MUMPS!

A Jail Outbreak and Public Health Response

Acute Psychotic Delirium and Sudden Death in Custody

Position Statement: Restraint of Pregnant Inmates
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Geriatric and Palliative Care Education for Correctional Health Professionals

Aging inmates are straining correctional health care systems across the country, and the burden is likely to increase as this segment of the inmate population continues its rapid growth. In Kansas, which ranks 10th among states in the percentage of the “oldest old,” an innovative multidisciplinary organization has long sought to improve care for the state’s geriatric population by providing health professionals with training and resources for high-quality, evidence-based care. Now, the Central Plains Geriatric Education Center has set its sights on correctional settings.

NCCHC has entered into a five-year agreement to help the CPGEC develop and deliver professional education on geriatric and palliative care for correctional populations. The aim is to collaborate with experts in a variety of health-related disciplines to determine needed competencies, generate content for attaining those competencies and develop multifaceted ways to meet the professionals’ learning needs. This education will be available to correctional health professionals throughout the nation. The CPGEC, which was launched in 1998, is housed at the Landon Center on Aging on the campus of the University of Kansas Medical Center.

This important project is a major step toward enabling correctional systems to provide evidence-based care to a challenging patient population, promising not only to transform care delivery and patient outcomes, but also to significantly reduce health care expenditures.

Welcome to New Board Members!

The National Commission and its board of directors welcome three new members to the board. Each officially joined in October, at the annual meeting of the board.
- Pauline Marcussen, RHIA, CCHP, representing the American Health Information Management Association
  Marcussen works as interdepartmental project manager in the medical records unit of the Rhode Island Department of Corrections; she also teaches at Community College of Rhode Island.
- Ryung Suh, MD, representing the American College of Preventive Medicine
  Suh is the president and chief executive officer of Atlas Research, a research and consulting firm based in Washington, DC; among other positions, he also teaches at Georgetown University Medical Center and other institutions, is a senior fellow at the National Opinion Research Center, and holds several hospital appointments.
- Patricia Voermans, RN, CCHP-RN, representing the American Nurses Association
  Voermans is a health services consultant primarily doing quality improvement and other special projects, as well as a nurse practitioner for the Wisconsin Department of Corrections; she also is a lead accreditation surveyor for NCCHC.

In Other News...

Board Election Results. Congratulations to Carl Bell, MD, CCHP, whom the NCCHC board of directors voted to be chair-elect at its annual meeting in October. Bell has represented the National Medical Association on the NCCHC board since it was established in 1983 and has been an active participant, serving on numerous committees, doing accreditation surveys, contributing to Standards manuals and more. A board-certified psychiatrist, he is the CEO/president of the Community Mental Health Council, a comprehensive mental health center on Chicago’s South Side, and director of the Institute for Juvenile Research in the Department of Psychiatry, College of Medicine, University of Illinois at Chicago.

In October 2009, the NCCHC board of directors chose Peter Ober, JD, MSED, PA-C, CCHP, as chair-elect. However, early in 2010 he stepped up into the chairman role when the sitting chair had to resign. Now, as he enters his second year of directing the board, he shares tidbits about his career, his views on correctional health care, and his focus for his term as chair.

First, some background. After completing his freshman year of college, Ober joined the U.S. Air Force when he learned that it offered both paid tuition and a paycheck. He trained as a medical technician and worked three years in a hospital emergency room, where he “became enthralled by the medical profession.” That led to a degree in the relatively new career of physician assistant. “It opened up a new world to me as I worked in family medicine and the emergency room at several USAF bases all over the country and in Japan.” In the mid-80s, he became chief of a primary care clinic and medical laboratory with responsibility for medical care of senior Air Force officers and Department of Defense officials.

During his 20 years in the Air Force, however, Ober’s educational and professional paths both expanded far beyond health care. He attained a master’s degree in education and later a doctorate in law and, related to his Air Force work, he trained in special investigations and counterintelligence.

In the final few years of his Air Force career, he commanded investigations in the United States and Saudi Arabia, and supervised training at the USAF Special Investigations Academy, where he also taught criminal law to new agents.

A Career Shift

So how did that career path lead to corrections? Ober calls himself an “accidental correctional health professional.” As Air Force retirement approached, he felt called to return to medicine and patient care. In May 1992, a physician assistant job at the Washington, DC, Department of Corrections provided the flexibility he needed to manage both roles.

His introduction to correctional health care shocked him, however. “Unlicensed practitioners, poor or no standards, too few health professionals for too many patients with very poor health,” Ober recalls. “I did the best I could under that system, but it was clear to me that it needed to be changed.”

He spent four years at that facility while simultaneously (upon retirement from the Air Force) working as chief physician assistant at Fredericksburg (VA) Emergency Medical Associates, a position he still holds.

In 1996, Ober took an opportunity to start a partnership with an emergency medicine physician and provide contract services to a new regional jail in Stafford County, VA. His goal was to create a health care system far better than what he experienced in DC. While researching jail medical operations he discovered NCCHC and used its standards and other information to develop the new system.

As he and his business partner began to attend NCCHC conferences and meet its staff, including vice president Scott Chavez, PhD, MPA, CCHP-A—also a physician assistant—he wanted to become involved with the Commission. He became certified through the CCHP program, took surveyor training and in 1999 sought, and attained, appointment to the board of directors representing the American Academy of Physician Assistants. “I believe that is when my real education about correctional medicine began,” he notes.

Today, Ober is still managing partner at Rappahannock Creative Health Care, based in Fredericksburg, VA, with a client roster of six county and regional jails and a weekly patient care workload of 20 to 30 hours. He also puts in 35 to 40 hours in the ER of a local hospital. Combined with management time for both roles, his workweeks sometimes reach 80 hours.

Challenges and Rewards

Pondering correctional health care, Ober notes the stark differences between his highly educated, generally healthy Air Force patients and the complex illnesses of inmate-patients. “The contrast hooked me pretty quickly,” he says. But these challenges are also the source of job satisfaction: “It is particularly rewarding to have a resistant and difficult patient with complex chronic disease see the light and make remarkable strides to recovery. That’s hard to match in any other area of medicine.” He credits NCCHC’s chronic disease guidelines for helping with this care.

The most difficult part of correctional medicine, Ober says, comes from the need to create and maintain good, trusting relationships with the facility’s senior administrators. “I do not mean playing golf or going to dinner,” he explains. “I mean developing an understanding of the way they think and helping them understand how and why you make your decisions. I find I have to communicate frequently with superintendents to avoid unpleasant surprises. Financial issues are in the forefront of most administrators’ minds, but with a full understanding of a patients’ needs we can find a way to make the right decision.”

With his entrepreneurial successes in correctional health care and his long history with NCCHC, including service on many committees and projects, Ober understands well that obstacles remain in this field and that new ones are continually emerging. At present, for instance, the economy is forcing budget cuts that are proving very difficult for correctional health services. The growing population of aging inmates with more serious health needs is also a concern.

At the same time, he appreciates the great strides that have been made in recent decades and believes the field is on the right path, even finding creative ways to manage these challenges. He says it is important to recognize those who are taking that path.

“NCCHC is an extremely well-run and focused organization. There isn’t much I can do to improve it. But as good as our standards and programs are, they are only as good as the people who use them every day. I want to place emphasis on the people who do great work with patients or make decisions that affect their care. We need to recognize correctional health care as the remarkable field it has become.”

Meet NCCHC Board Chair Peter Ober
I read with interest Scott Savage’s excellent article “Violent and Agitated Inmates: A Review of Management and a Call for Research.” (Summer 2010) I applaud Dr. Savage for bringing this important topic onto center stage. Dr. Savage is correct that virtually nothing has been published on this subject in the correctional medicine literature. However, there is another medical specialty that deals frequently with agitated and violent patients: emergency medicine. And there is a vibrant and large body of emergency medicine literature dealing with violent and agitated patients.

I know this also from personal experience. Before I discovered my true calling in correctional medicine, I worked for 22 years in emergency departments. Violent and agitated patients were not uncommon. Every emergency department sees such patients and has to have procedures for dealing with them. I saw and treated many, many such patients before I ever began working in jails.

Dr. Savage’s article motivated me to reread the emergency medicine literature on the topic. The subject is mentioned in all of the major emergency medicine textbooks. A particularly good and lengthy discussion of the use of physical and chemical restraints on agitated patients is found in Roberts and Hedges “Clinical Procedures in Emergency Medicine (Fifth Edition),” chapter 71, Physical and Chemical Restraint. I would recommend this as a great starting place for those interested in this subject.

As I reread the emergency medicine textbooks and research articles on emergency restraint, I was struck by the fact that this is not a controversial subject in the emergency literature as it sometimes is portrayed in correctional medicine. Chemical restraint of agitated patients, in fact, is the standard of care for out-of-control agitated patients in emergency departments. Chemical sedation is considered to be safer and more effective than physical restraint. In fact, physical restraint is used basically to facilitate chemical sedation of violent patients.

