADA have not been established in patients coinfected with HBV and HIV. Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV and who have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue TRUVADA. If appropriate, initiation of anti-HBV therapy may be warranted.

Dosage and administration

- Recommended dose: one tablet (containing 200 mg of emtricitabine and 300 mg of tenofovir disoproxil fumarate) once daily taken orally with or without food.
- Dose recommended in renal impairment: creatinine clearance (CrCL) 30–60 ml/min: take every 48 hours; CrCl <30 ml/min or hemodialysis: do not use TRUVADA. The safety and effectiveness of these dosing adjustment recommendations have not been clinically evaluated in patients with moderate renal impairment, clinical response to treatment, and renal function should be closely monitored in these patients.
- No dose adjustment is necessary for patients with mild renal impairment (CrCL 50–80 ml/min).

Warnings and precautions

- New onset or worsening renal impairment
- Lactic acidosis and severe hepatomegaly associated with steatosis have been reported with the use of nucleoside analogs, including VIREAD, a component of TRUVADA, in combination with other antiretrovirals.

References:

Please see brief summary of full prescribing information on following page.
Truvada U=emtricitabine/tenofovir disoproxil fumarate U=

ADVERSE REACTIONS

Adverse Reactions from Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The most common adverse reactions in adults (any severity) occurring in ≥5% of patients treated with Truvada in clinical trials were nausea, headache, bone pain, and diarrhea.

In clinical trials, the most common laboratory abnormalities were changes in hemoglobin, ALT, AST, alkaline phosphatase, creatinine, and total cholesterol.

CONTRAINDICATIONS

None

WARNINGs AND PRECAUTIONS

Lactic Acidosis and Severe Hyperammonemia

Lactic acidosis and severe hyperammonemia, with fatal outcomes, have been reported with the use of nucleoside analogues, including Emtricitabine/tenofovir disoproxil fumarate, a component of Truvada. These conditions, which require immediate medical attention, were also reported in patients who were coinfected with HIV and HBV and had a history of drug or alcohol use.

These conditions, which require immediate medical attention, were also reported in patients who were coinfected with HIV and HBV and had a history of drug or alcohol use.

Liver Transplantation

Liver transplant recipients who are positive for hepatitis B and hepatitis C and who are being treated with Truvada have been hospitalized or died due to hepatitis flares.

Patients with Hepatitis B

Patients with a recent history of hepatitis B infection may be at risk for developing exacerbation of hepatitis B. Patients with a recent history of hepatitis B infection may be at risk for developing exacerbation of hepatitis B.

Patients with Hepatitis C

Patients with a recent history of hepatitis C infection may be at risk for developing exacerbation of hepatitis C. Patients with a recent history of hepatitis C infection may be at risk for developing exacerbation of hepatitis C.

Lactic Acidosis

Lactic acidosis has been reported in patients taking nucleoside analogues, including Emtricitabine/tenofovir disoproxil fumarate, a component of Truvada. Lactic acidosis is a potentially fatal condition, and it requires prompt medical attention.

Severe Hyperammonemia

Severe hyperammonemia has been reported in patients taking nucleoside analogues, including Emtricitabine/tenofovir disoproxil fumarate, a component of Truvada. Severe hyperammonemia is a potentially fatal condition, and it requires prompt medical attention.

INFORMATION FOR PATIENTS

Please read the full Prescribing Information before using Truvada. The Prescribing Information includes information on how to use Truvada, how to take it, and important things to consider before using Truvada.

FOR MORE INFORMATION

To learn more about Truvada and its use, please visit www.truvada.com or call 1-800-332-1122.

Please see the full Prescribing Information for Truvada included at the end of this document.
Understanding of Key Jail Characteristics Needed to Inform Research Findings

All jails are alike and no two are the same.—Potter, 2007
If you’ve seen one jail, you’ve seen one jail.—Rosenberg, 2009

So begins the article titled “Jails, Public Health, and Generalizability” in the latest issue of the Journal of Correctional Health Care. Certainly those who work in the field of corrections grasp the fundamental differences between prisons settings and jail settings, and those who work in the latter appreciate the differences that characterize various types of jail facilities.

