Supreme Court OKs Overcrowding Reduction to Protect Inmate Health Rights

Pain Treatment: Striving for a Community Standard of Care

Insulin Dosing Made Simple

National Conference Preview: Baltimore!
Our field faces unprecedented pressures. Times such as these call for extraordinary solutions, and you will find them at NCCHC’s National Conference. This annual event features the most comprehensive and highest quality programming, all designed to help correctional health professionals sail through rough seas to quality of care and professional advancement. With more than 100 sessions, the National Conference is the most cost-effective way to earn continuing education—and the irreplaceable face-to-face networking is free!

LEARN MORE
www.ncchc.org or info@ncchc.org
CorrectCare™ is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, law and corrections.
A new resource center is being launched as the national source for support, training, technical assistance and research to help corrections and law enforcement professionals in complying with forthcoming national standards to eliminate sexual assault in confinement settings. NCCHC is among the half dozen partner organizations selected to help develop the center’s programs and will lend its expertise in designing training curricula.

Established through a cooperative agreement between the Bureau of Justice Assistance and the National Council on Crime and Delinquency, the National Resource Center for the Elimination of Prison Rape is an important “next step” in the effort that commenced with passage of the Prison Rape Elimination Act in 2003. That legislation provided funding for research, programs and training, and created the National Prison Rape Elimination Commission, charged with developing national standards to prevent and respond to sexual abuse in incarceration settings.

In June 2009, NPREC released a report containing its recommended Standards for the Elimination of Prison Rape. The Department of Justice is now engaged in required review and revision of national standards and expects to publish a final version in several months.

Focusing on prevention strategies, reporting and detection, investigation, prosecution and victim-centered responses, the resource center will identify promising programs and practices that have been implemented around the country and demonstrate models for keeping inmates, detainees and residents safe from sexual assault. It will offer a full library, webinars and other resources on its website, and will provide direct assistance in the field through skilled and experienced training and technical assistance providers. Information and support for management, staff and volunteers in all types of facilities as well as in community agencies will be available online and in person.

The center also will be advised by a broad spectrum of organizational and individual leaders from the corrections, law enforcement, juvenile justice, community corrections and advocacy fields.

Headquartered in Oakland, CA, NCCD is a not-for-profit organization that applies research to policy and practice in criminal justice and juvenile justice in its mission to promote just and equitable social systems.

• Learn more: www.nccd-crc.org/nccd/news

### Summer Boot Camps Wow ‘Em in Vegas

This summer saw the launch of the second in our Boot Camp series, this one geared to health services administrators. Held simultaneously with the Medical Director Boot Camp, now in its third year, the events were wildly successful, producing heaps of unsolicited praise. Here’s a sampling:

**Health Administrator Boot Camp**

It was a no-brainer to send our HSAs, and we also brought our medical director, purchasing manager and chief of operations from security. There was no question the program would be of high value—the breadth and depth of topics, the caliber and reputation of the presenters, and the reasonable cost made it a value beyond compare. There were years of learning and experience concentrated in two days! Invaluable, particularly since most of our HSAs have been in their positions for two years or less, and one for only two weeks. It turned out to be one of the best training programs I’ve ever attended. Not only did I learn new things, but the HSAs realized they were part of a larger whole, that there is a rationale behind everything we do and that the people establishing the standards are knowledgeable, compassionate and understanding of our responsibilities. I wish there had been a Boot Camp when I started in 1993!

— Jean Brock, President, Emerald Healthcare Systems, LLC

**Medical Director Boot Camp**

Thank you for a fantastic conference in Las Vegas. I learned a lot and made some great contacts… I am looking forward to continued professional development in corrections and will certainly look to NCCHC for guidance.

— Brent Gibson, MD, Clinical Director, U.S. Medical Center for Federal Prisoners

I sent an email to my assistant director before noon the first day informing her that the Boot Camp had already been worth the trip.

— Lou Anne Cummings, MD, MPH, Health Officer/County Jail Medical Director, Sutter County (CA) Human Services

### Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 20</td>
<td>CCHP exam, regional sites</td>
</tr>
<tr>
<td>Oct. 15-19</td>
<td>National Conference on Correctional Health Care, Baltimore</td>
</tr>
<tr>
<td>October 16</td>
<td>CCHP exam, Baltimore</td>
</tr>
<tr>
<td>November 18</td>
<td>Accreditation committee meeting</td>
</tr>
<tr>
<td>February 18</td>
<td>CCHP exam, regional sites</td>
</tr>
<tr>
<td>May 19-22</td>
<td>Updates in Correctional Health Care conference, San Antonio</td>
</tr>
<tr>
<td>May 20</td>
<td>CCHP exam, San Antonio</td>
</tr>
</tbody>
</table>

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

**Befriend Your Local Health Department!**

*by Robert J. Gogats, MA, and April Lyons, MSN, RN*

You can save money, time and anxiety by developing a mechanism for communication with your local public health departments. In the 21st century we have so many new tools available for communication that the barriers between the correctional institutions and the health departments should no longer exist. Any forward-thinking and engaged local public health department should recognize the importance of working with your facility to ensure improving the public’s health. Not communicating issues of chronic and communicable disease between agencies results in increased cost, slow action and a potential public relations nightmare.

Correctional facilities can benefit from the knowledge, resources and programs that many local health departments offer. The health departments can also facilitate a seamless transition into the community for inmates managing chronic diseases such as tuberculosis and HIV. In Burlington County, NJ, we have worked to establish relationships with the local jails. We offer STD and rapid HIV testing along with counseling to inmates. The health department has an affiliation with an infectious disease physician who is native to the community and highly respected. Through our early intervention program, he provides the management and care of HIV-positive inmates at the health department while they are incarcerated.

Another tremendous benefit from these types of collaborations occurs when inmates who are released have a pre-established resource and therefore become better equipped to effectively manage their own care. This reduces the likelihood of reincarceration due to lack of support and access to care, two factors known to contribute to recidivism. The ultimate collaboration would be a formal, detailed discharge-planning mechanism to successfully reintegrate the inmate population back into the community.

**Mutual Support**

Traditionally, jails and prisons were forced to hide problems for fear of the regulators imposing unnecessary and expensive bureaucratic fixes. Today, with correctional facilities aided by NCCHC’s standards and accreditation, each entity can freely share and assist each other, viewing one another as partners focused on mutual support and problem solving. Issues can get blown out of proportion in the media, but with the local health department’s skills at risk communication backing up the correction institution, a focused perspective will prevail.

Communication between local health departments and correctional facilities should be a two-way street. Just as correctional facilities can benefit from the services and programs provided by local health departments, the health departments should seize the opportunity to work symbiotically with the correctional facilities. It can be greatly beneficial for corrections representatives to attend medical audit committee meetings. MAC meetings incorporate and address a multitude of concerns while serving to cross-pollinate discussion about issues affecting the community at large as well as the incarcerated community. The local health department is aware of what is going on in the community and can bring emerging issues to the forefront of these discussions.

If you haven’t done so already, call your health department and arrange a meeting. There is so much they can offer to your facility. Local health departments often have experts in epidemiology, infection control and indoor air quality that are willing to assist you. Begin by meeting monthly to discuss how you can share staff and how you can increase screening and testing programs that are not already provided by your facility.

Furthermore, health education staff is available to work with your social workers. These services will be free of cost but extraordinarily valuable. Think of what the cost would be for a consultant or staff member to do this work. In addition, think of the time saved by using social media tools for rapid communication. It truly can be quick, easy and cost-effective to work in partnership with public health.

Robert J. Gogats, MA, is the health officer and April Lyons, MSN, RN, is the nursing director at the Burlington County (NJ) Health Department. Gogats also represents the National Association of County and City Health Officials on NCCHC’s board of directors.

**CALL FOR PROPOSALS!**

NCCHC’s 2012 Updates in Correctional Health Care conference will have a special emphasis on the role of correctional health professionals in the larger effort to reduce recidivism through discharge planning, reentry programming and collaboration with agencies in the community.

As always, however, it will also provide a solid core of topics pertinent to all aspects of work in this specialty. We invite innovative experts and leaders to this important forum to share information, insights and instruction. Your participation will not only help attendees to improve health care in their organizations but also contribute to community well-being through greater success in reducing recidivism.

Proposals must be submitted via the NCCHC website, where you will find details about submission requirements. If you have submitted a proposal before, you will love our new online interface! Visit www.ncchc.org.
California Prison Population Reduction
This issue’s cover story discusses the Supreme Court’s 5-4 decision that upholds a lower federal court’s order, issued in 2009, that the California Department of Corrections and Rehabilitation reduce its prison population by about 46,000 inmates. Since that Supreme Court ruling in May, the lower, three-judge court has set a series of strict deadlines and numbers for reduction, according to reporting by the Los Angeles Times. At the time of the high court ruling, the prison census was about 143,435—180% of capacity. By June 27, 2013, the total reduction must amount to 37,000 inmates. CDCR Secretary Matthew Cate points to progress already made (the population was at 200% of capacity in 2009) and has stated a goal of releasing no prisoners. A month before the May ruling, Gov. Jerry Brown signed a bill that would assign custody of some future prisoners to local authorities. The state sheriff’s association is concerned about the ruling’s impact on public safety as well county jails’ ability (financially and otherwise) to absorb reassigned inmates.

Meanwhile, inmates (varying from hundreds to thousands) at prisons across the state engaged in a three-week hunger strike to protest conditions in isolation units as well as treatment of gang members at the Pelican Bay facility, according to the San Francisco Chronicle.