As Dr. Savage discusses, there are a variety of agents that can be used for chemical sedation and restraint of violent and agitated patients. Which agent is used depends on the situation. However, the agent used most commonly in emergency departments across the country for chemical sedation of violent patients is haloperidol (often given with a small amount of a benzodiazepine). Haloperidol can be used safely IM or even IV push. No drug is totally without risks, but haloperidol is overall very safe and effective. It is certainly safer and more effective than prolonged physical restraints.

Studies of many other agents have been reported in the emergency medicine literature. In my opinion, no agent has yet been shown to be safer, cheaper or otherwise an overall improvement over haloperidol and benzodiazepines. Interestingly, ketamine is now being used by paramedics in some emergency medical services programs to ultra-rapidly sedate patients suffering from excited delirium (Emergency Medicine News, October 2010, “ExDS Protocol Puts Clout in EMS Hands”).

The management of the violent and agitated patient is an essential topic taught in depth in all emergency medicine residency programs. In fact, it is a core competency in emergency medicine. It should become a core competency in our profession, as well.

Jeffrey E. Keller, MD, FACEP
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We welcome your comments. Send an e-mail to editor@ncchc.org, or write to Editor, c/o NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614. Please include your full name and a phone number. Letters may be edited for clarity or length.
Position Statement: Restraint of Pregnant Inmates

NCCHC’s board of directors adopted this position statement in October 2010. All NCCHC position statements are available at the Resources section at www.ncchc.org.

Introduction

Pregnant inmates present special concerns for both the correctional administrator and health authority. Pregnancy is a medically fragile time where neither the expectant mother nor fetus should be exposed to unnecessary risks of falls or injury, particularly when security restraints are applied. Of course, pregnant inmates should receive medically appropriate prenatal, intrapartum, and postpartum care and treatment, including special diets, and these issues are addressed in the National Commission on Correctional Health Care’s Standards. This position statement provides additional guidance.

Position Statement

Restraint is potentially harmful to the expectant mother and fetus, especially in the third trimester as well as during labor and delivery. Restraint of pregnant inmates during labor and delivery should not be used. The application of restraints during all other pre-and postpartum periods should be restricted as much as possible and, when used, done so with consultation from medical staff. For the most successful outcome of a pregnancy, cooperation among custody staff, medical staff, and the patient is required.

Prepartum

1. Restraint should be done by the least restrictive means necessary and in a way that mitigates adverse clinical consequences.
2. Abdominal restraints that directly constrict the area of pregnancy should not be used.
3. Wrist restraints, if used, should be applied in such a way that the pregnant inmate may be able to protect herself and the fetus in the event of a forward fall.
4. Pregnant inmates should not be placed in a facedown position or in four-point restraint.
5. Leg and ankle restraints that restrain the legs close together should not be used because they increase the risk of a forward fall.

Partum

6. Restraints during transport to the hospital or during labor should not be used, except where necessary due to serious threat of harm to self, staff, or others.

Postpartum

7. Restraint should be avoided if possible during this period, because labor and delivery can result in exhaustion, dehydration, difficulty in urination or defecation, and complications such as hemorrhage. Necessary bed rest and rapid response to medical emergencies should also be taken into account, particularly for cesarean section (also known as a c-section) births.
8. If restraints are required, they should allow for the mother’s safe handling of her infant and mother-infant bonding, which is beneficial and very strong during the postpartum period.
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The average cost of treating a MRSA infection in the hospital has risen to over $60,000, and that cost does not include the staff time required to supervise a hospitalized inmate.

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National Corrections Health Care Data Collection and Reporting Program Takes Initial Steps

The Bureau of Justice Statistics is establishing a research agenda for a new National Survey of Prison Healthcare being developed by BJS and the CDC's National Center for Health Statistics. The long-term goal is to create a National Corrections Health and Healthcare Reporting Program.

This project aligns with NCCHC’s position statement on Health Services Research in Correctional Settings, which calls for a coordinated national health services research agenda to build correctional health care research capacity and endorse nine national research priorities.

BJS has routinely collected data and reported on correctional health in multiple data collections from a variety of correctional systems, facilities, parole agencies and persons under correctional supervision. However, the agency is now seeking to define “what we know, what we don’t know and how we might fill the gaps.”

BJS says its goal is “to produce high quality, useful data on the structure, provision and utilization of correctional healthcare and prevalence of infectious and chronic diseases, serious mental illness, substance dependence and abuse and dental problems among correctional populations.” This entails not only creating new data collections but also modifying existing BJS data collections.

The related National Survey of Prison Healthcare stems from NCHS’ intent to expand its National Health Care Surveys to institutional populations. These provider surveys are designed to answer questions of interest to health care policy makers, public health professionals and researchers, such as the factors that influence the use of health care resources; the quality of health care, including safety; and disparities in health care services provided to population subgroups.

Prioritizing Needs

In June, the two agencies convened a meeting with participants from NCCHC and other experts to identify priority data needs and, with regard to the long-term goal, to define a strategy for developing the reporting program.

The meeting agenda addressed six domains of information, leaving room to discuss others that might not be encompassed in the following:

1. Global structure of correctional health care
2. Correctional health care costs
3. Settings of correctional health care
4. Types and processes of correctional health care delivery
5. Prevalence of disease
6. Outcomes

For each, critical questions of measurement were asked:

• Are there standards for measuring the data of interest?
• Is there comparability of definitions of data elements across systems?
• What are the administrative obstacles to collecting such data?

Stay tuned for updates as this important national initiative progresses.
Medical Settlement for Nevada’s Ely State Prison

by Fred Cohen, LL.M

One of my favorite leisure time reading activities is to find a nice juicy settlement or consent decree and snuggle down with it by a nice fire. In Arizona, where I live, there is a two- or three-week window for an indoor fire.

I just finished reading the 31-page settlement agreement in the case of Riker v. Gibbons, Case No. 3:08-cv-00115-LRH-VPC (D. Nev. June 29, 2010), and portions of it are worth reporting on here. Riker deals only with medical care and only at Nevada’s Ely State Prison. Putting aside my opening efforts at humor, readers interested in prison medical care and the various permutations that these settlements can take should be interested in this model.

The settlement is unusually comprehensive and detailed within each category of care. The ubiquitous Ron Shansky, MD, is the appointed monitor and if he did not have a hand in drafting this agreement, his alter ego did. The plan is based on National Commission on Correctional Health Care standards and Dr. Shansky is a major player in that fine organization.

Let me set out just one section of the agreement, and a modest one at that, to illustrate my point on comprehensiveness:

INFIRMARY CARE: Under the guidance of the MONITOR, DEFENDANTS/STATE OF NEVADA will ensure that ESP provides adequate infirmary care for Patients requiring close medical monitoring and/or nursing assistance. At a minimum, DEFENDANTS/STATE OF NEVADA will ensure that all infirmary Patients must be within sight or sound of nursing or QUALIFIED HEALTH CARE PROFESSIONALS at all times. Physician and/or mid-level practitioner rounds shall be conducted on a daily basis or as specified by the categories of care being provided, and a RN or higher level medical provider shall be present at the infirmary each day with a minimum of eight (8) hours of RN care and sixteen (16) hours of LPN care per day. Custody staff will not provide any routine medical care or medical observation in the infirmary. Patients admitted in the infirmary will not have to “kite” (submit a medical request form) for medical care.

The Model

With a single subject, a single monitor, who is also the subject matter expert, and with comprehensive detail there is a mutual expression of confidence in the monitor while simultaneously limiting some of his discretion. Indeed, the monitor’s duties as to site visits, areas to be covered in reports and even a monitoring tool (or protocol) are made explicit.

The only things missing are what the monitor is required to have for lunch and how he shall dress during site visits. Thus, there is a modicum of trust displayed here.

It would be reasonable to assume that the sort of settlement detail I am describing here converts a live monitor to a sort of RoboDoc who whirls through treatment areas, blinks at records and says, “Hi, my name is _____” to ailing inmates. Not so. Detailed requirements alone do not eliminate or even reduce discretion. Detailed requirements simply change where and how that discretion is exercised.

In the present situation, the monitor’s residual power is in qualitative assessments. Visits and records must be timely, continued on page 10
there may be face-to-face assessments, staff vacancies may be filled—but timeliness, for example, says nothing about the quality of the medical encounter or the medical records.

Indeed, I would suggest that the more checklist-like the anterior requirements, the greater the allowable discretion to the monitor on quality.

This model and its possible consequences may be exactly what the parties desire and I do not mean to suggest one model of settlement and monitoring is superior to another. An open-ended agreement calling for enhanced access to medical care, physicians and nurses adequate to meet the standard of care, electronic medical records within a reasonable time—and the like—simply postpones the day of reckoning on detail and, at least initially, removes it from counsel or the judge. I say “at least initially” because the details may lead to serious battles between the parties, in the California mode, and they are fought out over open checkbooks and court dockets.

In speaking with one of the key figures in this settlement, I was told that this model does, indeed, try to eliminate (or reduce) subjectivity and, perhaps more importantly, prevent compliance measures changing with who does the monitoring on a particular day. The latter issue, often referenced as “moving the goalposts,” is an issue where there are different people on a team doing the assessment and the monitor is not up to the task of maintaining consistent standards.