Yet the research literature is filled with what JCHC author Roberto Hugh Potter, PhD, calls “vaccine thinking.” That is, in the realm of public health, conventional wisdom seems to be that if something works in one jail, it will work in all jails. To illustrate, Potter presents several examples from the literature that make broad statements about the significance of research findings as well as recommendations for “jails” in general. However, those studies often focused on just one or a few facilities and, more problematic, often failed to note important contextual aspects of the setting.

There are more than 3,000 jail systems in the United States, and they are complex and decidedly not homogeneous, says Potter, who is the director of research and a professor in the department of criminal justice and legal studies at the University of Central Florida, Orlando. Potter is also a member of JCHC’s editorial board. “This lack of acknowledgment of the distinctions among systems makes the generalizability of the recommendations and statements weak,” he writes.

Elements That Matter
To improve researchers’ understanding of how jails operate and to help strengthen their study methods, analyses and conclusions, Potter explains five factors that “matter” when seeking to generalize knowledge about jails in efforts to develop or recommend health practices and policies. Each factor is discussed in depth in the article, but in brief they are as follows:

- The process by which individuals come to and are processed through the jail. The two systems described are indirect (from lock-up) or direct (from the arresting officer). This determines who ends up in jail (vs. being released on bond, for example) and, to a large extent, their population status.
- The size of the jail or system, defined as small, medium or large based on average daily population. Most studies have been done in large jails or systems with more than 1,000 inmates. Conversely, very little is known about health issues in jails of fewer than 250 inmates, although about half of all jails fall into this category.
- The region of the country (Northeast, Midwest, South, West) and urban vs. rural county. Jails are not distributed evenly across the country, with the South accounting for half of all jails and nearly half of the large jail networks.
- Similarly, neither crime patterns (reasons for arrest) nor health problems are uniform across the country. However, a disproportionate number of studies are from the Northeast, the region with the fewest jails.
- Classification/assessment procedures. “Clinical” approaches are variable and subjective whereas “actuarial” approaches are standardized and objective. These aspects are that assessment of an inmate’s risk determines housing and is especially meaningful for vulnerable populations.
- Architecture and supervision style: Four generations are noted. First is the traditional linear design, second is podular indirect supervision, third is the newer open plan that enables direct supervision, and the fourth builds on the open plan by providing various inmate services in the common area. Again, these features can have an impact on risk.

Finally, the article provides a generalizability grid to aid researchers in drawing appropriate conclusions.

JCHC Volume 16, Issue 4
Jails, Public Health, and Generalizability — Roberto Hugh Potter, PhD
Association of Medically Attended Traumatic Brain Injury and In-Prison Behavioral Infractions: A Statewide Longitudinal Study — Eric J. Shiroma, MED, MS, E. Elisabeth Pickelsimer, DA, Pamela L. Ferguson, PhD, Mulugeta Gebregziabher, PhD, Pamela K. Lattimore, PhD, Joyce S. Nicholas, PhD, Tony Dukes, PhD, Kelly J. Hunt, PhD
Evaluation of a Psychometric Instrument Designed to Assess the HIV Risk Behaviors of Ex-Prisoners — Joseph A. Balogun, PT, PhD, Titilayo C. Abiona, MD
Correctional Nursing Competency Development in the Connecticut Correctional Managed Health Care Program — Deborah Shelton, PhD, RN, CCHP, Constance Weiskopf, PhD, APRN, CCHP, Michael Nicholson, MBA, RN
Jail-Based Providers’ Perceptions of Challenges to Routine HIV Testing in New York City Jails — Charulata J. Sabharwal, MD, MPH, Kathy Hunt Muse, JD, Howard Alper, PhD, MS, Elizabeth Begier, MD, MPH, Michele McNeill, Ghairunisa Galeta, MPH, Katy Huang, MMSc, RN, Woodman Franklin, and Farah Parvez, MD, MPH
Young Prisoners: An Important Group for Health Research? — Käte van Dooren, BSc, Stuart A. Kinner, PhD, Tony Butler, PhD

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

Members of the Academy of Correctional Health Professionals receive JCHC (hard copy and online) as a benefit of membership. To learn how to obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
Prevention can cost less than you think; treatment may cost more.