CrimeSolutions.gov Lists ‘Programs That Work’
Looking for data-driven, evidence-based programs that can be replicated in your system? The Office of Justice Programs (part of the Department of Justice) has launched an online database to help practitioners and policymakers understand what works in justice-related programs and practices. It includes information on 150 programs and assigns “evidence ratings”—effective, promising or no effects—that indicate whether a program achieves its goals. Although many of the programs listed are aimed at preventing and reducing crime, several relate to correctional health care, particularly substance abuse treatment and behavioral therapies for juveniles, as well as reentry initiatives. Programs can be recommended for inclusion in the database.
Site: www.crimesolutions.gov

In 10 Cities, Male Arrestees Likely to Be on Drugs
In the 10 cities/counties that took part in a 2010 federal data collection effort, more than half of the adult males arrested tested positive for at least one drug, with rates ranging from 52% in Washington, DC, to 83% in Chicago. The findings appeared in the 2010 Arrestee Drug Abuse Monitoring Annual Report (ADAM II), issued by the White House Office of National Drug Control Policy.

NIC/HHS to Award Funds for Medicaid Access Research
In 2014, the Affordable Care Act will expand access to Medicaid for low-income individuals. At that time, an estimated 35% of inmates being released will be eligible to apply. Given the potential that this new group of applicants may have on corrections and correctional health, the National Institute of Corrections and the U.S. Department of Health and Human Services are offering an award to experts from the corrections and/or health care fields to examine how early access to Medicaid benefits might affect reentry outcomes. The application due date is Aug. 11. The solicitation will be awarded Sept. 13.
NIC application: www.nicic.gov/cooperativeagreements

Corizon brings together the two best and most experienced firms in our industry.

We are Corizon – the nation’s leader in correctional healthcare solutions. We have created one team with best-in-class experience, staffing depth, industry best practices and leadership on a solid financial platform. And, we will continue to discover new and better ways to provide exceptional care for our partners and patients. We invite you to join us on our journey as Corizon.

www.corizonhealth.com
SUSTIVA®
(efavirenz) 600 mg tablets

Bristol-Myers Squibb
Cephalosporin-Resistant Gonorrhea Emerging
Gonorrhea, one of the most common sexually transmitted diseases, seems to be developing resistance to cephalosporins, described as the “last line of defense” in the CDC’s recommended antibiotic treatment for the disease. As explained in a CDC fact sheet published in July, analysis of surveillance data collected from 2000 through 2010 found patterns of declining susceptibility to cephalosporins. Although no treatment failures have been seen in the United States, a few failures have been reported in other parts of the world. The patterns detected are similar to those of fluoroquinolone-resistant gonorrhea less than a decade ago. The CDC plans to ramp up surveillance and says it may modify treatment recommendations “as dictated by surveillance and susceptibility trends.” At present, health care providers are encouraged to promptly treat all patients with gonorrhea according to CDC guidelines, obtain cultures to test for decreased susceptibility from any patients with suspected or documented gonorrhea treatment failures and report any suspected treatment failure within 24 hours. The agency also calls for development of effective new treatments.

• Fact Sheet: www.cdc.gov/nchhstp/Newsroom/docs/Antibiotic-Treatment-of-GC-fact-sheet.pdf
• MMWR Report: www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a2.htm?s_cid=mm6026a2_w
• Treatment Guidelines: www.cdc.gov/std/treatment/2010/

HIV Screening During Prison Intake Medical Evaluation
Since switching to routine opt-out HIV screening of male inmates in March 2010, the Washington State Department of Corrections found that this approach (recommended by the CDC since 2006) has led to a greater proportion of inmates tested without decreasing the rate of case detection. WADOC studied intake HIV testing data for a five-year period (2006-2010) during which the testing policy changed twice.

• HIV testing provided on request: 5% of inmates tested, 0.50% positive
• Opt-in testing: 72% of inmates tested, 0.11% positive
• Opt-out testing: 90% of inmates tested, 0.13% positive

WADOC has an average daily male population of about 15,000 with annual male admissions of about 6,700, all of whom pass through a central reception center. HIV prevalence among male inmates has been stable over the past decade at 0.6% to 0.7%.

An editorial that provides context to this MMWR report notes that findings emphasize the importance of not relying on risk-based testing.


Updated Guide for HIV/AIDS Clinical Care
The Health Resources and Services Administration has published an updated guide that provides clinicians with practical medical information on treatment of HIV/AIDS. The guide is organized into 10 sections that include information on HIV testing, prevention, treatment, coinfections and complications, medication interactions, neuropsychiatric disorders and oral health. Chapters are linked to related HRSA HIV/AIDS Bureau performance measures and where appropriate are based on recommendations of the various Department of Health and Human Services clinical guidelines panels. Another section has links to additional resources for clinicians and patients. The entire manual is available online, and printed copies can be ordered.

Source: http://hab.hrsa.gov/deliverhivaidscare/clinicalguide11
Continuity of care is a concern in all areas of health care—medical, mental health and dental. In juvenile detention and confinement facilities, we want to ensure that all aspects of health care are in keeping with current community standards and that juveniles receive treatment and diagnostic tests ordered by clinicians.

Physician chart review was part of the Continuous Quality Improvement Program standard (A-06) in the 2004 edition of the Juvenile Standards. The 2011 edition has placed this critical function into compliance indicator (CI) #7 of Y-E-12 Continuity of Care During Incarceration: “Physicians’ clinical chart reviews are of sufficient number and frequency to ensure that clinically appropriate care is ordered and implemented by on-site health staff.” You will notice that the concept of physician chart review is a bit different in the 2011 Y-E-12 standard.

NCCHC defines physician clinical chart review as an evaluation by a physician of the timeliness and appropriateness of the clinical care provided to patients. The previous standard for CQI recommended conducting clinical chart reviews of about 5% of all patients’ health records on a quarterly basis. We now generally see physicians conducting their chart reviews on a monthly basis; however, it is up to the discretion of the responsible physician as to how often and how many health records are reviewed. The number and frequency of chart reviews are expected to increase if significant problems are identified.

It is important to note that this review is not the clinical performance enhancement review described in Y-C-02; rather, it is best described as the physician’s review of the totality of care. Here, the physician is focusing on a single clinician’s care in a particular health record for the purpose of enhancing that clinician’s performance. Instead, the physician is determining whether the care provided at the facility is acceptable from admission to discharge. How is continuity of care? Should the patient have been referred from sick call to the clinician sooner? Are appropriate outside consultations ordered? Did the consultation occur? Was it timely? Do clinicians document their review of results? Do additional diagnostic studies need to be ordered for this patient? These are the types of questions the physician might consider during chart review.

Follow-Up Protocols and Treatment Plans

The 2011 standard also highlights the need for protocols in the event a youth returns from an emergency room visit or hospitalization (see CI #2 and #3). In either case, the physician should see the patient, review the discharge orders and issue follow-up orders as clinically indicated. If the physician is not on site when a youth returns from the emergency room, designated health staff should contact the on-call physician to review ER findings and obtain orders as appropriate. And, if the physician is not on site when a juvenile returns from hospitalization, designated staff should immediately review the hospital’s discharge instructions and contact the facility physician for orders as needed. The Discussion section of the standard goes on to note that in proactive health systems, clinician visits are automatically scheduled following diagnostic testing, specialty consultation, ER visits and hospitalization. Qualified health care professionals should review the medical orders and instructions when a juvenile returns from an off-site health facility to ensure continuity of care, and the visits also serve as a safety net to ensure that any treatment recommendations are reviewed, followed or revised as appropriate.

The updated standard expects that treatment plans be used to guide treatment for episodes of illness and that they include the elements noted in the new compliance indicators #6a-c; clinicians should use diagnostic and treatment results to modify the treatment plans as appropriate (CI #4). When diagnostic tests and specialty consultations are completed, the clinician should review the findings with the patient in a timely manner (new CI #1c). If changes in treatment are indicated, the changes should be implemented or clinical justification for an alternative course should be noted, as reflected in CI #5. Documenting in the health record that the “loop has been closed” with the patient helps to ensure that continuity of care is in place.

Episodes of acute illness are resolved more quickly and negative health consequences avoided when the treatment is planned, documented and monitored. The format for the treatment planning may vary, but should include, at a minimum, the frequency of follow-up for medical evaluation and adjustment of treatment modality; the type and frequency of diagnostic testing and therapeutic regimens; and, when appropriate, instructions about diet, exercise, adaptation to the correctional environment and medication. Outcomes should be recorded until the health issue is resolved.

Some responsible health authorities use a standardized form to ensure that all elements of treatment plans for episodes of illness are documented in the health record, but a special form is not necessary to achieve compliance with the standard. For example, all treatment plan elements could be documented in the health record progress notes.

Lastly, please note that although periodic health assessments are included in E-12 in the jail and prison versions of the Standards, this activity remains under the Y-E-04 Health Assessment standard for juvenile detention and confinement facilities.

Jennifer E. Snow, MPH, CCHP, is NCCHC’s director of accreditation. To contact her, write to accreditation@ncchc.org.
Historic Times, Extraordinary Solutions

Our field faces unprecedented pressures. Times such as these call for extraordinary solutions, and you will find them at the National Conference on Correctional Health Care. Year after year, the National Conference features the most comprehensive and highest quality educational programming, all designed to help correctional health professionals sail through rough seas to quality of care and professional advancement.