The settlement discussed here is available at www.aclu.org/files/assets/ely_settlement.pdf. Anyone writing, litigating or simply functioning in correctional medical care should take a look at this document. You will get the whole story and in detail.

With Ron Shansky on the case, I believe, as the parties must, that they will get a high degree of professionalism and fairness. Ely State Prison will get oversight monitoring and, even more importantly, a type of consulting; a series of on-site tutorials on how to do it right.

No, I am not an agent for Dr. Shansky.

Fred Cohen, LL.M, is the coeditor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2011 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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From July through September, 2010, an outbreak of 28 confirmed cases of mumps occurred in the Bexar County Jail in San Antonio, TX. The entire county, which has a population of more than 1.6 million, typically reports one or two cases per year. The jail consists of 12 pods with an average daily population of 3,500. Other outbreaks of mumps have been reported in Iowa in 2006 and in New York and New Jersey in 2009 despite high levels of vaccine coverage in the United States. The viral strain in all three of these outbreaks was genotype G. This article outlines the Bexar County Jail outbreak and the public health response to investigate and contain it.

The first two suspected cases presented to jail health care workers on July 15 for jaw swelling and fever. No immediate diagnosis was made, but the individuals were placed in isolation to prevent the spread of a potentially contagious disease. Two days later, the inmates were transferred to a local hospital for precautionary and investigative reasons where they were presumptively diagnosed with mumps. Local health officials were notified of these infections on July 20 as well as four similar cases at the jail. Public health officials recommended that jail authorities immediately isolate both these and future suspected cases (anyone presenting with jaw or upper neck swelling on one or both sides corresponding to the parotid or other salivary glands) for nine days or until infection was ruled out. Furthermore, the pods from which the affected inmates had come were to be quarantined for 25 days past the date of symptom onset.

The Centers for Disease Control and Prevention defines a confirmed case of mumps as any individual with two or more days of parotitis and either positive labs or a direct link to a confirmed case; therefore, mumps should not necessarily be ruled out by negative labs. The CDC guideline committee that investigated the 2006 mumps outbreak recommended isolation of cases for only five days following parotitis onset since the risk of transmission after this time is low. However, studies have shown that patients may still shed virus up to Day 9 in 4% of the population. Although individuals are generally considered infectious for three days prior to parotitis, the virus has been isolated up to seven days prior to symptom onset.

In the jail inmate population, however, medical histories are considered notoriously poor and inmate contact tracking is complicated. Thus, the Infectious disease committee that investigated the 2006 mumps outbreak recommended isolation of cases for only five days following parotitis onset since the risk of transmission after this time is low. However, studies have shown that patients may still shed virus up to Day 9 in 4% of the population. Although individuals are generally considered infectious for three days prior to parotitis, the virus has been isolated up to seven days prior to symptom onset.

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The average incubation period for mumps is 16 to 18 days from exposure to onset of symptoms, but can be as much as 25 days. Additionally, 15% to 20% of all infected
individuals are asymptomatic, more commonly in adults, and up to 50% of individuals infected have nonspecific, flu-like symptoms. Hence, the diagnosis is easily missed. Plus, transmission of the virus is greatly facilitated in situations in which prolonged close contact occurs.

For all of these reasons, control measures can be quite difficult. San Antonio public health officials decided to take a conservative approach to the outbreak due to the close and crowded quarters in the facility and recommended a full nine days of isolation and 25 days of quarantine.

The Contact Investigation Begins

Laboratory confirmation of mumps infection for the first two cases was obtained on July 23 and public health officials performed a formal contact investigation at the jail that same day. During the contact investigation, public health officials noted that infected inmates had been in contact with multiple pods prior to isolation while they were suspected of being infectious. Thus, these additional pods were also placed under quarantine.

Over the next two months, 22 more cases of mumps were identified; 13 of these were restricted to Bexar County Jail, including two employees. Two had been transferred from the jail to the Mentally Impaired Offenders Facility and two were employees at the MIOF. The contact investigation involved home visits of released inmates who had spent time in one of the quarantined pods during the infectious time periods. While no new cases were identified in this way, a local hospital reported that a noninmate female had been diagnosed with mumps. Upon questioning by public health officials, she admitted to contact with a jail inmate. Four more cases of mumps were identified at an intermediate sanction facility, three of whom had previously spent time at the Bexar County Jail in quarantine. Such transfers were allowed and accepting facilities completed the 25-day quarantine.

A Coordinated Response

Conference calls between local health officials and the Texas Department of State Health Services, the Bexar County Jail and the Texas Department of Criminal Justice began on Friday, July 23, and open lines of communication between these agencies continue through the time of this writing. Area weekly emergency preparedness meetings were also informed of developments starting July 26. The DSHS distributed “Mumps Fact Sheets” and “Control Measures” to all involved agencies on July 27. The strategies implemented after coordination between these entities were to define the at-risk population, keeping that population as confined as possible and immunizing those at risk. (See General Recommendations above.)

Except for the index cases who were transferred to a hospital for diagnosis, affected inmates required only symptomatic treatment. None of the identified cases during the jail outbreak involved serious complications such as meningitis, although six did suffer from orchitis (testicular inflammation causing pain).

Prior immunization with at least one mumps, measles and rubella (MMR) vaccination was documented for 10 of the cases. An additional 10 individuals were educated in the Texas public school system, where vaccination is mandatory. The development of disease in previously immunized individuals was reported in the 2006 and 2009 outbreaks, as well. Investigations into the 2006 mumps outbreak found that individuals who had received two doses of MMR vaccine had significantly lower infection rates than those who had received just one. The CDC’s Advisory Committee for Immunization Practices has since issued new guidelines stating that acceptable vaccination now requires two doses for high-risk individuals. MMR effectiveness is estimated to be between 73% and 91% for one dose and 76% to 95% for two doses. Although immunization after exposure to mumps has not been demonstrated to be protective, the CDC recommends vaccination for susceptible individuals with no history of vaccination or one dose only.

Because of this recommendation and the realization that previous vaccination status was difficult to confirm in this population, the Texas DSHS recommended vaccination of all exposed inmates with one dose of MMR vaccine. The vaccinations were administered on July 27 to consenting inmates in quarantined pods; very few refused vaccination. On July 28 and 30, jail employees were offered the vaccine on a voluntary basis.

Because of the long incubation period for mumps, cases were expected to continue to occur even among newly vaccinated persons who may have been infected before vaccination. This situation occurred with one of the MIOF employees, who was vaccinated and then was diagnosed with mumps two and a half weeks later. Thus, a surveillance period of 50 days, two incubation periods, after the last known case presentation has been implemented to allow for identification of transmission from subclinical infections. At the time of this writing, this surveillance period has not concluded and sporadic cases are expected for at least another month.

continued on page 22

General Recommendations

- Inmates or staff with visible or reported symptoms should be immediately referred to health services.
- An inmate with symptoms of mumps should be isolated for at least nine days after the onset of symptoms or until infection is ruled out.
- Staff with symptoms of mumps should be excluded from the workplace for at least nine days from onset of symptoms or until infection is ruled out.
- Exposed inmates should be quarantined until 25 days have passed after the last date of exposure.
- Any staff member who had close contact with an individual diagnosed with mumps during the seven days prior to symptom onset should not work with unexposed staff or inmates for a full 25 days.
- Who should be vaccinated with one dose of MMR vaccine?
  - Inmates quarantined due to exposure
  - Any staff who will work with quarantined or isolated inmates
  - Any trustees or staff who visited a quarantined area during the probable exposure or communicable period
- As few personnel as possible should be assigned to cover quarantined areas.
- If the transfer of a quarantined inmate is necessary, the inmate should be transferred alone and should immediately enter quarantine upon arrival at the new facility.
- Exposed inmates can be released to the community but household immunizations are recommended.
Acute Psychotic Delirium and Sudden Death in Custody: Tips for Prevention

by Holly Mathis, MSN, RN, ANP-BC

Without warning, a detainee changes from a tabby cat to Tyrannosaurus rex. There’s a good chance that the cause is acute psychotic delirium, which is associated with numerous therapeutic and recreational drugs. Given the increase in use and abuse of drugs that have psychogenic side effects, it is vitally important that correctional staff and health care professionals recognize APD, understand the factors related to managing it and be prepared and trained to manage its occurrence as a team.

First, what is acute psychotic delirium? APD is an abrupt onset of a cluster of global, transient changes and disturbances in attention, cognition, psychomotor activity, level of consciousness and/or the sleep/wake cycle that develops over a short period of time. It reflects a significant change from previous functioning and can affect attention, concentration, speech, memory and perception.

Drugs of abuse commonly associated with APD include cocaine, alcohol and PCP. Additionally, abusers of cocaine, methamphetamine and alcohol are at increased cardiac risk because of the physiologic action of these drugs on the heart. But drugs aren’t the only culprit. Conditions that may cause an altered level of consciousness or delirium are summarized by the well-known mnemonic “AEIOU TIPS”:

A = Acidosis
E = Epilepsy (seizures or convulsions)
I = Infection
O = Overdose drugs or alcohol
U = Uremia
T = Trauma to head; tumor
P = Poisoning psychosis
S = Stroke (transient ischemic attack or cerebrovascular accident)

APD is considered a serious medical emergency. Individuals in this state display extraordinary strength and endurance when struggling, apparently without fatigue. A correctional officer may see bizarre and alarming behavior and perceive it as strictly a control-and-arrest or containment situation. The individual may be partially clothed or naked, incoherent or speaking in gibberish, yelling or screaming. APD victims are disoriented or hallucinating and perceive it as strictly a control-and-arrest or containment. Respirations are necessary to resolve respiratory acidosis, but attempts at restraint serve to impair ventilatory capabilities because of the techniques used to subdue the individual.