The average cost of treating a MRSA infection in the hospital has risen to over $60,000\(^1\), and that cost does not include the staff time required to supervise a hospitalized inmate.

Correctional facilities are at high risk for the spread of skin infections due to the close quarters and crowding that is unavoidable in these environments.

Hibiclens\textsuperscript{\textregistered} and Hibistat\textsuperscript{\textregistered} wipes can help prevent bacterial infections and viral illnesses by providing an extra benefit on the skin. Both products contain CHG, which bonds to the skin and provides continuous killing action for up to 6 hours after use\(^2\). It is simply not possible to wash and bathe after every potential contact with contaminants, but Hibiclens and Hibistat wipes can help provide lasting protection against contamination that may lead to illness or infection. Hibiclens has also been proven in a dermatological test to be non-irritating to the skin\(^3\).

We can assist you with a plan to reduce infection rates and fit within your budget. You can find your local Representative by going to www.Hibiclens.com or by calling 800.849.0034.

Hibiclens and Hibistat wipes are available through your correctional distributor. They may also be purchased at CVS, Walgreens, Rite Aid, Target, Walmart, Stop & Shop, Giant, and SuperValu stores in the first aid section.

Tobacco Returns to Some Oklahoma Prisons

When tobacco was banned in all Oklahoma prisons in 2004, a key reason cited was that smoking-related health care made up nearly half of all hospital expenses in the system. In a change of policy, inmates in minimum-security facilities may now smoke in designated outside areas. The rationale is that monitoring the contraband is more difficult now with budget-imposed deep staff cuts, and that smoking in this population won’t have much impact on health care because of their shorter sentences. No policy change is planned for medium- and maximum-security prisons.

Source: www.newsok.com/smoking-to-be-allowed-again-in-some-oklahoma-prisons/article/3478368

Death Rate Down in Local Jails

The annual mortality rate per 100,000 local jail inmates declined from 152 to 141 deaths between 2000 and 2007, according to the Bureau of Justice Statistics. However, the total number of deaths rose during each year, from 905 in 2000 to 1,103 in 2007, due to a growing jail population that jumped 31\% in the same period, from 597,226 to 782,592.

The suicide rate declined from 48 to 36 per 100,000 jail inmates in the eight-year period, continuing a longer decline from 129 per 100,000 in 1983. Nevertheless, suicide was the leading cause of death, accounting for 29\% of the deaths. Suicide rates were higher in small jails than large jails. In jails holding 50 or fewer inmates, the suicide rate was 169 per 100,000; in the largest jails, the rate was 27 per 100,000.

Various illnesses accounted for 53\% of all deaths, with heart disease the single leading illness-related cause (22\%). Deaths from AIDS-related causes accounted for 5\% of all deaths in jails.

Source: bjs.ojp.usdoj.gov/content/pub/press/mlj07pr.cfm

Know Hepatitis?

The CDC’s National Training Center for Integrated Hepatitis HIV/STD Prevention Services offers six new training webinars for frontline workers. They can be viewed for free at the KnowHepatitis Web site. Among the topics are What Every Outreach Worker Should Know About Hepatitis C Treatment; Chronic Hepatitis B in Asian American, Native Hawaiian and Other Pacific Islander Communities; Viral Hepatitis and Persons Living with HIV; and Gay Men and Viral Hepatitis: What Front Line Providers Need to Know.

Source: www.knowhepatitis.org

Fingerstick Devices: One Per Person, Please

We know that our smart readers would never do such a thing, but the CDC is reminding clinicians that using a fingerstick device on more than one person introduces risk of transmitting bloodborne pathogens. The concern stems from increasing reports of hepatitis B infections that are linked to diabetes.

Source: www.cdc.gov/injectionsafety/Fingerstick-DevicesBGM.html
The GEO Group’s success around the world has been achieved by our highly-trained work force. Our team of over 13,000 highly skilled professionals manages approximately 55,000 offenders and residents on behalf of government agencies worldwide.

Our philosophy is to hire only the best professionals in their field. In return, we provide our employees with competitive compensation and excellent benefits as well as an environment in which personal goals are encouraged and professional opportunities are within reach. GEO provides the work-life balance, training, education, and mentoring you need to make your vision a reality.