TIP: Register by September 2 for significant early-bird savings! If you also reserve a room in one of the official NCCHC hotels by that date, you will be entered into a drawing to receive two nights free! See the Preliminary Program for other money-saving tips.

GET MORE BANG FOR YOUR BUCK!

Regular early registration is $415 for up to 18 hours of stellar continuing education designed specifically for correctional health care professionals. That’s a mere $23 per credit hour, and the irreplaceable face-to-face networking is FREE! That registration fee also includes two breakfasts, two lunches, two beverage breaks and a reception. What a value!

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

PRECONFERENCE SEMINARS

Get your educational experience off to a good start by attending a seminar over the weekend. Presented by some of the most respected names in this field, the seminars provide an in-depth look at fundamental elements of delivering quality health services in correctional settings. Registration to the conference is not required to attend these seminars.

Seminar fees are $185 for full-day sessions (7 hours of CE credit) and $99 for half-day sessions (3.5 hours of CE credit). Fees include all course materials and refreshment breaks.

Saturday, October 15

9 am - 5 pm

- An In-Depth Look at NCCHC’s Standards for Health Services in Prisons
- An In-Depth Look at NCCHC’s Standards for Health Services in Jails
- An In-Depth Look at NCCHC’s New Standards for Health Services in Juvenile Detention and Confinement Facilities
- An In-Depth Look at NCCHC’s Standards for Mental Health Services in Correctional Facilities

Sunday, October 16

8:30 am - 12 pm

- Practical Preparation for Initial NCCHC Accreditation
- 1:30 pm - 5 pm

- Infectious Disease Update: New and Emerging Issues
- Advanced Nursing Assessment for Triage and Health Assessments
- Pain Management: A Multidisciplinary Approach

Presented by the National Commission on Correctional Health Care
Find details about the meeting, the preliminary program and online registration at www.ncchc.org.
October 15-19 • Baltimore Convention Center

OPPORTUNITIES GALORE
Choose from more than 100 concurrent sessions to create a curriculum tailored to meet your needs. To enhance your conference experience, take advantage of all the additional educational and networking opportunities we have in store for you.

- Preconference seminars
- Welcome reception
- Opening ceremony and keynote address
- Educational breakfasts and luncheons
- Special interest discussion groups
- Session proceedings on CD-ROM
- Educational poster display
- Informative exhibits
- Networking breaks and activities
- Exhibit hall raffles

THE BALTIMORE BUZZ
Baltimore is a colorful, diverse city known for its history, beautiful harbor, quirky, distinctive neighborhoods and unique museums. You’ll be right in the heart of the bustling Inner Harbor just steps from world-class dining, entertainment and cultural attractions. Visit the National Aquarium, the Maryland Science Center or the Edgar Allen Poe House and Museum. Don’t miss Fort McHenry, the birthplace of the American National Anthem. Then indulge in mouth-watering crab cakes and other blue crab delicacies. You’ll find no shortage of amazing things to do, see, eat and drink in your free time in Baltimore!

NETWORKING ADVENTURES
The National Conference has always provided an environment for making valuable professional contacts and this year is no exception. In Baltimore you’ll have many opportunities for personal networking and knowledge sharing. These activities will enhance the meeting’s value and enable you to return to your organization with a wider base of peer support.

MARKETPLACE TRADESHOW
The work we do would not be possible without the countless suppliers that support us. Come meet with these invaluable partners in the exhibit hall. Knowledgeable representatives from more than 100 exhibiting companies will be on hand to show you the products and services available to assist you in your work. Visit our Buyers Guide at www.ncchc.org for information on the many past exhibitors who support our field.

The exhibit hall is also where you can win fabulous prizes during the raffle drawings! You might be one of the lucky few to win a Kindle, medical equipment, gift card, goody basket or other great prize donated by our generous exhibitors, or even a free NCCHC conference registration!

ROUNDTABLE DISCUSSIONS
The roundtable exchanges held each day are not instructional in nature; instead, they are discussions on emerging trends and hot topics. Open to all attendees, these special gatherings are the best time to interact, debate issues, seek advice and exchange ideas with your peers. You’re guaranteed to come away with lots of great ideas.

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

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

- Regular: early-bird $415; after Sept. 2 $465
- Academy Member: early-bird $330; after Sept. 2 $390 (you may join the Academy when you register for the conference)
- One Day: $205 (entitles you to participate in all events that day)
- Guest Registration: $60 (exhibit hall events only)

ACCOMMODATIONS
So many choices, so little time! But we’ve done the work for you. We negotiated to get the guaranteed best rates with three great hotels, all within walking distance of the convention center. These rates (single/double + tax) are available online only when you visit the National Conference page at ncchc.org and click on the hotel of your choice. Or call the hotel and mention that you will be attending the NCCHC conference. Book by Sept. 16 to lock in the special rate.

Hyatt Regency Baltimore on the Inner Harbor – $199
300 Light St.; 410-528-1234
Renaissance Harborplace Hotel – $179
202 E. Pratt St.; 410-547-1200
Holiday Inn Inner Harbor – $169
301 W. Lombard St.; 410-685-3500
The U.S. Supreme Court moved to strengthen inmate health care rights in California on May 23 when it approved a population reduction plan that may lead to the release of thousands of prisoners to reduce overcrowding that was thwarting compliance with federal court orders. Seven of the nine justices agreed that federal courts have such power to enforce prisoners’ right to health care under the Prison Litigation Reform Act. Five of the justices ruled that the trial evidence and the law justified the lower court to exercise this power and to limit California’s prison population.

Sadly, the conditions that led to the order are the same ones that “shocked the conscience” 40 years ago and many observers believed would never be seen in this scope again: a preventable death every week, prolonged illness and unnecessary pain, suicidal inmates held in cages without toilets. Things got to this point because of California’s persistent noncompliance with orders in two class actions.

**The California Health Care Class Actions**


In 1995, after a 39-day trial, the Coleman court found “overwhelming evidence of the systemic failure to deliver necessary care to mentally ill inmates.” It appointed a special master to develop a remedy.

In *Plata*, the state conceded that its correctional medical care was unconstitutional and it agreed to a detailed consent decree. Four years later, the court found massive noncompliance and an “unconscionable degree of suffering and death.” It displaced the defendants with a receiver, who was given control over all personnel, financial and operational functions of the medical delivery system. Even this sweeping authority was not enough.

By 2009, the prison system had been operating at 200% of capacity for 11 years. The special master, despite issuing more than 70 orders about mental health, reported that services had deteriorated over the previous 12 years due to overcrowding and warned that progress could not be made without a reduction in the prison census. Mortality reports from the receiver detailed needless suffering and preventable death.

The receiver’s plan called for spending more than $7 billion dollars, bonded over 25 years, with $250 million initially. When the moneys were denied, he sought contempt against the governor and the state controller.
Health Cases Become Overcrowding Litigation

Meanwhile, the prisoners sought relief from overcrowding by invoking the Prison Litigation Reform Act, arguing that population reduction was the only effective remedy to protect their health care rights. Other parties joined the litigation.

The 35,000-member correction officers union intervened on behalf of the inmates. Some 144 individual parties joined as defendants to support the state, including legislators, district attorneys, police chiefs, sheriffs, probation officers and county governments.

The court’s opinion on the health system’s deficiencies and the justification for release is 184 pages long. The order reducing overcrowding, entered six months later, was based on a plan submitted by California at the court’s direction, and it was stayed pending Supreme Court review.

In the Supreme Court, 18 state attorneys general filed a joint “friend of the court” brief in favor of California. Many of the supporting organizations of NCCHC filed briefs siding with the inmates, as did a consortium of criminal justice professionals.

Ruling for the inmates, the Supreme Court did not consider individual cases of failed care in isolation. It also focused on “systemwide deficiencies” that fell “below the evolving standards of decency that mark the progress of a maturing society.”

A prison’s failure to provide sustenance for inmates may actually produce physical “torture or a lingering death.” Estelle v. Gamble… [A] prisoner may… suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society. — Brown v. Plata, Slip Opinion at 12

Violation of Estelle’s Three Basic Rights

The litigation applied the three basic rights guaranteed by Estelle v. Gamble: the right to access to care, the right to care that is ordered and the right to a professional judgment. All were persistently violated.

Significant delays in access to care existed at every point in the system; some prisons had up to 700 inmates waiting to see a doctor. A prisoner with extreme chest pain died after waiting for eight hours to see a physician. Another had been dead for several hours in a gymnasium before he was noticed. Staff vacancy rates ran as high as 25% for physicians, 39% for nurse practitioners and 54% for psychiatrists.

There were massive failures to deliver ordered care. The wait for a mental health professional often reached as long as 12 months, and six months for patients already segregated. The state used telephone-booth-sized cages to hold inmates awaiting psych referral because “there was no place to put them”; some were left unattended to decompose in their own waste. Unusually, the Supreme Court included a photograph in its decision (shown above). There were four- to five-year waits for mental health beds, with increasing numbers of truly psychotic inmates “trapped in lower levels of treatment” that could not meet their needs.

Inmates committed suicide by hanging after placement in cells that needed only a simple fix to remove attachments that could support a noose.

It was common for “urgent” specialist referrals to remain “pending” for six months to a year. Among the inmate deaths were delays of five weeks for abdominal pain, 17 months for testicular pain, 16 months for abnormal liver mass, eight months for chemotherapy. At San Quentin, referrals to an ophthalmologist (“immediate”) and a nephrologist (“urgent”) for a prisoner with hypertension, diabetes and renal failure had not occurred when the patient died three months later.