Death related to positional asphyxia is a particular risk not only for those experiencing a prolonged struggle prior to restraint, but also for the obese and those with significant respiratory and cardiac medical history. Obesity itself results in decreased lung capacity (restriction) and is related to sleep apnea. Known in extreme circumstances as obesity hypoventilation syndrome, or the Pickwickian syndrome, after the Charles Dickens character in “The Pickwick Papers,” this condition causes difficulty with chest excursion because the body’s excessive weight creates pressure against the diaphragm, particularly when supine but exacerbated when prone. The prone position reduces lung capacity in nonobese individuals, as well. During restraint, the situation may be compounded by pressure exerted by the restraining officer.

Steps for Prevention

There are steps that can be taken to reduce death from positional asphyxia. Most importantly, avoid obstructing the airway. Next, make it a policy to avoid hog-ties completely. It is preferable to apply restraints to extremities separately, avoiding pressure to chest, back, lungs, diaphragm...
or stomach in order to allow respiration, particularly as soon as the individual has been safely restrained. Avoid sitting or lying on the individual, particularly juveniles. Right after restraint, move the position from stomach to side-lying or sitting (if alert). Don’t allow the person to sit leaning or “slumped” forward. Do not leave a person who struggled before and during restraint efforts unattended!

Always assign an observer to note the situation from the beginning of the restraint process, to monitor the patient for any breathing problems or, more ominously, loss of consciousness. Loss of consciousness after a challenging restraint often leads to death in conjunction with APD and requires quick intervention, including CPR and immediate transport to an emergency room.

The key to success is advance training. The “Four Rs” summarize the steps necessary to successful management of this situation:
- Recognize the situation for what it is
- Respond appropriately
- Restrain quickly
- Refer immediately

Recognizing the situation is easy: Once you see it, you will not easily forget. Awareness of the situation and the potential for it will put you at a distinct advantage.

Responding appropriately is critical. It is vital to avoid obstructing airway and breathing capabilities during and after containment. It is important to restrain the patient quickly, avoiding hog ties and extended prone containment. Make sure that there are enough people to contain the patient at the outset in order to prevent a prolonged struggle.

Restraining quickly requires advance planning and practice. A “TARP” plan, or total appendage restraint procedure, may facilitate these efforts. Consider developing a coordinated plan in advance in collaboration with site personnel, including medical providers, plus the local emergency medical services and local hospital emergency department personnel. Training officers and EMS dispatchers ahead of time to recognize the urgency of the situation will improve the chances of a favorable outcome.

Finally, referring the patient experiencing APD and respiratory compromise to the hospital as soon as possible will increase your chance to prevent demise. At the very least, this patient needs medical attention to ameliorate the psychotic behavior such as combativeness, recover from metabolic and respiratory acidosis and address the underlying cause of psychosis. For those at increased risk of death after restraint, the situation may be better managed early by emergency-trained health care providers.

Holly Mathis, MSN, RN, ANP-BC, is a nurse practitioner employed by Correctional Medical Services and working in the Arkansas Department of Correction. To contact her, email hollyanp@email.com.
Correctional Nursing Practice: What You Need to Know (Part 4)

NCCHC’s Certified Correctional Health Professional program 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/cchp-rn, where you can also view the entire test outline (see downloads).

Screening, Sick Call and Triage

Correctional nurses use specialized assessments to screen, triage and evaluate patients to determine the correct level of health care services needed. The reason for the assessment governs the focus and direction of the service.

Screening

Nurses in correctional settings use many screening techniques and tools to examine, identify and act upon certain clinical conditions or needs that an inmate may have. The key concepts of screening are that it takes place very quickly, it identifies all that it should identify, the tools and process are standardized, it uses the least amount of resource for the most gain, and errors made are on the side of overidentification and patient safety.

The correctional nurse must be knowledgeable and competent to complete various screening processes. This means knowing the purpose, focus of data collected and time frame for screening to take place. Reasons for screening include the following:

- Intake or admission
- Work clearance
- Assessment for segregation
- Referral to alcohol or drug treatment
- Transfer to another facility or to court
- After a use-of-force incident

In the correctional setting, nurses must be able to screen inmates for a broad range of things, including need for urgent dental or mental health care and preventive care. However, screening of an inmate in segregation, for example, is very different from screening to decide whether an inmate can be assigned to work in the kitchen.

Assessment in segregation is to identify and address any inmate whose health status (medical and mental health) is deteriorating. The nurse will ask questions and use observation to identify cognitive and affective changes, note any bruising or signs of injury and identify any other physical changes from the inmate’s norm. This screening is conducted either every day or several times a week, depending on the degree of isolation.

In comparison, screening before work assignment in the kitchen is to identify any infectious condition that could be transmitted to others by a food handler. In this context, the nurse will consider the inmate’s communicable disease history and immunizations and examine the inmate for skin and respiratory conditions.

Quick and effective screening is aided by use of standardized tools and techniques, which enable the nurse to focus on the results gained from each step in screening rather than what question to ask next. Also, screening is simply to identify an inmate with a condition, characteristic or change that needs attention, but it does not need to be addressed comprehensively at that moment, unless it is a life-threatening emergency. The quality of subjective and objective information gained from the inmate is better when the encounter provides auditory and/or visual privacy and the nurse’s demeanor is calm, professional and nonjudgmental. The nurse must be able to factor in the degree to which these elements influence the quality of information obtained.

Nurses use professional judgment to determine the disposition of each inmate screened. With intake screening, nurses decide if an inmate has an urgent condition that needs immediate attention and referral. If the inmate has a condition that needs ongoing treatment but it is not urgent, the nurse will make arrangements to continue care until the provider appointment takes place. The types of decisions made by nurses as a result of intake screening include any particular housing assignments or accommodations; notifying custody personnel of special equipment (e.g., a wheelchair), supplies (e.g., keep-on-person medication) or other important information (e.g., suicide potential); referral and appointments for follow-up by medical, dental and mental health personnel; and initiating arrangements to provide continuity of care (e.g., requesting health records from previous provider, verifying prescriptions). In such decisions, it is important that screening overidentify and/or overrefer in favor of the patient and safety.

The nurse has a responsibility to communicate the findings and conclusions of screening. This includes providing custody or other personnel who are not part of the health care team with sufficient information so that the inmate and others are safe. The nurse also needs to convey the screening results to the inmate so he or she knows what to expect and how to request additional assistance, if needed. Finally, the nurse communicates to the other members of the health care team the screening results and subsequent decisions through documentation in the health record.

Sick Call

Correctional health care is guided by several fundamental principles. Inmates may make a request for health care attention at any time. Requests that are emergent are
attended to immediately. Requests that are not emergent are reviewed every day; this often is called sick-call triage. Nurses usually are the professionals responsible for reviewing and responding to requests for health care attention via sick call. If the request describes a clinical symptom, the inmate must be seen in a face-to-face sick-call encounter within the next work day (24 hours on weekdays and no longer than 72 hours on the weekend). Any triage of a request for health care attention should include a review of the inmate’s health record.

Nurses may use protocols for the face-to-face evaluation of requests for health care attention. Requirements for the use of protocols are as follows:

- Protocols are jointly developed by the nurse and physician administrator.
- They are reviewed annually.
- They comply with the nurse practice act.
- They do not include use of prescription drugs except for emergencies.
- They provide guidelines for referral to higher level care.
- Every nurse must be trained in use of the protocols initially, with annual skill review thereafter. Training must take place whenever a protocol is revised or before a new protocol is introduced. Nurses should have knowledge of normal anatomy and physiology as well as common abnormalities, communicable disease, substance abuse, psychiatric conditions and oral health. Nurses must also demonstrate skill in focused physical assessment.

Evaluation of requests for health care attention should take place in an area appropriate for delivery of health care. The area must be of adequate size, provide auditory or visual privacy, have a sink and water, and have washable hard surfaces. Equipment nurses use for sick-call evaluation includes the health record, thermometer, stethoscope, sphygmomanometer, handheld light, exam gloves, dressing supplies, germicidal solution and reference material.

A face-to-face evaluation of a request for health care attention includes several steps:

- Welcome the patient (establish therapeutic milieu)
- Elicit and listen to the patient’s description of the health concern (subjective data)
- Examine the patient and collect data (objective data)
- Assess and diagnose (synthesis and critical judgment)
- Establish a plan of care (inform and educate the patient)
- Evaluate plan effectiveness (patient understands and consents)
- Follow through on the plan (patient advocacy)

Triage

Based on the assessment of the inmate and evaluation of the health complaint, the nurse may initiate treatment using the protocol, provide advice or recommend some form of self-care, educate or inform the patient about an aspect of care or symptom management, and/or refer for higher level care. Although the protocols guide the nurse’s judgment in whether to refer the inmate for higher level care, they are not always precisely applicable and definitive to the patient care situation. In addition to guidance in the protocol, the nurse should refer for higher level care when the patient has abnormal vital signs, when the evaluation requires diagnostics that exceed the limits of the protocol (radiographs, lab studies, etc.), when the nurse is unable to come to a diagnostic conclusion and when the patient’s complaint has not resolved (seen more than twice for the same complaint).