Discover a world of opportunities…visit our website and explore the many outstanding careers available to talented individuals like you.

Opportunities are available in many of our facilities across the country, such as:

HEALTH SERVICES ADMINISTRATOR, RN (South Florida)
REGISTERED NURSES
PHYSICIANS (full and part-time)
MEDICAL SERVICES DIRECTOR
NURSE PRACTITIONERS

There’s never been a better time to join our growing group of professionals.

Take the first step towards a “World of Opportunities” by visiting www.geogroup.com. Click on “Careers,” then “Career Search.” For more information, you may also contact:
Nichole Vinci-Adamson, Manager, National Recruitment, Toll Free: 866-301-4436, Ext 7537
Fax: 561-443-3839 • Email: nvinci@geogroup.com

www.geogroup.com
Equal Opportunity Employer • All candidates must be able to pass background investigation, drug screen and medical evaluation
Congrats to First CCHP-RNs!
Fourteen registered nurses who participate in the Certified Correctional Health Professional program make up our inaugural group of CCHP-RNs! Designed to recognize the work that correctional RNs do and the difference they make, this specialty certification program held its first exam earlier this year; certification for this group begins Oct. 1. Exams will be held several times a year, including at NCCHC conferences (see calendar below). To learn more and to obtain an application, visit www.ncchc.org/cchp-rn.

- Dyni Brookshire, RN, CCHP-RN
  Health Services Administrator
  Jefferson County Jail, Lumberton, TX
- Cristi Davis, BSN, RN, CCHP-RN
  Director of Health Services
  Emerald Health Systems, Lubbock, TX
- Janice Hill, MPH, RN, CCHP-A, CCHP-RN
  Health Care Consultant
  Redington Beach, FL
- Lisa Hirsch, BSN, CCHP-RN
  Jail Nurse
  Coconino County Detention Facility, Flagstaff, AZ
- Diane Hollenbeck, RN, CCHP-RN
  Southern State Correctional Facility, Vineland, NJ
- Liza Jervis, RN, CCHP-RN
  Department Nurse Manager
  UMDNJ University Correctional HealthCare, Saddle Brook, NJ
- Mari Knight, MSN, RN, CCHP-RN
  Regional Director of Nurses
  Correctional Medical Services, Trenton, NJ
- Linda Lawrence, ASN, RN, CCHP-RN
  Regional Clinical Coordinator
  Correctional Medical Services, Calera, AL
- Peggy Minyard, BSN, MSHCA, CCHP-RN
  Regional Director of Nursing
  Correctional Medical Services, Helena, AL
- Tre O’Brien, BSN, RN, CCHP-RN
  Clinical Education Specialist
  Correctional Medical Services, Moriarty, NM
- Bernardine Scott, RN, CCHP-RN
  RN Staff Educator/Trainer
  Oregon Department of Corrections, Philomath, OR
- Nancy Sue Smith, MSN, RN, CCHP-RN
  Asheville, OH
- Jean Squires, BSN, RN, CCHP-RN
  Supervising RN II
  Salinas Valley State Prison, King City, CA
- Ellen Timmreck, ADN, RN, CCHP-RN
  Southern State Correctional Facility, Green Creek, NJ

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location/Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 19</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>May 22</td>
<td>Phoenix, AZ</td>
</tr>
<tr>
<td>July 10</td>
<td>Las Vegas, NV</td>
</tr>
<tr>
<td>August 20</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>October 16</td>
<td>Baltimore, MD</td>
</tr>
</tbody>
</table>

For more information 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.
Beyond a reasonable doubt...

*Medi-Dose® and TampAlerT®*

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They’re tamper-evident, ultraviolet inhibitant and minimize errors and pilferage. Plus Medi-Dose contains no metal or glass!

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitant polyethylene, with either regular or child-resistant screw caps. Each cap contains a tamper-evident seal. And TampAlerT contains no metal or glass!

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

There’s no doubt about Medi-Dose and TampAlerT, proven in correctional facilities for over 30 years.