Medications and basic medical equipment were not available, and facilities were in an “abysmal state of disrepair.” Frequent lockdowns (449 in year 2006) impeded continuity of care, and staff could not perform medical programming or deliver services requiring escort. The medical record system lacked “the capacity to deliver records regarding this many prisoners.”

The exercise of professional judgment was affected by such restrictions and by the limited available financial resources. As the Supreme Court has written about the “inherently coercive” nature of corrections: “These factors can, and most often do, have a significant impact on the provision of medical services in prisons” (West v. Atkins). Overcrowding had increased violent injury and the incidence of infectious disease and had overtaken the resources of prison staff, interfering with professional judgment, imposing demands beyond capacity and creating unsanitary and unsafe conditions that made progress in the provision of care difficult if not impossible to achieve.

Staff had only one-half of the clinical space needed to treat patients. Health providers were expected to provide professional services (and judgment) from gymnasiums, dayrooms, storage closets, bathrooms and other makeshift facilities that placed their safety in jeopardy and compounded the difficulty.

Quality control and even competence review were absent, with no “feedback loop to providers as to the key problems.” Morale plummeted.

The Defendants’ Failure to Fund Health Care

The receiver’s reports were “not intended to be a criticism of the hard work done on a daily bass by thousands of health care professionals … struggling to provide care in a chaotic environment” without support of “adequate clinical, administrative and housing facilities.” The receiver told

continued on page 12
Overcrowding (continued from page 11)

The court that only “substantial investments today ... will make up for 30 years of systematic under-investment in prison health care.”

The Supreme Court found that the defendants were subjecting inmates to a “substantial risk of serious harm,” quoting Farmer v. Brennan, which is often cited to support the defense of lack of the requisite intent to violate inmates’ civil rights. That was unavailing here, where defendants knowingly allowed conditions to persist despite available remedies. All prisoners were at risk so long as the state continued to provide inadequate care.

The State’s desire to avoid a population limit ... creates a certain and unacceptable risk of continuing violations of the rights of sick and mentally ill prisoners, with the result that many more will die or needlessly suffer. The Constitution does not permit this wrong. — Brown v. Plata, Slip Opinion at 36

Squarely facing the core funding dilemma, the Supreme Court wrote that it “cannot ignore the political and fiscal reality behind this case. California’s Legislature has not been willing or able to allocate the resources necessary to meet this crisis absent a reduction in overcrowding.” [Editor’s note: A bill has since been signed that provides funding to counties for the transferred prisoners.]

The Dissents

Four justices dissented. Justice Alito and Chief Justice Roberts implicitly conceded the import of Estelle’s reach, but they found that overcrowding reduction was not yet ripe. California should be given more time, things were improving (unnecessary deaths were down in 2009, per the mortality report) and the public safety was inadequately considered. They maintained that risks to inmates were not “objectively intolerable” or certain to continue. The majority found the record adequate and consistent over decades, and it chose not to remand for updated findings after a 21-month appeal had elapsed with the lower court order stayed.

Justice Scalia, joined by Justice Thomas, rejected Estelle v. Gamble and its entire 35-year class action progeny, maintaining that an Eighth Amendment claim cannot be based on “systemic deficiencies.” This view has never garnered more than two votes on the court. They wrote that the remedy in this case exceeded the powers of federal courts under the Constitution or laws and that the release order was “perhaps the most radical injunction issued by a court in our Nation’s history”—a distinction usually reserved for Chief Justice Taney’s 1856 decision in Dred Scott v. Sanford.

A ‘Shot Across the Bow’

After two years, upon compliance with the court order, the California penal system will operate at 137.5% of capacity. The policy considerations underlying California’s prison overcrowding are beyond the scope of this article, but this writer remembers the court orders reducing the Rikers Island population in the 1980s crisis: Those released first had the lowest unmet bail. Here, California can comply with the orders enforcing Estelle without releasing anyone, as the Supreme Court emphasized. Use of good time credits, parole or transfer to county jails are options; so are construction to increase capacity and appropriation of funds to provide adequate health care services for those higher risk inmates who will remain.

The remedy is a “last resort”—or, as Justice Scalia wrote in the context of a future motion to modify the order, a “shot across the bow.” Release is the default against which future performance will be measured. As a former special master, Vincent Nathan, wrote after the Texas health care litigation, “No serious student of American correctional history can deny that litigation has provided the impetus for reform of medical practice in prisons and jails.” Brown v. Plata is an extreme example of the collapse of an underfunded system and a sobering harbinger of déjà vu to other states. It is a warning to the correctional community and to the public. Lifting the stay, the Supreme Court ended its decision with an impetus: “The State shall implement the order without further delay.”

William J. Rold, JD, CCHP-A, is an attorney and former judge. He represented the American Bar Association on the NCCHC board of directors from 2001 to 2007 and is a recipient of NCCHC’s Bernard P. Harrison Award of Merit. He consults on correctional health care and the law. He may be reached at williamjroldesq@verizon.net.
Beyond a reasonable doubt...

Medi-Dose® and TampAlerT®

The most trusted names in tamper-evident unit dose packaging

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

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

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

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

Medi-Dose, Inc. 

EPS, Inc.

Responding to pharmacy packaging needs around the world
Pain comes in many shapes and forms, from the agony of cancer pain to the trauma of severe emotional pain. Medical professionals in the community have long accepted the importance of adequately treating and controlling pain in their patients. But how does the need for adequate pain identification and control integrate into the management of the correctional population?

The terms manipulative and drug seeking often come to mind when considering the type of inmates housed in our correctional facilities, and, in all fairness, a large number of those arrested and serving time have substance abuse problems on admission, as numerous studies have shown.

Nevertheless, a significant number of the correctional population at some time or another will have a true need for pain control. The inmate diagnosed with terminal cancer, the inmate who suffers from chronic, intractable pain or the inmate who recently had major surgery, like the population in the community, will have a valid need for adequate pain control. Multiple studies have shown that patients who receive adequate pain relief require less medication than those who have inadequate pain relief.

The ‘Fifth Vital Sign’

Pain assessment and management have always been a key part of a nursing or medical assessment. In 1998, the Veterans Health Administration initiated a National Pain Management Strategy that addresses the subject of pain and its treatment in a systematic, comprehensive manner. In 1999, the state of California designated pain as the “fifth vital sign” and enacted Assembly Bill 791, which states, “It is the intent of the Legislature that pain be assessed and treated promptly, effectively, and for as long as pain persists.” The California Board of Registered Nursing’s policies on pain control state that pain must be assessed each time the nurse takes vital signs, and that the assessment is based on the patient’s self report.

With both the California Board of Registered Nursing and VHA setting standards for pain assessment, adequate pain assessment and treatment will become the standard of care nationwide. Currently, numerous hospitals, including the City of Hope and Johns Hopkins, have policies and procedures for the assessment and treatment of pain. In addition, pain management clinics have become widespread in the past 10 years.

Policies and Procedures

In formulating policy and procedures, you first must define pain as well as determine when and how to assess pain. Correctional health administrators should expect resistance from staff, especially those who have become accustomed to dismissing inmate complaints of pain as manipulation. The key to staff compliance is education. Assessing pain along with vital signs helps ensure that staff will remember to perform an assessment. Initial assessment should include the location, onset, duration, quality and radiation of pain, as well as alleviating and provoking factors.

Although the level of pain, by definition, is based on the patient’s subjective report, pain can be quantified. A numerical scale and the Wong-Baker facial grimace scale provide a simple method to assess the severity of pain. Numerous other pain assessment scales are in use nationwide, including scales to assess pain in patients with cognitive impairment and dementia.

Depending on the patient’s report of pain, staff may use nonpharmacological approaches to treatment such as relaxation, hot pack, cold packs, deep breathing, meditation or exercise.

When nonpharmacological methods show no effect, nursing protocols can provide staff with the option to give the patient over-the-counter medication such as Tylenol or Motrin, in keeping with the facility’s policies.

Staff will require education not only on nonpharmacological treatment of pain but also on when to refer pain to an advanced practice provider or the physician. Inmates who have chronic, long-term, nonresolving pain not controlled with nonpharmacological measures should be evaluated by a higher level practitioner.

In addition, inmates suffering from acute onset of pain will require careful assessment for emergent or life-threatening conditions and possible referral to a higher level practitioner or to the emergency room, if necessary.

Treatment of the inmate with severe, progressive, intractable pain may become highly problematic, especially in facilities that have policies that do not allow narcotic pain medication. For example, treatment of an inmate with terminal cancer may require the facility to send the inmate to a hospital for inpatient admission for narcotic pain control.
An inmate with a history of drug addiction presents a unique challenge in treatment. However, the goal here is the same as for a nonaddicted patient: to relieve pain and to restore function. Treatment of the addicted inmate may require additional education and perhaps even a written contract concerning the goals of treatment, frequency of prescriptions and refills, and frequency of visits to the advanced-level practitioner.

Once pain is assessed and treated, staff should follow up with the inmate to reassess the effect of the intervention. Follow-up might consist of instruction to the inmate to submit a medical message slip stating that the pain has not resolved or scheduling inmate for reassessment with the RN or the physician.

Thorough documentation of the inmate complaint of pain, assessment, intervention and reassessment of the treatment gives providers an accurate history and assists in the provision of continuity of care.