Know the Essentials

Nurses preparing to take the CCHP-RN exam are advised to know the purpose of the various activities nurses perform in the correctional setting and the fundamentals or principles of each activity as expressed in NCCHC’s accreditation standards. Nurses also should be familiar with national standards for nursing practice and professionalism.

Catherine Knox, MN, RN, CCHP-RN

Catherine Knox, MN, RN, CCHP-RN, recently retired from California Prison Health Care Services and now does occasional work as a consultant and as an NCCHC accreditation surveyor; she is based in Arizona. This column is coordinated by Lorry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media; she is based in Pennsylvania. Both are members of the CCHP-RN task force and are collaborating on a book titled “Essentials of Correctional Nursing.” For correspondence about this column, write to editor@ncchc.org.
2010 Honorees Exemplify the Best in Correctional Health Care

The National Commission’s annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud the 2010 recipients of these prestigious awards, which were presented Oct. 11 during the opening ceremony of the National Conference on Correctional Health Care, held in Las Vegas.

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

Ronald Shansky, MD, MPH, FSCP
For distinguished service to the field of correctional health care

If one word could sum up the entirety of Dr. Shansky’s work in correctional health care, that word would be quality. Of course, one word is woefully insufficient, so let’s add to that expertise, dedication, integrity and mentorship—to list just a few. And, nearly 40 years after stepping into a jail as part of a joint effort with the National Institute of Justice to update the health services standards for prisons and jails for both NCCHC and the American Public Health Association, there was no turning back. Although his professional activities have been very broad, public health and care for the incarcerated have always been at the forefront.

Dr. Shansky began his correctional career in the Metropolitan Correctional Center of Chicago and later became medical director for the Illinois Department of Corrections. Early on, he made quality his mission and became expert at evaluating health care systems through work as a surveyor for the Joint Commission on Accreditation of Healthcare Organizations. He also is board certified in quality assurance.

As his reputation grew, Dr. Shansky was increasingly called upon for consultation to correctional facilities, agencies and courts across the country and since 1993 has made consulting a full-time endeavor. Notably, he directed the turnaround of health care in the District of Columbia jail in the 1990s as its federal court appointed receiver. Today he is the undisputed “go-to” expert. He has had a long career as a correctional psychiatric consultant, working for dozens of defendants, judges, special masters and court monitors, as well as plaintiffs. For 15 years he also has taught at the University of Colorado School of Medicine as a clinical professor in the departments of psychiatry and pediatrics, and since 1992 he has been associate director of the university’s forensic psychiatry fellowship program.

Dr. Shansky’s interest in correctional mental health care dates to the end of his psychiatric residency at the University of Colorado Health Sciences Center in the late 1970s, when he was involved in a landmark federal lawsuit, Ramos v. Lamm, that ultimately forced a dramatic change in prison conditions—including mental health care—across the state of Colorado. Dr. Metzner was part of a committee that reviewed the state’s proposed remedial plans. None were acceptable, so the governor’s office hired him to help write a plan and, until the case was closed, he monitored the mental health aspects of the plan he helped to create.

In a sense, that remedial plan was one of the early written works for which Dr. Metzner is being honored with the Anno Award of Excellence in Communication. He is a prolific writer, with published works including some 30 peer-reviewed journals articles, nearly two dozen book chapters and numerous newsletters articles and book reviews. He also has contributed to the literature as a peer reviewer for many journals over the years, including the Journal of the American Academy of Psychiatry and the Law, and has
served on the editorial board of *Behavioral Sciences and the Law* since 2001. Much of that vast body of work deals with correctional mental health care. Dr. Metzner, who was in the first group to achieve Advanced CCHP certification in 1991, also made important contributions to NCCHC's *Standards*, writing appendices on mental health considerations for segregated inmates.

Dr. Metzner's works have greatly enriched the knowledge base in this field. But it's not purely academic. By committing his research and knowledge to writing, he has had a significant impact on the daily practice of thousands of correctional health professionals.

**NCCHC Facility of the Year Award**

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

**Tipton Correctional Center, Tipton, Missouri**

At its accreditation survey in March, Tipton Correctional Center was noted to have no health staff vacancies. Out of 26.5 FTE positions, no vacancies! Perhaps that's not so surprising: Who would want to leave such a positive, rewarding place of employment?

The prison has been accredited by NCCHC since 1997. The health services operation is a tight ship, complying closely with both the letter and the spirit of NCCHC's *Standards for Health Services*.

But something else stands out: utmost professionalism. According to accreditation surveyors and the awards committee, the staff consistently demonstrates excellence in health services delivery, professionalism and a commitment to continuity of services. Also of note are the close cooperation between the medical and mental health staffs (which are provided by two different contractors) and with custody staff.

Tipton, which is about 50 miles southwest of Columbia, MO, houses minimum and medium security adult male inmates. It has an average daily population of nearly 1,200 and an average daily intake of five. New admissions arrive from the Missouri Department of Corrections' reception center or other prisons.

Inmates with health needs do not slip through the cracks here. Upon arrival, each inmate is interviewed and each health record is reviewed to ensure all necessary elements have been completed; if any portion was not completed at reception, the inmate is referred that day to the physician for assessment and completion of missing elements.

Health staff are on site around the clock. Quality improvement programs are in place to ensure continual evaluation and improvement of both processes and outcomes. Training is important here, and all health and correctional staff stay current on professional education.

Discharge planning is handled well. Nursing staff complete a form that details post-discharge medications and follow-up care. Inmates are given a 30-day supply of maintenance medications and are referred to local health departments, university clinics or mental health agencies.

Overall, Tipton Correctional Center exemplifies a highly organized and effective health services system that not only serves its patients well, but also results in employee satisfaction.

**NCCHC Program of the Year Award**

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

**Disaster Planning Program**

*Orleans Parish Sheriff’s Office, New Orleans, Louisiana*

If any city knows "disaster," it's New Orleans. Hurricane Katrina and the subsequent flooding wrought massive devastation five years ago, and the Orleans Parish Sheriff's Office was among the victims. The department's infrastructure was destroyed, medical support in chaos and people's lives shattered.

Lesson learned: Clearly, the perfunctory approach to policies and procedures for emergency response was dangerously inadequate. As the agency rebuilt itself, disaster planning became a high priority and remains so today.

Logistically, the jail poses some challenges. The jail deals with a *lot* of people. The average daily population hovers around 3,300 and annual intake is about 63,000. Eight buildings are spread over several city blocks, and many units require motor vehicles to transport staff and health records for routine and emergency care. In addition, the medical division is staffed 24 hours a day, seven days a week.

The new disaster planning and preparedness efforts encompass this complex set-up in systemwide fashion. It didn't take long before the plans were put to the test: In September 2008, Hurricane Gustav forced evacuations throughout New Orleans. In a matter of hours, the OPSO staff evacuated 2,500 inmates to safer locations. They set up disaster response stations to identify and process each inmate to be transferred. Medical summaries were prepared to accompany each inmate. Food, extra clothing and personal items were organized, as well. The entire jail population was safely transported to and returned from multiple inland sites.

Hurricanes aren't the only menace, of course, and in 2009 and 2010 the entire facility staff participated in drills to test staff ability to quickly organize, prepare for and provide medical and security response to other types of large-scale disasters.

Today the OPSO disaster planning program is ingrained into the culture of the institution, with staff viewing it as a routine aspect of daily operations. In fact, the staff take pride in their ability to respond effectively to catastrophe. As they should: This program stands out as a model for others to emulate.

*To hear interviews with each of the award winners, visit www.BlogTalkRadio.com/NCCHC. For photos of the award winners, see the About NCCHC section at www.ncchc.org, or visit our Facebook page for these and other photos from the 2010 National Conference, www.facebook.com/NCCHC.*
Updates in Correctional Health Care
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Emerging Issues
New treatment modalities, updated practice recommendations, evolving standards of care, shifts in patient presentation trends, ever-changing laws and regulations, innovative cost containment — there’s a lot going on in the complex work of correctional health care and it can be a challenge to keep up. Updates 2011 is designed to shed light on many of the emerging issues that affect our work and to propose strategies for managing them. A broad array of well-crafted presentations will share information, insights and solutions for these and other timely topics.