---

**Medi-Dose, Inc.**

**EPS®, Inc.**

Responding to pharmacy packaging needs around the world

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.medidose.com
E-mail: info@medidose.com
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

National Sheriffs’ Association

Congratulations to B. J. Roberts, who in June was sworn in as the NSA’s new president. Roberts is the sheriff for the city of Hampton, VA, and represents the NSA on NCCHC’s board of directors. The association represents the nation’s 3,083 elected sheriffs. Over the next year, Roberts will guide NSA’s efforts to support sheriffs’ offices nationwide, particularly with regard to public safety, jail operations and federal legislation.

Robert Wood Johnson Foundation

RWJF has named a correctional health professional as a recipient of its Community Health Leaders Award for her efforts to provide health care to current and former inmates, and thereby improve the health of the communities where they live. Early in her career, Shira Shavit, MD, worked in a clinic where pregnant inmates gave birth and later in the Alameda County (CA) Jail. When she observed that new releasees had a high risk of dying within two weeks as result of losing access to jail-based health care, she joined the Transitions Clinic in San Francisco, an independent clinic that collaborates with the public health department to provide care for former inmates and help manage their transition to the community. They also have a program with the San Quentin prison to provide inmate health services that continue upon reentry. The selection committee lauded Shavit’s “courage and commitment to an often forgotten and unsympathetic population.”

Thomas J. Fagan, PhD

Already a prolific author, Tom Fagan, PhD, has notched another one. Coedited with Robert Ax, PhD, Correctional Mental Health: From Theory to Practice offers best practices for this challenging area of care. Fagan, who represents the American Psychological Association on NCCHC’s board of directors, has vast expertise in this topic. He spent nearly 25 years at the Federal Bureau of Prisons in various roles including regional psychology services administrator and director of clinical training for psychology services. For the past 10 years he has taught at the college level. The book is due to be published by Sage in December. Look for it at the NCCHC bookstore (online and at conferences).
Updates in Correctional Health Care
Sheraton Hotel • Phoenix, Arizona • May 21-24, 2011

With a theme of “Emerging Issues,” Updates 2011 is designed to shed light on many of the hot topics that affect this field and to propose strategies for managing them. A broad array of sessions will address new treatment modalities, updated practice recommendations, evolving standards of care, shifts in patient presentation trends, ever-changing laws and regulations, innovative cost containment and more. Where better to educate potential customers about your products and services than here? Nearly 1,000 correctional health professionals will be in attendance and looking for solutions from you!

Vast Potential
With 2.3 million individuals incarcerated in the United States, serving their wide-ranging health care needs is big business. In fact, correctional facilities spend roughly $7 billion each year to provide this government-mandated care. Services span the spectrum, from acute care to chronic disease management to routine care, including dental and mental health, along with substance abuse treatment, prevention and health education. That’s a big challenge—and a big opportunity for companies that serve this market.

Exhibitor Benefits
• 2 full conference registrations per 10’ x 10’ booth
• Discounted full registration for up to 5 additional personnel
• 75-word listing in the Final Program (deadline applies)
• Electronic attendee lists for pre- and post-show marketing
• Free basic listing in NCCHC’s online Buyers Guide
• Discounted advertising in meeting programs & CorrectCare
• Lead retrieval technology available for rental on site
• Opportunity to participate in raffle drawings
• Priority booth selection for the 2011 National Conference

Sponsorship Opportunities
Enhance your presence and maximize marketing dollars through these outstanding opportunities.
• Premier programming: Educational sessions and breakfast/luncheon programs give attendees a fresh experience while giving your company exclusive exposure.
• Final proceedings: With your company's name on the cover, the CD-ROM enables attendees to continue their learning with these PowerPoint presentations.
• Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
• Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
• Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

Registration Information
Don’t miss this great opportunity to meet with important contacts and raise your profile in this specialty field. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details and a reservation form, see the Exhibitor Prospectus, available online at www.ncchc.org, or contact Kim Simoni, exhibits and sales manager, at conference@ncchc.org or 773-880-1460.
EMPLOYMENT