Quality Care

The standard of care for correctional institutions is the same as that in the community. Many studies have shown that patients who receive adequate pain relief use less pain medication and have a better quality of life. With careful planning and proper education, policies dealing with the adequate control of pain can be effective in the correctional environment.

Jane Grametbaur, RN, CCHP-RN, CCHP-A, is the principal for Grametbaur & Associates Legal Nurse Consultants, Riverside, CA, and specializes in correctional cases. To contact her, email jgrametbaurrn@aol.com.

Resources

- Pain and Symptom Management: Pain Assessment Tools, available at the website of City of Hope Pain and Palliative Care Resource Center http://prc.coh.org/pain_assessment.asp
- International Association for the Study of Pain www.iasp-pain.org

Prevention can cost less than you think; treatment may cost more.

The average cost of treating a MRSA infection in the hospital has risen to over $60,000¹, and that cost does not include the staff time required to supervise a hospitalized inmate.

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

Hibiclens® and Hibistat® wipes can help prevent bacterial infections and viral illnesses by providing an extra benefit on the skin. Both products contain Chlorhexidine Gluconate (CHG), which bonds to the skin and provides continuous killing action for up to 6 hours after use². It is simply not possible to wash and bathe after every potential contact with contaminants, but Hibiclens and Hibistat wipes can help provide lasting protection against contamination that may lead to illness or infection. Hibiclens has also been proven in a dermatological test to be non-irritating to the skin³.

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

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

Hot off the Press

Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research

This new book from the Institute of Medicine assesses the state of the science regarding pain research, care and education and offers a blueprint for developing a population-level strategy to increase awareness about pain and its treatments. It contends that successful treatment, management and prevention of pain require an integrated approach that responds to all of the factors that influence pain. Visit www.nap.edu to buy the book—or read it for free online.

Jane Grametbaur, RN, CCHP-RN, CCHP-A, is the principal for Grametbaur & Associates Legal Nurse Consultants, Riverside, CA, and specializes in correctional cases. To contact her, email jgrametbaurrn@aol.com.
Insulin Dosing Made Simple

by Jeffrey E. Keller, MD, FACEP

I have found, in my years of practicing correctional medicine, that few practitioners who come to corrections are comfortable with insulin dosing. In my experience, this is especially true for physician assistants and nurse practitioners, but many physicians have problems, too. Insulin dosing can be complicated and tricky at times, but for most patients, 10 simple rules will get you to where you need to be.

We first need to cover some groundwork and some terms. Insulin terminology can be confusing. First, it is very important to remember that this discussion applies to type 1 diabetics only. Type 2 diabetics sometimes use insulin, but that’s a “whole ‘nother ballgame.”

There are two types of insulin used for two very different purposes when treating type 1 diabetics. The first is basal insulin, which is used to replace the insulin that the normal pancreas releases constantly—whether we eat or not. Long-acting insulin is used to provide coverage for the basal metabolic needs of type 1 diabetics. Examples are insulin glargine (Lantus) and insulin detemir (Levemir). The most commonly used long-acting insulin is Lantus, so I am going to use that name in this article. (I have no financial ties to the maker of Lantus—I use that name because it is the name most commonly used by patients).

The second type of insulin that type 1 diabetics need is short-acting insulin, which is given to cover the carbohydrates in the food they eat. Short-acting insulins are given just before a meal or snack and, ideally, the dose should vary depending on how many carbohydrates are in the food. Examples of short-acting insulins are insulin regular, insulin aspart (Novolog) and insulin lispro (Humalog).

Again, I will use the term Humalog in this article because it is the term most often used by patients themselves. And again, I have no ties to the maker of Humalog.

Finally, I must point out that there are other insulin dosing systems besides the Lantus-Humalog system I am presenting here. For example, many patients now use insulin pumps, and some still use the older NPH-Humulin system.

10 Rules of Insulin

We are going to apply our rules to two imaginary patients. “Jeffrey” has been newly diagnosed as being a type 1 diabetic. “Ernest” has been taking insulin since he was a child. Both have come to our jail and need insulin orders written. By going through the rules of insulin, we can quickly and easily calculate appropriate insulin orders for these two patients.

Rule No. 1

The basic unit of insulin dosing is the total daily dose, abbreviated TDD. If you count up every unit of insulin that a patient takes in one day, that is that patient’s TDD. Example: Yesterday, Ernest took 33 units of Lantus insulin and 57 units of Humalog. His TDD was 90.

Rule No. 2

The TDD for most patients should be approximately 0.5-1.0 unit per kilogram of weight. Ernest weighs 100 kg. Multiply this by 0.5 to 1.0 units and you get a range of 50 units to 100 units of insulin a day. Ernest’s TDD is 90, which is about right, though at the high end of the range.

Jeffrey is a newly diagnosed type 1 diabetic. What should his beginning insulin dosage be? Generally, you should begin dosing at the low end of the range and gradually move up. Jeffrey weighs 80 kg and we want to start at around 0.5 units per kilogram, which equals a TDD of 40 units per day.

Rule No. 3

Approximately half of each patient’s TDD should be Lantus and half Humalog. We calculated Jeffrey’s initial TDD at 40 units, so half of this, 20 units, should be given as Lantus and the other 20 units will be given as Humalog. Lantus normally is dosed once a day.

Notice that Ernest is taking too little Lantus. He is taking 33 units of Lantus per day, but since his TDD is 90, his dose should be around 45. That change should reduce his need for Humalog, which should fall to around another 45 units.

Rule No. 4

Humalog covers what the patient eats. It should be split between the meals the patient eats during the day. If a patient eats six equal meals, the Humalog units should be split by six. However, since inmates generally eat only three meals a day (and assuming that the three meals contain approximately the same number of carbohydrate grams), the Humalog should be split into thirds.

We have calculated that Ernest’s daily Humalog dose is 45 units. Divide that by 3 and Ernest should get approximately 15 units before each jail meal.

We estimated Jeffrey’s initial daily Humalog dose to be 20 units. Let’s add one to that (these are estimates, after all, so let’s make things easy) to get 21 units. Divide that by three and Jeffrey will get 7 units before each meal. By the way, it is OK to unbalance the 50-50 ratio a little to make dosing work. When we do, the patient should usually take a little more Humalog.

So, to summarize, the initial orders for Jeffrey will be Lantus 20 units daily and Humalog 7 units before each meal. The initial orders for Ernest will be Lantus 45 units daily and Humalog 15 units before each meal.

Rule No. 5

We can use the TDD and the “Rule of 500” to calculate how many grams of carbohydrate each unit of Humalog will cover. 500 divided by the TDD equals the number of carbs covered by one unit of Humalog. Jeffrey has a TDD of 41. 500 divided by 41 equals about 12. Each unit of Humalog will cover approximately 12 grams of carbohydrates. For Ernest, 500 divided by 90 (his TDD) equals about 6. Each unit of Humalog will cover approximately 6 grams of carbs. This becomes important if, as sometimes is done, these patients are given a diabetic snack at bedtime. Snacks should be covered by Humalog! So if the diabetic snack is, say, a peanut butter sandwich containing 24 grams of carbohydrates, Jeffrey should get 2 units of Humalog to cover the snack and Ernest should get 4 units.
Rule No. 6
Let’s say that we check Jeffrey’s blood sugar before lunch and discover that it is a whopping 500. Jeffrey is already getting 7 units of Humalog to cover his meal. How much extra should he get to bring his blood sugar down to normal? The “Rule of 1800” will solve this problem. Here, 1800 divided by the TDD tells you how far the patient’s blood sugar will drop with each unit of Humalog. In Jeffrey’s case, 1800 divided by 41 equals about 44. Since each unit of extra Humalog will be expected to drop his blood sugar by around 44, if we want to drop him from 500 to 100, we will need to give him an extra 9 units of Humalog along with his regular dose of 7 units. So we can give him 16 units of Humalog before lunch and expect his blood sugar to fall to around 100 after lunch.

In Ernest’s case, 1800 divided by his TDD of 90 equals 20. So his blood sugar will only drop by around 20 points with each extra unit of Humalog he is given. To drop his blood sugar from 500 to 100, he will need 20 extra units of Humalog. Add these to the 15 units we are giving him to cover lunch, and the total is 35 units of Humalog.

The rule of 1800 can be used to create a patient-specific sliding scale so that high blood sugar levels are addressed each time they arise.

Rule No. 7
This rule tells us how fast to adjust a patient’s insulin dose. Let’s say Jeffrey’s blood sugars are consistently in the 300s. His insulin dosage needs to be increased. This rule says to increase the dosage by no more than 5% to 10% every two to three days until you reach your goal. You must remember to keep the (approximate) 50-50 balance between Lantus and Humalog. Since Jeffrey was taking a TDD of 41 units, 5% to 10% of that is 2 to 4 units. One way to add another 4 units to Jeffrey’s TDD would be to increase his Lantus dose to 21 units a day and increase his Humalog to 8 units each meal. If he is still running too high in 2 to 3 days, we can increase his Lantus by 3 units to bring him back to perfect 50-50 balance (24 units of Lantus, 24 units of Humalog divided between three meals).