Scale to New Heights
- Discover evidence-based tools, techniques and solutions
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Session Sampler
The 50-plus sessions will address these topics and much more:
- A Critical Thinking Program for Front-Line Nursing Staff
- Eight Best Practices for Achieving and Maintaining National Standards
- Establishing Integrated Systems of Care From Intake Through Release
- Forecasting Pharmacy Expenditures in Corrections
- Healthy Inmates 2020: Looking Forward
- Infusing Multicultural Awareness Into Correctional Mental Health
- Medicaid Payment for Inmate Hospitalizations: Today and in 2014
- Research and Teaching in the Correctional Environment: The New Academic/Practical Paradigm
- Shared Specialty Care: A New Model

Deepen Your Knowledge at Preconference Seminars
Full-Day Seminars (Saturday)
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- An In-Depth Look at NCCHC’s Standards for Juvenile Facilities
- CCHP-RN Certification Review Course

Half-Day Seminars (Sunday)
- Advanced Nursing Assessment for Triage and Health Assessments
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Up to 25 hours of CE credit is available in five categories (includes attendance at weekend seminars). See the conference program or website for details.
- Certified Correctional Health Professionals: Category 1 credit for CCHP recertification
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Phoenix Fun
Things are different in the desert. The sky is bigger. The stars are brighter. The sunsets stop you in your tracks. Projected against this rich backdrop is a panorama of urban sophistication that is Phoenix, America’s fifth largest city and its sunniest metropolis.

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Conference Site
The all-new Sheraton at Phoenix Civic Plaza downtown is surrounded by great dining, shopping and nightlife. The 31-story hotel redefines the skyline with its cloudlike rooftop that turns translucent at night. This chic style is also reflected within the hotel, with restaurants that boast stunning city views, a large outdoor pool and a fitness center. The spacious guest rooms offer the latest in creature comforts.


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For more details about the conference or to register, visit www.ncchc.org.
New STD Treatment Guidelines

Over 19 million cases of sexually transmitted disease occur each year in the United States, disproportionately among young people and racial and ethnic minority populations. Find treatment, screening and prevention guidance in the Centers for Disease Control and Prevention’s new 2010 STD Treatment Guidelines. An update of its 2006 guidelines, the report includes expanded STD prevention recommendations, including HPV vaccination; revised gonorrhea treatment regimens; new treatment regimens for genital warts and bacterial vaginosis; the role of Mycoplasma genitalium and chlamydia in the evaluation of urethritis and cervicitis and treatment-related implications; and revised guidance on the diagnostic evaluation and management of syphilis. A webinar with CME credit is available online.
Source: www.cdc.gov/std/treatment/2010

Mumps (continued from page 13)

Lessons Learned, Lingering Questions

Management of an outbreak such as this presents many challenges. In reviewing the series of events, agencies can learn lessons that will improve future responses. One lesson from this outbreak is that early communication and collaboration among medical staff, facility administration and public health officials is essential. Face-to-face communication has proven most effective and should be arranged whenever possible to avoid misunderstandings. Open communication with the inmate population is important, as well, to elicit early reporting of symptoms to facilitate disease control. In addition, early establishment of the communication hierarchy in affected institutions and agencies is crucial. Identification of the appropriate supervisors with whom to communicate will ensure a smooth working relationship among all involved.

This outbreak raises a compelling issue regarding disease prevention measures among the inmate population. Should inmates be vaccinated for hepatitis B given the fact that this population is well known to be at increased risk for infection? Should inmates be vaccinated for influenza to prevent an outbreak? Should entrance screening be more extensive? Outbreaks in correctional facilities are costly in terms of staff overtime, staff sick days, supplies and space restrictions, all of which should be included in any analysis of the cost-effectiveness of prevention programs. This outbreak presents an opportunity for correctional officials to reassess the preventive measures currently in effect.

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Correctional Populations, 2009

The number of adults under correctional supervision in the United States declined by less than 1% in 2009, dropping to 7,225,800 (48,800 fewer than at year-end 2008), the Bureau of Justice Statistics reports. This was the first measured decline since BJS began reporting these data in 1980.

In incarceration settings, the number of jail inmates totaled 760,400 at mid-year 2009, down 2.2% from 2008. The number of state and federal prisoners rose by 0.2% in 2009 to reach 1,613,740 at year-end; this marks the slowest annual increase this decade and the third consecutive year of a declining growth rate. While the federal prison population rose by 3.4%, the state prison population had the first measured decline (0.2% or 2,857 prisoners) since 1977.

State prison admissions also decreased by 2.4% in 2009. The number of state and federal prisoners rose by 0.2% in 2009 to reach 1,613,740 at year-end; this marks the slowest annual increase this decade and the third consecutive year of a declining growth rate. While the federal prison population rose by 3.4%, the state prison population had the first measured decline (0.2% or 2,857 prisoners) since 1977. State prison admissions also decreased by 2.4% in 2009.

Source: http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus09.pdf

Resurgences of Mumps

Mumps vaccine was licensed in the United States in 1967. The Advisory Committee on Immunization Practices made an official recommendation for one dose of mumps vaccine in 1977. In 1989, children began receiving two doses of mumps vaccine because of the implementation of a two-dose measles vaccination policy using the combined measles, mumps and rubella vaccine.

Reported mumps decreased steadily from 152,209 cases in 1968 to 2,982 in 1985. During 1986–1987, a resurgence occurred with more than 20,000 reported cases. The primary cause was low vaccination levels among adolescents and young adults. In the late 1980s and the 1990s, outbreaks were reported among highly vaccinated populations. By 2003, only 231 mumps cases were reported, the lowest annual number since reporting began.

However, in 2006, another resurgence occurred, with 6,584 reported cases. The incidence was highest among persons aged 18–24 years, many of whom were college students. Approximately 63% of all case-patients with known vaccination status in the main outbreak states had received two doses of MMR vaccine. Since the 2006 outbreak, the number of annual cases has declined; 800 cases were reported in 2007, 454 cases in 2008, and 938 cases through December 19, 2009, including an outbreak in the latter part of 2009 that comprised 586 of the reported cases for the year.

Cases of mumps imported into the United States will likely persist as long as mumps continues to be endemic globally. Mumps vaccine is routinely used in 57% of countries in the world.

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Opt-Out Screening as a Gateway to Research and Interventions

Can routine opt-out screening and vaccination in jails improve public health in the community? At the Los Angeles County Jail, an ambitious effort seeks to use opt-out programs not only to directly help the inmates in the jail’s care, but also to extend its reach into the community, informing research that can lead to efficacious and cost-effective public health interventions. Although hard data will be forthcoming, epidemiologist Mark Malek, MD, MPH, and colleagues present their case in the January 2011 issue of the Journal of Correctional Health Care.

LACJ is the largest jail in the nation, with an average daily population of nearly 20,000, an annual intake of about 180,000 and a daily intake that ranges from 400 to 600. Most of these inmates soon return to their home communities, which are largely characterized by socioeconomic disadvantage and poor health care.

Since the health of these inmates “is intimately connected to that of the local population,” increasing diagnosis and linkages to care during their time in jail offers a great opportunity to improve public health in the communities to which they return, the authors say.

One example cited is flu vaccination: If an inmate acquires a pandemic flu virus during incarceration and is released while infectious, this can amplify transmission to the community. Conversely, routinely vaccinating inmates would interrupt transmission of the virus both in the jail and in the community. Other jail-based screenings that target significant problems for the jail population as well as their home communities include rapid testing for HIV, hepatitis B and C, tuberculosis, syphilis, gonorrhea and chlamydia.

Programs at LACJ

In Los Angeles County, the sheriff’s department, including the jail’s infection control and epidemiology unit, has collaborated with the department of public health on several projects that focus on screening and vaccination for common communicable diseases, thus preventing transmission both within the jail population and in the community.

- Comprehensive MRSA surveillance and control (all inmates with a skin or soft tissue infection are tested) that has reduced the disease burden for the past two years
- Seasonal influenza vaccination for general population inmates, thought to be the only program of its kind in a U.S. jail
- Hepatitis A/B immunization (a combined immunization using the FDA-approved accelerated dosing schedule) for high-risk men who have sex with men and general population inmates
- The jail is also conducting a study to assess a rapid HIV testing algorithm that, if successful, would provide inmates with definitive HIV results in one hour, rather than one week, along with timely referral to medical care. Opt-out rapid testing, the authors say, would not only greatly improve HIV detection in the county but also reduce costs compared to traditional testing methods.

Obstacles and Opportunities

Challenges to such proactive efforts do exist, such as finding a balance between the expansion of these public health programs and ensuring continuity of care to this high-turnover population—for example when follow-up care is necessary to complete treatment regimens or when providing test results from private laboratories. This also requires maintaining connections to community agencies and health care providers.

However, such projects also offer an opportunity to gather epidemiological and other data that would be useful in developing strategies to reduce infection rates, analyzing costs and guiding future research. Coupled with behavioral risk factor surveys, these public health interventions could be used to tailor programs to particular groups and thus reduce cost, the authors say.
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, in combination with other antiretrovirals.

TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of TRUVADA have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV-1 and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue TRUVADA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

Indication and usage

TRUVADA, a combination of EMTRIVA® (emtricitabine) and 1oVX® (tenofovir disoproxil fumarate), is indicated in combination with other antiretrovirals (such as nonnucleoside reverse transcriptase inhibitors or protease inhibitors) for the treatment of HIV-1 infection in adults.

The following should be considered when initiating therapy with TRUVADA in HIV-1 infection:

• It is not recommended that TRUVADA be used as a component of a triple nucleoside regimen.