Come Join Our Winning Correctional Health Team at CFG Health Systems

CFG Health Systems, LLC (sister corp. of Center for Family Guidance, PC) is a physician-owned and operated healthcare organization providing comprehensive mental health and medical services to thousands of inmates across the region. With its comprehensive experience in psychiatry, medicine, nursing, psychology and dentistry, CFG is a full service provider of care dedicated to meeting the needs of its patients. We offer many diverse career opportunities with excellent benefits and are currently looking to place professionals within several correctional facilities in the Mid-Atlantic Region:

- Medical Directors/Physicians
- Psychiatric Nurse Practitioners
- Dentists (General Dentistry)
- Medical Nurse Practitioners
- DON’s/RNs/LPN’s
- Administrators

Please contact:
Frank Zura, MA, Ed., 856 797-4760, fzura@cfgpc.com, www.cfghealthsystems.com
Nancy DeLapo, Director, 856 797-4761, ndelapo@cfgpc.com, www.in-sight.net

Associate Medical Director
Taycheedah Correctional Institution

The Wisconsin Department of Corrections is seeking a dynamic leader who is board certified in family medicine or internal medicine to fill our Associate Medical Director position at Taycheedah Correctional Institution.

Correctional healthcare experience a plus but not necessary. Become a part of our healthcare team addressing both individual healthcare and population health and quality improvement. This position will be approximately 2/3 patient care and 1/3 leadership and management. The position reports to the Department Medical Director. Travel to other female institutions will be required to provide supervision and guidance to physicians and nurse practitioners.

Starting salary at $195,000 annually plus an excellent benefits package.

Excellent benefits package to include: immediate coverage under the Wisconsin Retirement System, health plans available to meet your needs at low premiums, sick leave (5 hours/pay period), unused sick time converted to extended health care benefits upon retirement, 3 weeks paid vacation, 4.5 personal days/year, 9 paid legal holidays/year, life insurance, supplemental retirement saving program, worker’s compensation.

Application Information
For a detailed job description and application information, please see announcement on http://wisc.jobs.

We are an Equal Opportunity Employer.

ADVERTISER INDEX

Abbott Laboratories – Kaletra.................................9
Bristol-Myers Squibb – Sustiva..............................5
CCHP-RN Certification...........................................IFC
Correctional Health Partners...............................7
CorrecTek..............................................................24
Dentrust Dental.....................................................25
GEO Group............................................................21
Gilead Sciences – Truvada.................................17-18
Hibiclens & Hibistat..............................................20
Medi-Dose.............................................................23
MHM Services......................................................BC
Prison Health Services (PHS)..............................14, 27
Spectra Diagnostics..............................................IBC
Standards for Health Services..............................28
Wexford Health Sources......................................22
Wisconsin Department of Corrections..............26, 27
Dentist
Wisconsin Department of Corrections

We are seeking Dentists to work at the following facilities:

- New Lisbon Correctional Institution (New Lisbon) (.75 FTE)
- Wisconsin Secure Program Facility (Boscobel) (.30 FTE)
- Oshkosh Correctional Institution (Oshkosh) (.50 FTE)

Must possess a license to practice Dentistry in the State of Wisconsin.

Starting salary for full-time (1.0 FTE) is at least $135,383 annually ($64,839/hour) plus an excellent benefits package.

As a full-time state employee this position has an outstanding benefits package. Benefits include:

- Paid vacation
- 36 hours personal holiday
- 16 sick days per year
- Health insurance
- Ability to convert sick leave to pay for health insurance on retirement
- Retirement plan currently at 11.2% annually
- Optional deferred compensation program available

Application Information

For a detailed job description and application information, please see announcement on http://wisc.jobs.

We are an Equal Opportunity Employer.

About CorrectCare™

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

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

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

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

A LEADERSHIP OPPORTUNITY WITH AN INDUSTRY LEADER

Enjoy work that is challenging and rewarding, in a place where the standards for employee safety and satisfaction couldn’t be better.

PROGRAM MEDICAL DIRECTOR

PHS Medical Services, PC is seeking a dynamic physician leader to serve as the Program Medical Director for its comprehensive medical and mental programs at Rikers Island and Manhattan Detention Center. Under a contract with the New York City Department of Health and Mental Hygiene, PHS Medical Services, PC provides cutting edge correctional healthcare to an average population of 12,750 patients using state of the art equipment and systems. As the Program Director, the successful candidate will oversee 750 clinical staff members including specialists and ancillary healthcare staff. Responsibilities will also include site audits, chairing the PC’s Quality Assurance Program, representing the PC at internal and external interdisciplinary meetings and the development of policies, procedures and protocols.