If you have been using a sliding scale, another way to make insulin dose adjustments is to add all of the sliding scale doses the patient has been given to the previous TDD and then recalculate the 50-50 Lantus-Humalog split based on the new TDD. For example, Ernest was taking a TDD of 90 units. However, he also received an average of 10 units of sliding scale insulin every day. His new TDD is 90 plus 10 for a total of 100 units. Divide this in half and his new Lantus order is 50 units and his new Humalog dose is 50 units divided between three meals. Notice that this is a much more aggressive increase of insulin dose. Be sure to consider the next rule, No. Eight, each and every time before you make a large insulin dose adjustment.

Rule No. 8
If a patient’s blood sugar is running high, check his commissary purchases! Remember that blood sugar is dependent on two factors: what the patient eats and how much insulin he is taking. If you cannot bring blood sugar under control, often the reason is that the patient is eating extra “junk” that he purchased from the commissary. This is also often true of patients whose blood sugars jump around a lot—now way too high and now too low. Let’s say we notice that we have steadily increased Ernest’s TDD of insulin until he is taking more than 1.0 unit per kilogram. “That’s odd,” we think. So applying Rule No. 8, we check his commissary purchases and find that he is buying an average of 10 ramen noodles, 15 candy bars and 10 bags of chips each week. Ernest needs some serious diabetic nutrition counseling. If we don’t change his eating habits, we will never control his diabetes adequately.

Rule No. 9
Approximately 20% of type 1 diabetics need to have their Lantus dose divided and given twice a day. The reason is that Lantus lasts for 20 to 24+ hours, depending on the patient. If Jeffrey is a rapid metabolizer of Lantus, he will “run out” of Lantus in less than 24 hours. We will know this because his blood sugars will be running high just before he takes his Lantus dose. The solution is to divide the dose and give it BID. If Jeffrey is taking 24 units of Lantus, we would divide this and give him 12 units BID.

Rule No. 10
What about NPH? This intermediate-acting insulin is usually given twice a day. In type 1 diabetics, NPH is usually given along with regular insulin. Lots of patients who come into the jail are still taking NPH and Humulin insulin, often prepackaged as 70-30 insulin, which contains 70% NPH and 30% Humulin. So it is useful to know how to dose NPH insulin. NPH and Humulin are dosed using the “2/3, 1/3 Rule,” which states that the TDD is split as 2/3 NPH and 1/3 Humulin. Furthermore, 2/3 of the daily dose is given in the morning and 1/3 is given in the evening. So let’s say that John’s TDD of insulin is 90 units. Each day he will take 60 units of NPH and 30 units of Humulin. These will be split so that he takes 40 units of NPH plus 20 units of Humulin in the morning and 20 units of NPH plus 10 units of Humulin in the evening. Since NPH and Humulin usually are already conveniently packaged as 70-30 insulin, all we have to do is give 2/3 of the patient’s dose in the morning and 1/3 in the evening.

To Learn More ...
These 10 rules should be enough to get those practitioners started who have had little experience prescribing and changing insulin dosages. These rules are just a beginning, however. There is still much more to learn. For those interested, an excellent tutorial that goes into much more detail can be found at www.2aida.org/aida/tutorial.htm.

Jeffrey E. Keller, MD, FACEP, is the medical director of the Ada County Jail in Boise, ID, and the Bonneville County Jail in Idaho Falls, ID. Contact him at jkeller@badgermedicine.com.
Correctional Nursing Practice: What You Need to Know (Part 7)

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/cchprn, where you can also view the entire test outline (see downloads).

Preparing to Take the CCHP-RN Exam
So you’ve decided to take the CCHP-RN certification exam. Congratulations! You are on your way to obtaining a credential that recognizes your knowledge of the specialty practice of correctional nursing. Every valuable goal requires planning and preparation for success. Preparing to sit for a certification exam is a rigorous cognitive development program much as preparing for a running marathon is an intensive physical conditioning program. They both require determination, sacrifice and focus.

Those who study exam performance have found that success involves three components of differing proportions. As expected, the majority of success is determined by your specialty practice knowledge base. However, a significant portion of success is determined by your test-taking skills and personal characteristics. Therefore, consider all three factors in your preparation plan.

Knowledge Base (60% to 70%)
Start with a copy of the exam blueprint or study guide. Every certification program has a published guide to the content of the exam. The percentages of the exam in each subject area will be found in this guide. Perform a self-evaluation of your starting knowledge against the exam blueprint. You may have differing levels of understanding and experience based on your correctional career. For example, you may have many years of experience with a male population and need more in-depth study of female conditions. Once you have a list of areas for study, map out a plan based on the number of weeks to the exam date. Take into account your work, family and community obligations in creating your study plan. Also consider your most productive time of day and whether you prefer small frequent study periods or large blocks of time.

Personal Issues (10% to 15%)
Your reaction to tests can also affect your success. Can you see yourself in any of the test-taking personality types listed at left? Test reaction patterns develop over our lifetime through positive and negative educational experiences. By determining your tendencies, you can begin to modify them to improve your potential for exam success.

Test-Taking Skills (25% to 30%)
Knowledge and expertise go a long way toward exam success but can be thwarted by poor test-taking habits. Spend some time becoming adept at answering four-option multiple choice questions. Although there are no CCHP-RN practice tests yet available, you can locate other clinical practice tests to help develop skill. Here are helpful hints to improve your abilities:

- Identify the key words in the question; don’t jump to conclusions.
- Time yourself to avoid spending too much time on any one question. Return to difficult ones.
- Read the full question before looking at the answer options.
- Eliminate answers you know are incorrect.
- Don’t assume or add any information not given.
- Select the best of the viable, available options using logic.

Select the best of the viable, available options using logic.

Test-Taking Personality Types
- Rusher: Rushes to complete the test before forgetting all the facts
- Turtle: Moves slowly, methodically and deliberately through the exam
- Personalizer: Relies heavily on personal experience for answers to exam questions
- Squisher: Threatened by exams and preoccupied with grade
- Philosopher: Searches questions for hidden or unintended meaning
- Second Guesser: Frequently changes initial responses
- Lawyer: Places words or ideas into exam question (leads the witness)


Larry Schoenly, PhD, RN, CCHP-RN, is a member of the CCHP-RN task force and coordinates this column. She is an independent consultant specializing in correctional health care and social media and is based in Pennsylvania. For correspondence about this column, write to editor@ncchc.org.
The GEO Group’s success around the world has been achieved by our highly trained work force.

Opportunities available:

**DENTISTS - GA, MS, & CO**  
**PSYCHIATRISTS - FL & MS**  
**PHYSICIANS and MEDICAL DIRECTORS - TX, GA, MS, VA, SC, OK, MI & CO**  
**NURSE PRACTITIONERS and PHYSICIAN ASSISTANTS - TX & NC**  
**PSYCHOLOGISTS - TX & MS**

GEO’s operations include the management and ownership of 116 correctional, detention and residential treatment facilities with 80,000 offender and residential beds worldwide including North America, Australia, South Africa, and the United Kingdom. Our team of over 18,000 professionals is dedicated to the safety and care of the individuals assigned to our custody on behalf of federal, state, and local government agencies.

For A World of Opportunities, visit:  
**JOBS.GEOGROUP.COM**

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.
3 MEDICATIONS IN 1 ADDS UP TO A COMPLETE HIV REGIMEN

ATRIPLA can be used alone or in combination with other antiretroviral agents.

ATRIPLA is the only DHHS-preferred HIV regimen available as 1 pill daily for antiretroviral-naive patients.

INDICATION

• ATRIPLA is indicated for use alone as a complete regimen or in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults.

IMPORTANT SAFETY INFORMATION

WARNINGS: LACTIC ACIDOSIS/SEVERE HEPATOMEGALY WITH STEATOSIS and POST-TREATMENT EXACERBATION OF HEPATITIS B

• Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including tenofovir disoproxil fumarate (DF), a component of ATRIPLA, in combination with other antiretrovirals.

• ATRIPLA is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of ATRIPLA have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who have discontinued EMTRIVA® (emtricitabine) or VIREAD® (tenofovir DF), which are components of ATRIPLA. 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 ATRIPLA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

*Pill not shown at actual size.
DHHS = Department of Health and Human Services.

Important Safety Information about ATRIPLA

Contraindications
- ATRIPLA is contraindicated in patients with previously demonstrated clinically significant hypersensitivity (e.g., Stevens-Johnson syndrome, erythema multiforme, or toxic skin eruptions) to efavirenz, a component of ATRIPLA.
- Coadministration of ATRIPLA with bepridil, cisapride, midazolam, pimozide, triazolam, or ergot derivatives is contraindicated, since competition for CYP3A by efavirenz could result in inhibition of metabolism of these drugs and create the potential for serious and/or life-threatening adverse reactions.
- Concomitant use of ATRIPLA with voriconazole, atazanavir (with or without ritonavir), St. John’s wort (Hypericum perforatum) or St. John’s wort-containing products is not recommended.

Warnings and Precautions
Coadministration with Related Products
- Since ATRIPLA contains efavirenz, emtricitabine, and tenofovir DF, ATRIPLA should not be coadministered with SUSTIVA® (efavirenz), EMTRIVA, VIREAD, or TRUVADA® (emtricitabine/tenofovir DF). Due to similarities between emtricitabine and lamivudine, ATRIPLA should not be coadministered with drugs containing lamivudine, including Combivir® (lamivudine/zidovudine), Epivir® or Epivir-HBV® (lamivudine), Epzicom® (abacavir sulfate/lamivudine), or Trizivir® (abacavir sulfate/lamivudine/zidovudine).

ATRIPLA should not be administered with HEPSERA® (adefovir dipivoxil).