• TRUVADA should be coadministered with 1oVX® (tenofovir disoproxil fumarate 300 mg) or EMTRIVA® (emtricitabine 200 mg).

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

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: consider clearance (CL) of 30 to 60 mL/min; 1 tablet every 48 hours; CL < 30 mL/min or hemodialysis do not use TRUVADA. The safety and effectiveness of these dosing interval recommendations have not been studied 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 (CL 50 to 80 mL/min).

Warnings and precautions

• New onset or worsening renal impairment:

  - Renal impairment and toxicities may be exacerbated by the kidney.
  - Renal impairment may include acute tubular necrosis or Fanconi syndrome.

• Access G3 before initiating treatment with TRUVADA. Routinely monitor Clcr and serum phosphorus in patients at risk for renal impairment, including patients who have previously experienced renal events while receiving 1oVX® (tenofovir disoproxil).

• During intervals of TRUVADA and dose monitoring of renal function should be monitored in all patients with CLcr 10 to 50 mL/min. No safety or efficacy data are available in patients with renal impairment who received TRUVADA using these dosing guidelines, so the potential benefit of TRUVADA therapy should be assessed against the potential risk of renal toxicity.

• Avoid administering TRUVADA with concurrent or recent use of nephrotoxic drugs.

TRUVADA is a fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate. TRUVADA should not be coadministered with 1oVX® (emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) or EMTRIVA® (emtricitabine 200 mg). Due to similarities between emtricitabine and tenofovir disoproxil fumarate, TRUVADA should not be coadministered with other drugs containing emtricitabine, including Atripla® (emtricitabine/rilpivirine), Stribild® (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate), or Complera® (emtricitabine/tenofovir disoproxil fumarate).

TRUVADA should not be administered with REGAVIR.

• Decreases in bone mineral density (BMD) can be monitored in patients with a history of pathologic fracture or those at risk for osteoporosis. Cases of osteomalacia (associated with proximal renal tubulopathy and which may contribute to fracture) have been reported in association with the use of 1oVX®.

• Renal dysfunction/exclusion of body fat: observed in patients receiving tenofovir disoproxil fumarate.

• Immune reconstitution syndrome may necessitate further evaluation and treatment.

• Tuberculosis: you should be informed of the potential risk of tuberculosis and which may contribute to fracture.

• Drug interactions:

  - Didanosine (ddi): tenofovir disoproxil fumarate increases ddI concentrations. Consider dose reductions or discontinuations of ddI if warranted.

  - Isoniazid (INH): coadministration decreases INH concentrations and increases tenofovir concentrations. Give INH with TRUVADA only with irinotecan, monitor for evidence of tenofovir-associated adverse reactions.


MAA-approved patients and treatment guidelines: Department of Health and Human Services: Confirm the use of tenofovir disoproxil fumarate, 300 mg twice daily.

References:

The following is a brief summary of TRUVADA® (emtricitabine/tenofovir disoproxil fumarate) (TDF/FTC) tablets for prescribers information, including VIREAD® (tenofovir disoproxil fumarate), a component of TRUVADA, in combination with other antiretrovirals [See Warnings and Precautions].

TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection in patients who have not been treated with anti-HBV therapy before. TRUVADA has not been established in patients infected with HIV and HBV-1.

Severe acute exacerbations of hepatitis B have been reported in patients who were coinfected with HBV and HIV-1 and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months after discontinuation of TRUVADA and discontinuation of antiretroviral therapy. If appropriate, initiation of antiviral hepatitis B therapy may be warranted [See Warnings and Precautions].

INDICATIONS AND USAGE
TRUVADA, a combination of/emtricitabine (EMTRICITABINE) and VIREAD, is indicated in combination with other antiretrovirals for the treatment of HIV-1 infection in adults who have not been previously treated for HIV-1 infection or in adults who have been treated previously with antiretroviral therapy and who have developed resistance to multiple antiretrovirals [See Warnings and Precautions].

TRUVADA should not be administered with any antiretroviral agents that are known to have clinical activity only against HIV-1 or with antiretrovirals that are not intended for treatment of HIV-1 infection. [See Warnings and Precautions].

TRUVADA should not be used to treat patients who have never been treated for HIV-1 infection who have untreated HIV-1 infection [See Warnings and Precautions].

TRUVADA should not be used in patients infected with HIV-1 and HBV-1. It is recommended that patients with HIV-1 infection who have coinfection with HBV-1 be treated for the presence of chronic HBV before initiating antiretroviral therapy TRUVADA should be used in patients with chronic HBV and HIV-1 should be used in patients with chronic HBV and HIV-1 in the absence of evidence that the patient's HBV infection is not active [See Warnings and Precautions].

Contraindications
None.

WARNINGS AND PRECAUTIONS
Lactic Acidosis and Severe Hepatomegaly with Steatosis and Post Treatment Acute Exacerbation of Hepatitis B
Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues, including VIREAD [See Warnings and Precautions].

TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection in patients who have not been treated with anti-HBV therapy before. TRUVADA has not been established in patients infected with HIV and HBV-1. Severe acute exacerbations of hepatitis B have been reported in patients who were coinfected with HBV and HIV-1 and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months after discontinuation of TRUVADA and discontinuation of antiretroviral therapy. If appropriate, initiation of antiviral hepatitis B therapy may be warranted [See Warnings and Precautions].

ADVERSE REACTIONS
Adverse Reactions
Truvada is a fixed-dose combination tablet of emtricitabine and tenofovir disoproxil fumarate. It is an antiretroviral therapy for the treatment of HIV-1 infection.

Table 1: Design for Patients with Altered Creatinine Clearance

<table>
<thead>
<tr>
<th>Recommended Dosing</th>
<th>C/H/C</th>
<th>&lt;50</th>
<th>50-99</th>
<th>&lt;100 (Including Patients Requiring Renal Dosing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every 24 hours</td>
<td>TRUVADA must be administered.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS
None.

WALKING AROUND AND PRECAUTIONS
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TRUVADA is not approved for the treatment of chronic hepatitis B virus (HBV) infection in patients who have not been treated with antiretroviral therapy before. TRUVADA has not been established in patients infected with HIV and HBV-1. Severe acute exacerbations of hepatitis B have been reported in patients who were coinfected with HBV and HIV-1 and have discontinued TRUVADA. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months after discontinuation of TRUVADA and discontinuation of antiretroviral therapy. If appropriate, initiation of antiviral hepatitis B therapy may be warranted [See Warnings and Precautions].

Hepatitis
Hepatitis or/or Hepatitis Occur During Treatment:
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First Architect CCHP Uses Good Design to Improve Health Care Environment

When grappling with issues like cost control, security and employee burnout, consider looking beyond the facility’s policies and take a look at the facility itself. That’s exactly what architect and new CCHP Gregory Cook, AIA, LEED AP, does. As project designer in the justice practice of HOK (Hellmuth, Obata + Kassabaum, Inc.), Cook considers how his clients work and how they want to work, then creates designs to meet a facility’s specific needs.

Cook joined HOK’s justice practice in 2008 with more than 10 years of multidisciplinary design experience. Since then, his team has completed designs for several large penitentiaries, jails and municipal facilities.

The unique health care aspects of such projects require special consideration, Cook says. “Correctional health is a rapidly evolving field, and the challenges inherent in planning correctional health facilities—security, cost, staffing, quality control, safety—are all tied to the success of the architectural design solution. Good design is the reward for taking on these challenges.”

Facility design has always been security driven and most architects understand safety concerns, Cook says, but when it comes to design that helps health care providers to deliver the best care, corrections has been lagging. He recalls comments made at the Correctional Mental Health Seminar last July that providers can’t see what they are doing, and that the noise level is distracting. He cites poor working conditions as a factor in employee burnout.

To address safety, Cook uses three dimensional modeling software with visibility analysis tools that show security angles. For a healthy environment conducive to quality care, he strives for good air, light and daylight. “Beyond the medical facility, something as simple as daylight can really affect your mood and overall well-being.” He notes a positive trend in that advances in correctional health care do seem to be influencing correctional architecture, resulting in better overall health of the inmates.

Cook is now working on Iowa State Penitentiary, a new, 44-acre complex consisting of three buildings to house maximum- and medium-security inmates, as well as a mental health center. Ground-up construction is a rare opportunity, he says, but that doesn’t mean existing facilities cannot make improvements. “All states have antiquated facilities that have potential to evaluate their needs and make better use of what they have.”

Building Knowledge Through Certification

Although Cook is the first architect to pursue CCHP certification, it made perfect sense to him. Noting that “great ideas are essential to the design process,” he says he wanted to gain detailed knowledge of this field and, by joining the community of CCHPs, increase his awareness of emerging trends. “This allows me to provide essential thought leadership to our clients.”

The networking is both enriching and inspiring, he says. “The opportunity to meet with a wide range of incredibly dedicated professionals has been invaluable. They inspire me to further explore and try to invigorate an area of design that has in the past been neglected.” Cook encourages designers and programmers to seek certification to become more familiar with the issues that correctional health providers deal with every day.