The successful candidate must have a New York license to practice medicine and a Board Certification in Internal Medicine, Family Practice or Surgery. The candidate must also have 15 years of clinical experience, progressive managerial/leadership responsibilities within an advanced information technology environment, 5 years of correctional healthcare experience, a Masters of Public Health and a CCHP are recommended.

The salary and benefits are commensurate with the Greater New York City area and responsibilities. Please submit your resume to PHS Medical Services, PC at PHSNYC@riepf.com or fax to 718-777-3649.

www.ncchc.org
Sharing Forensic Information

**Q** Where do we draw the line on what is considered “confidential” patient information? Health services conducted a urine toxicology screen of a prisoner and the results indicated the presence of an illicit drug. Is this protected medical information or should we notify custody? Do we just drop a hint, or do we name names?

**A** Assuming that the test was for clinical purposes (and it should have been, as per standard I-03 Forensic Information), the results should be used for clinical reasons only. You may share with the appropriate officials your concern that the substance may be present in the prison so that they can look into the possible security breach. However, the inmate’s identity must be protected. To avoid conflict or pressure from custody, health services policies and procedures should address the role of health staff in such an event and the warden and custody staff should have a clear understanding of this role. (See A-03 Medical Autonomy and H-02 Confidentiality of Health Records.)

Mental Health Screening Personnel

**Q** Who is allowed to do mental health screenings of inmates admitted to our jail? We already use nurses to do the health assessments. Can we train them to do the mental health screenings, as well?

**A** This issue is addressed in the “screening” element of important standard E-05 Mental Health Screening and Evaluation (the standard for prisons is exactly the same except it is designated as essential). This standard’s intent is to “ensure that the inmate’s serious mental health needs, including those related to developmental disability and/or addictions, are identified.”

All inmates are to receive an initial mental health screening that covers the issues listed in Compliance Indicator 2. This screening may be done by mental health staff, which NCCHC defines as qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services. If so trained, your nurses would qualify as mental health staff for the purposes of this standard.

Those nurses may not, however, conduct the subsequent evaluation of inmates who screen positive for mental health problems. Rather, the evaluation must be done by a qualified mental health professional, such as a psychiatrist, psychologist, psychiatric nurse or psychiatric social worker (Compliance Indicator 4).

Mental Health Staff and CPR

**Q** We don’t think that cardiopulmonary resuscitation certification should be required for mental health liaisons because we don’t view them as qualified health care professionals like our medical staff are. Are we correct?

**A** No. NCCHC defines qualified health care professionals as physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients. Therefore, if the mental health liaisons are evaluating and caring for patients, then these mental health professionals fit into the definition of qualified health care professional and are required to be current in CPR technique under essential standard C-03 Professional Development.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. If you have a question about the NCCHC standards, please write to info@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A columns, visit the Resources section at www.ncchc.org.
58 million tests
a year have taught us one thing:
you deserve more from your
lab than just test results.

Visit us at www.spectradiagnostics.com
to learn how we're personalizing lab services
for the correctional healthcare community.

© 2010 Fresenius Medical Care Holdings, Inc. All rights reserved.
Spectra, Spectra Diagnostics, and are trademarks of Fresenius Medical Care Holdings, Inc.
"WE REDUCED SELF-INJURIOUS BEHAVIOR BY 67% AND RELATED HOSPITALIZATIONS BY 83."

“MHM’s clinical operations team goes on-site to client facilities to design custom behavioral management interventions that work – for even the most difficult inmates.”

MHM is the leading national provider of correctional mental health services. By identifying the functional reasons for severe self-injury, our behavior management experts create and implement interventions that minimize incidents and hospitalization. As a result, our clients realize lower costs and safer facilities.

Delivering correctional healthcare the right way costs less. To find out how, contact Dr. Sharen Barboza at 800.416.3649 or sbarboza@mhm-services.com.

MHM Correctional Services, Inc
The Public-Private Partner for Healthcare

www.mhm-services.com