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

Nervous System Symptoms
- Fifty-three percent of subjects reported central nervous system symptoms (including dizziness [28.1%], insomnia [16.3%], impaired concentration [8.3%], somnolence [7.0%], abnormal dreams [6.2%], and hallucinations [1.2%]) when taking efavirenz compared to 25% of subjects receiving control regimens. These symptoms usually begin during Days 1-2 of therapy and generally resolve after the first 2-4 weeks of therapy; they were severe in 2.0% of subjects, and 2.1% of subjects discontinued therapy. After 4 weeks of therapy, the prevalence of nervous system symptoms of at least moderate severity ranged from 5% to 9% in subjects treated with regimens containing efavirenz. Nervous system symptoms are not predictive of the less frequent psychiatric symptoms.

New Onset or Worsening Renal Impairment
- It is recommended that creatinine clearance (CrCl) be calculated in all patients prior to initiating therapy and as clinically appropriate during therapy with ATRIPLA, and routine monitoring of CrCl and serum phosphorus be performed for patients at risk of renal impairment, including patients who have previously experienced renal events while receiving adefovir dipivoxil. ATRIPLA should not be given to patients with CrCl <50 mL/min. Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphatemia), has been reported with the use of tenofovir DF. ATRIPLA should be avoided with concurrent or recent use of a nephrotoxic agent.

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

Please see Important Safety Information, including Boxed WARNINGS, for ATRIPLA and brief summary of Full Prescribing Information on adjacent pages.
ATRIPLE (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg tablets)

Brief Summary of Prescribing Information. For complete prescribing information consult official package insert.

ATRIPLA is contraindicated in patients with previously demonstrated clinically significant hyperbilirubinemia or Stevens-Johnson syndrome, erythema multiforme, or toxic skin eruptions, to a component of ATRIPLA.

Concomitant Drugs: For some drugs, caution for COXPIA by efavirenz could result in the prolongation of their metabolites and the potentiation of their adverse reactions. Drugs that are contraindicated or not recommended for use with ATRIPLA include anticonvulsants such as barbiturates, carbamazepine, phenytoin, and phenobarbital, or any drug that is known to induce hepatic microsomal enzymes. COXPIA should be reinitiated in patients interrupting therapy because of rash. ATRIPLA should be discontinued in patients developing severe cutaneous adverse reactions. The most common adverse reactions that have been associated with significant increases in psychiatric manifestations are: delusions, dizziness, hallucinations, headache, insomnia, nervousness, paresthesia, tremors. In patients with persistent elevations of serum transaminases to greater than five times the upper limit of the normal range, the benefit of continued therapy with ATRIPLA needs to be weighed against the risks.

Decreases in Bone Mineral Density (BMD): Monitoring should be considered for patients treated with ATRIPLA because the use of antiretroviral drugs is associated with decreased bone density.

Cases of osteomalacia (associated with reduced renal tubular function) and which may contribute to fractures have been reported in patients treated with the use of the antiretroviral drug tenofovir in combination with the use of nucleoside reverse transcriptase inhibitors.

If appropriate, initiation of anti-hepatitis B therapy may be considered for patients with hepatitis B infection. The benefit of continued therapy with ATRIPLA needs to be weighed against the risks of etonogestrel. If etonogestrel is used as contraceptive failure in patients treated with efavirenz-exposed patients. Also, since contraceptive failure has been observed in patients treated with efavirenz and etonogestrel, contraceptive counseling should be offered. If appropriate, initiation of anti-hepatitis B therapy may be considered for patients treated with the use of nucleoside reverse transcriptase inhibitors.

If appropriate, initiation of anti-hepatitis B therapy may be considered for patients treated with the use of nucleoside reverse transcriptase inhibitors. The benefit of continued therapy with ATRIPLA needs to be weighed against the risks of contraceptive failure in patients treated with efavirenz-exposed patients. Also, since contraceptive failure has been observed in patients treated with efavirenz and etonogestrel, contraceptive counseling should be offered. If appropriate, initiation of anti-hepatitis B therapy may be considered for patients treated with the use of nucleoside reverse transcriptase inhibitors.

If appropriate, initiation of anti-hepatitis B therapy may be considered for patients treated with the use of nucleoside reverse transcriptase inhibitors. The benefit of continued therapy with ATRIPLA needs to be weighed against the risks of contraceptive failure in patients treated with efavirenz-exposed patients. Also, since contraceptive failure has been observed in patients treated with efavirenz and etonogestrel, contraceptive counseling should be offered. If appropriate, initiation of anti-hepatitis B therapy may be considered for patients treated with the use of nucleoside reverse transcriptase inhibitors.
Emtricitabine and Tenofovir DF: Since emtricitabine and tenofovir are primarily eliminated by the kidney, coadministration of this combination with nephrotoxic drugs should be used with caution. Drugs that may cause renal dysfunction (e.g., amphotericin B, cimetidine, sulindac, indomethacin, probenecid, salicylates, and others) should be used with caution when administered with ATRIPLA. Close monitoring of renal function and dose adjustments of these coadministered medications should be considered. Debilitated or elderly patients, or those with pre-existing renal impairment, may be more susceptible to this effect. Some patients have developed renal insufficiency and acute renal failure following the use of tenofovir DF; renal impairment may progress to dialysis-dependent renal failure. Close monitoring of creatinine clearance or serum creatinine should be used to detect diminutions that may occur in patients treated with ATRIPLA. It is recommended that care be exercised in interpreting laboratory values of serum creatinine and that creatinine clearance be calculated in patients receiving concomitant therapy with ATRIPLA. Coadministration of concomitant drugs that are renally excreted, such as amlodipine, isoniazid, and propranolol, may result in increased concentrations of these drugs and their metabolites. Concomitant treatment with emtricitabine and tenofovir may result in increased concentrations of lamivudine. In clinical trials with emtricitabine and tenofovir, increases in lamivudine concentrations were observed compared to when lamivudine was administered as a single agent. Therefore, the dose of lamivudine (as a component of ATRIPLA, EMTRIVA, or VIREAD) should be reduced to 150 mg daily. Patients with impaired renal function may require reduced doses of concomitant medications that are renally excreted. See [Drug Interactions].

Emtricitabine and Tenofovir DF: In clinical trials, reductions in CD4+ cell counts and viral loads were observed in adults treated with the fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate (300 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg). The safety and effectiveness of this combination were similar to those of the individual components when each was administered as monotherapy. The pharmacokinetics of emtricitabine and tenofovir are additive when the combination is coadministered. The incidence of drug-related adverse experiences is similar to that of the individual components when given as monotherapy. Some examples include, but are not limited to, headache, nausea, diarrhea, vomiting, abdominal pain, flatulence, and coughing.

Emtricitabine and Tenofovir DF: In clinical trials, reductions in CD4+ cell counts and viral loads were observed in adults treated with the fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate (300 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg). The safety and effectiveness of this combination were similar to those of the individual components when each was administered as monotherapy. The pharmacokinetics of emtricitabine and tenofovir are additive when the combination is coadministered. The incidence of drug-related adverse experiences is similar to that of the individual components when given as monotherapy. Some examples include, but are not limited to, headache, nausea, diarrhea, vomiting, abdominal pain, flatulence, and coughing.

Emtricitabine and Tenofovir DF: In clinical trials, reductions in CD4+ cell counts and viral loads were observed in adults treated with the fixed-dose combination of emtricitabine and tenofovir disoproxil fumarate (300 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg). The safety and effectiveness of this combination were similar to those of the individual components when each was administered as monotherapy. The pharmacokinetics of emtricitabine and tenofovir are additive when the combination is coadministered. The incidence of drug-related adverse experiences is similar to that of the individual components when given as monotherapy. Some examples include, but are not limited to, headache, nausea, diarrhea, vomiting, abdominal pain, flatulence, and coughing.
Those who work with incarcerated populations have long been aware of the "inconsistencies and shortcomings of institutional health care programs aimed at assisting inmates during incarceration and preparing them for readjusting to community living." So write the guest editors of a special issue of NCCHC’s Journal of Correctional Health Care, being published in October. Because ethnic factors "play a substantial role in sentencing, with African Americans three times more likely than Hispanics and five times more likely than Whites to be incarcerated," an examination of health disparities affecting African Americans involved with the criminal justice system is warranted.

In their call for manuscripts, Ronald Braithwaite, PhD, and Jean Bonhomme, MD, of the Morehouse School of Medicine along with C. Debra Furr-Holden, PhD, of Johns Hopkins University "sought to delineate particularly neglected health issues prevalent among the incarcerated and to propose novel and innovative interventions."

The resulting series explores innovative research, services and programs that target inmate populations with a focus on African Americans. Specific topics addressed include substance use disorders, sexually transmitted infections, trauma, ethnic disparities, neighborhood environments, the reentry process and mental health.

Although these articles only scratch the surface of the large number of concerns pertinent to incarcerated populations, as a whole this issue of JCHC reinforces the need to focus more intently on how health-related issues affect the likelihood of incarceration, the welfare of inmates and community public health in terms of recidivism, drugs, crime and disease. The guest editors conclude with a call for greater collaboration among community-based health and human service providers, correctional agencies and discharge planning to address multiple health care needs.