Cook also brings his talents and expertise to a very different audience: children. He serves on the board of directors of the Saint Louis City Open Studio and Gallery, a nonprofit organization that provide a safe and educational environment for children of all ages to explore the arts.

20 Years of Professional Certification!

As the Certified Correctional Health Professional program reaches its 20th anniversary, we invite you, our participants and supporters, to share in the celebration. Whether you were among the first group of CCHPs or joined the ranks more recently, we would love to hear your anecdotes about the experience. What has changed over the years? What have you gained from certification? What would you like to see happen with the program in the future? Send your comments to cchp@ncchc.org.

Fun fact: The first exam was held in November 1990, with 183 professionals becoming certified in early 1991. Today, 19 of those first CCHPs still hold the credential!

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Month</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 10</td>
<td>Cottage Grove, OR</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>

We are seeking additional sites for 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. Learn more at www.ncchc.org/cchp.
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in corrections institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

**Henry C. Weinstein, MD**

A longtime NCCHC board member, Henry C. Weinstein, MD, recently informed CorrectCare that he was the 2009 recipient of the Seymour Pollack Distinguished Achievement Award conferred by the American Academy of Psychiatry and the Law. Weinstein represents the American Psychiatric Association on NCCHC’s board, and AAAPL is a supporting organization of NCCHC.

The award was given in recognition of Weinstein’s “significant contributions to the teaching and educational functions of forensic psychiatry, especially in reference to persons with mental illness in the criminal justice system.” His innumerable contributions to this discipline have led to several other teaching awards over the years. He also has written or contributed to numerous published works, including the APAs “Psychiatric Services in Jails and Prisons.”

Weinstein is director of the program in psychiatry and the law at NYU Medical Center and Bellevue Psychiatric Hospital and a clinical professor at the NYU School of Medicine.

**Cynthia B. Palomata, BSN, RN, CCHP**

The staff at NCCHC were saddened by the death of Ms. Palomata, who in October succumbed to injuries inflicted while she was on duty at Contra Costa County (CA) Detention Facility. Palomata had taken and passed the Certified Correctional Health Professional examination just weeks before. She worked as a nurse in Bay Area hospitals for more than 20 years. In December 2005, she joined Contra Costa Health Services, which contracts medical services for the jail. According to authorities, the inmate faked a seizure and while in Palomata’s care struck her in the head with a desk lamp. The inmate, who had been booked that morning, reportedly had no criminal record and showed no signs of aggression before the attack. Palomata was a member of the California Nurses Association, which is calling for “urgent reforms to crack down on a disturbing trend of violence in all facilities where medical care is provided.”

**Academy of Correctional Health Professionals**

The 2010 board of directors election was especially exciting, with 10 highly qualified candidates vying for five open seats. The results were announced during the annual meeting in October. The first five individuals listed below are the newly elected members; the remaining two are newly appointed.

- Vickie Alston, LCSW
- Kelly O’Brien, MD, CCHP
- Joel Silberberg, MD
- Mark Szarejko, DDS, CCHP
- Tracey Titus, RN, CCHP
- Theodore Jolley, CCHP
- Jane Grametbaur, RN, CCHP-RN, CCHP-A

Board officeholders for 2011 will be as follows:

- Ralf Salke, chair
- Sue Lane, chair-elect
- Susan Laffan, immediate past chair
- Judith Robbins, secretary
- Eileen Couture, treasurer
- Edward Harrison, president
Exhibitor Opportunity

Updates in Correctional Health Care
Emerging Issues
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.

Make Your Mark
• Associations
• Contract management
• Diagnostic equipment
• EHR/EMR technologies
• Infection control
• Medical devices
• Mobile medical solutions
• Pharmacy services
• Research organizations
• Consulting
• Dental supplies/equipment
• Educational materials/training
• Emergency preparedness
• Information technology
• Medical supplies/equipment
• Pharmaceuticals
• Recruitment and staffing
• University programs

Build Relationships With the Industry’s Best
Our multidisciplinary audience is a microcosm of the health care field at large. They are the leaders—and emerging leaders—in this field. Connecting with these influential professionals extends your reach to the departments, facilities and staff they work with every day.

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.

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

Registration Information
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.

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**NURSE PRACTITIONERS**

GEO expanded operations following a recent merger with Cornell Companies and now owns and manages 119 correctional, detention and residential treatment facilities with 81,000 offender and residential treatment beds worldwide, including North America, Australia, South Africa, and the United Kingdom. Learn more about where we are growing since our recent merger with Cornell Companies!

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For more information, contact:
Nichole Adamson • Manager, National Recruitment • Toll Free: 866-301-4436, Ext. 7537
Fax: 561-443-3839 • Email: nadamson@geogroup.com

Equal Opportunity Employer • All candidates must be able to pass background investigation, drug screen, and medical evaluation.
New! Nurses’ Handbook of Health Assessment, 7th Ed.
Renowned for its holistic perspective and see-and-do approach, this full-color, pocket-sized handbook offers step-by-step guidance on every phase of the nursing assessment—for adults, children and special populations. The focus is on what nurses need to know to assess clients: the health history, physical examination, normal and abnormal findings, nursing interventions and nursing diagnoses. This edition completely updates all content and references, with new chapters on mental status and assessing frail elderly clients. By Janet Weber, RN, EdD. Lippincott Williams & Wilkins (2009). Spiralbound, 4.25 x 7.125, 800 pages, 230 illustrations. $49.95

New! Correctional Mental Health: From Theory to Best Practice
This broad-based guide presents a biopsychosocial approach for professionals learning to treat criminal offenders in a correctional mental health practice. Featuring a wide selection of readings, it offers a thorough grounding in theory, current research, professional practice and clinical experience. Balanced between theoretical and practical perspectives, the text provides a big-picture framework for assessing correctional mental health and criminal justice issues, offering clear strategies for addressing these challenges. It also examines special correctional mental health populations such as juveniles, women and sex offenders. Chapters were written by established correctional practitioners or administrators at the federal, state, or local level or by academics in the field. Edited by Robert Ax, PhD, and Thomas Fagan, PhD. Sage (2010). Softcover, 432 pages, $54.95

Standards Reference Sets
• NCCCH Reference Set—Save 25%
The Standards for Health Services manuals for jails, prisons and juvenile detention and confinement facilities, plus the Standards for Mental Health Services in Correctional Facilities and the Correctional Health Care Guidelines. A $314.75 value, the discounted set is only $236.10.
• CCHP Study Package—Save 30%
The Standards for Health Services manuals for jails OR prisons (choose one) and for juvenile facilities, plus the Correctional Health Care Guidelines. A $174.85 value, the discounted set is only $122.40.

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.
CQI Studies

Q Our question is about P-A-06 Continuous Quality Improvement Program and compliance indicator 4ci “a study is completed.” We realize that we are required to do two process and two outcome studies a year due to our ADP being over 500, but we aren’t sure of what the difference is or what evidence is required to meet this indicator.

A A “study” is a process of reviewing an identified problem to assess potential causes. A CQI study is one in which a facility problem is identified, a study is completed, a plan is developed and implemented, results are monitored and tracked, and improvement is demonstrated or the problem is restudied. Subsequent corrective action is documented and evaluated to see if the intervention was effective in addressing the problem. Process studies focus on implementation of policies and procedures (usually involving more than one category of staff) and the effectiveness of those processes. For example, examining your chronic care procedure might involve looking at how you identify chronic care patients, how you schedule them for clinics, whether security escort problems cause delays, how documentation is kept, etc. Process studies often focus on timeliness and efficiency. An outcome study on the same subject might focus on whether the chronic care patients’ symptoms are actually decreasing or at least are not worsening as a result of the care. These studies question whether the expected outcomes of patient care were achieved (degree of control is a helpful consideration). The evidence would be documentation of the studies—either the actual study documents and summary of results, or a detailed discussion of the same in the CQI meeting minutes.

Forensic Information Collection

Q Our health services team is clashing with security about collecting forensic information. Our facility is accredited, and we argue that we cannot be involved according to NCCHC standards. We also feel it is a conflict of interest and would interfere with patient relationships. Security claims that certain activities are “medical” and they want the nurses to take blood samples, DNA swabs, etc.

A You are correct; standard J-I-03 intends that health staff serve the health needs of their patients, and this means that they should not gather forensic information because of the professional and ethical conflicts in taking actions that (a) are typically done without inmate consent, (b) could lead to adversarial action against the patient and (c) undermine professional credibility. Some states require that certain forensics-related acts be conducted by health professionals; in those cases, the services should be provided by a staff member who is not involved in that patient’s care or by an outside party. That said, the standard does make an exception in Compliance Indicator 1. To summarize, health services staff may participate in the following circumstances:

• State law requires a blood sample, so long as the inmate consents and health staff are not involved in punitive action if the inmate refuses to consent
• A physician orders a body cavity search or blood/urine testing for medical purposes (e.g., to test for alcohol or drugs in the blood)
• With inmate consent, conducting court-ordered lab tests, exams or radiology procedures
• With inmate consent, gathering evidence from a victim of sexual assault

Finally, you should educate security officials that many techniques for collecting forensic information do not require health expertise. These include urine testing and oral and buccal swabs for DNA testing.

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