JCHC Volume 17, Issue 4

Racial/Ethnic Disparities in Patterns and Determinants of Criminal Justice Involvement Among Youth in Substance Abuse Treatment Programs — Dionne C. Godette, PhD, Mesfin S. Mulatu, PhD, MPH, Kimberly Jeffries Leonard, PhD, Suzanne Randolph, PhD, and Natasha Williams, PhD, JD, MPH

Neighborhood Disorder and Incarceration History Among Urban Substance Users — Damiya Whitaker, PsyD, Camelia Graham, PhD, C. Debra Furr-Holden, PhD, Adam Milam, MHS, and William Latimer, PhD

A Qualitative Study of Relationships Among Parenting Strategies, Social Capital, the Juvenile Justice System, and Mental Health Care for At-Risk African American Male Youth — Joseph B. Richardson, Jr., PhD, and Mischelle Van Brakle

Integrated Trauma Treatment in Correctional Health Care and Community-Based Treatment Upon Reentry — Barbara C. Wallace, PhD, Latoya C. Conner, PhD, and Priscilla Dass-Brailsford, EdD

Challenges and Strategies of Frontline Staff Providing HIV Services for Inmates and Releasees — Alyssa G. Robillard, PhD, CHES, Ronald Braithwaite, PhD, Paige Gallito-Zaparaniuk, MS, and Sofia Kennedy, MPH

Each issue also has a self-study exam that offers continuing education credit. Academy of Correctional Health Professionals members receive JCHC (print and online) as a benefit of membership. To learn how to obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
Patient Safety Effort Leads to Group Exam

In May, 33 PHS Correctional Health Care executives and upper-level management staff successfully completed the CCHP examination at their corporate headquarters in Brentwood, TN. This special, on-site test administration occurred following a daylong, on-site training on the NCCHC Standards provided by National Commission cofounder B. Jaye Anno, PhD, CCHP-A.

NCCHC Standards are widely recognized as setting the bar for health services in correctional institutions. Because the exam is based on the Standards, many candidates attend the Standards preconference seminar at our Updates and National Conferences to brush up before taking the examination. Candidates emphatically agreed that the opportunity to review just one day prior to the examination was extremely helpful. Many also praised Anno as a "tremendous speaker."

The events were held as the result of a corporate effort to focus on patient safety. Two PHS executives—Becky Pinney, RN, CCHP-RN, president of metropolitan corrections systems, and Jessica Lee, MSN, CCHP, director of professional development and training, coordinated the effort to kick off the company’s annual management meeting. Pinney has served on the CCHP board of trustees since 2007. The group was thrilled to be rewarded for their efforts in learning that they achieved an unprecedented 97% passing rate. Surely this team-oriented approach to excellence has served them well in integrating with Correctional Medical Services to become Corizon, one of the nation’s largest correctional health services management companies. The merger occurred in June.

20 Years of Professional Certification!

The Certified Correctional Health Professional program is gearing up for a big party in Baltimore in October. At the National Conference we will celebrate our 20th anniversary with a host of activities and promotions, and we are shining the light on extra-special CCHPs and supporters.

Did you know? The CCHP program was announced to the public in the January 1990 issue of CorrectCare. The first exam, given in November 1990, was a take-home exam in essay format. It is now a proctored, written examination offered four times a year at NCCHC conferences and regional sites across the country.

For information about the CCHP program, including test dates and sites, as well as the National Conference, visit www.ncchc.org.

CCHP Exam Dates

| September 8 | Newport, OR |
| October 16 | Baltimore, MD |
| February 18 | Multiple regional sites |
| May 20, 2012 | San Antonio, TX |

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 manager at 773-880-1460 or cchp@ncchc.org. Learn more at www.ncchc.org/cchp.
Big Numbers, Big Opportunity
With 2.3 million individuals incarcerated in the United States, serving their wide-ranging health care needs is a big business. In fact, the nation’s correctional facilities spend roughly $7 billion each year to provide this government-mandated care. Just as in the community, 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.

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.

Effective Outreach
• Exhibitions are the #1 source for attendees who make purchasing decisions.
• Exhibition leads cost 56% less to close than field sales calls.
• Exhibitions allow you to reach an average of 88% of unknown prospects.
Source: The Center for Exhibition Industry Research (CEIR)

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
• Lead retrieval technology available for rental on site
• Opportunity to participate in raffle drawings
• Priority booth selection for the 2012 Updates conference

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

Registration Information
The National Conference is the premier event where you can meet with important contacts and raise your profile in this specialty field, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details and a reservation form, please see the Exhibitor Prospectus, available online at www.ncchc.org, or contact the exhibits and sales manager at conference@ncchc.org or 773-880-1460.
NEW! The Legal Health Record: Regulations, Policies, and Guidance, 2nd Ed.

This important book explains, from a record manager’s perspective, how to create health records that are better organized and offer better legal defensibility, and how to lead teams through the processes necessary to clearly understand and organize strategies and work flows. As health records migrate to electronic environments, this book will assist in meeting the related challenges. The tools and strategies provided straddle the legal and record management/information technology arenas. Key features: expanded explanatory information; components of the legal health record; customizable forms and templates; litigation response and subpoenas; EHR system attributes that affect the legal health record; details about e-discovery, federal rules of civil procedure and uniform rules. By William Kelly McLendon, RHIA, and Michael R. Lowe, JD, technical editor. AHIMA Press (2011). Soft cover, includes CD-ROM, $59.95

Substance Abuse Treatment for Criminal Offenders: An Evidence-Based Guide for Practitioners

Part of the APA’s Forensic Practice Guidebooks series, this book takes a comprehensive look at what interventions work in assessing and treating substance-abusing offenders. It is packed with practical information on traditional and cutting-edge approaches to treating offenders, including women, juveniles and those with the dual diagnoses of substance abuse and a mental disorder. Most substance abuse treatment today is provided to the criminal population so there is a pressing need for resources that bridge criminal justice and addictions treatment. From assessment and diagnosis through individual, family and group interventions and monitoring probationers, this is an essential resource for psychologists, psychiatrists, social workers, criminologists, sociologists, correctional officers and others working in institutional and community-based settings. By David Springer, PhD, C. Aaron McNeece, PhD, and Elizabeth Mayfield Arnold, PhD, LCSW. American Psychological Association (2003). Hardcover, 252 pages, $39.95

CCHP Items

As the Certified Correctional Health Professional program celebrates its 20th year, be sure to stock up on these professional items adorned with the CCHP logo. Find product descriptions and order online via the publications catalog at www.ncchc.org.

- CCHP Pin Enhancer to mark 5, 10 or 15 years of participation in the program. (20-year pins will be available in the fall.) $10
- CCHP Business Card Case, a stylish way to tote your business cards. $8
- CCHP Cup and Coaster, 11 oz. white porcelain cup with coaster that can serve as a lid to keep beverages warm. $7.50 for one, $6 for two
- CCHP Executive Organizer with mini binder, calendar, address book and more. $20

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.
Chronic Disease Services

Q Is anything in print regarding the time lines by which chronic disease patients should be seen? If they are well controlled without any incidents, is it really necessary to see them every 90 days? In the community, people with chronic diseases that are well controlled do not see a provider every 90 days. Can you give me some guidance as to where I might be able to find such information?

A NCCHC’s G-01 Chronic Disease Services standard leaves the frequency of follow-up for medical evaluation to the provider’s clinical judgment. There isn’t a hard and fast rule in the standard that all patients with chronic disease must be seen every 90 days. The standard does expect that the responsible physician establishes and annually approves clinical protocols consistent with national clinical practice guidelines and that treatment plans are in place for patients with chronic disease. The elements of the treatment plans should indicate that the protocols are being followed and that deviations from protocols are documented with clinical justification. NCCHC has guidelines for disease management you may wish to refer to; visit the Resources section at our website, www.ncchc.org.

CQI Process Study or Outcome Study?

Q Our jail is changing to a new pharmacy and we want to make sure that changing this vendor does not affect patient outcomes or the expected standard that patients would continue to receive their medications as ordered by the physician for their treatment plan. Can we use this study for one of our outcome studies as required by J-A-06 Continuous Quality Improvement Program?

A This is a great CQI study topic, but it sounds like it is best classified as a process study (and can certainly be used as such to meet J-A-06). Remember that outcome studies examine whether patients’ conditions are improving under the care provided. From what you describe, you are assessing the pharmacy delivery system—a process. The “outcome” of the patient receiving ordered medications is part of a process and is not a clinical outcome. We have seen CQI outcome studies on topics such as the effect of valproic acid administration on the rate of violence among mentally ill inmates, monitoring to reduce hemoglobin A1c levels and degree of control in hypertensive patients. Keep up the good work on monitoring whether patients receive ordered medication as part of their continuity of care.

Designated Mental Health Clinician

Q What exactly do you mean by the term “responsible mental health clinician”? I can’t find a definition in the Standards.

A I assume that the mental health authority is separate from that of health services in your facility. Just like health services are required to have a responsible physician, there should be a similar counterpart for mental health services; in the Standards, the term used is “designated mental health clinician” (A-02 Responsible Health Authority, compliance indicator #6). Here’s the definition: A designated mental health clinician refers to a psychiatrist, psychologist or psychiatric social worker who is responsible for clinical mental health issues when mental health services at the facility are under a different authority than the medical services.

Jennifer E. Snow, MPH, CCHP, is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Thanks to Mackenzie Bisset, MSPH, NCCHC’s accreditation compliance specialist, for her contribution to this column. Send your question to accreditation@ncchc.org.
58 million tests a year have taught us one thing: you deserve more from your lab than just test results.
“LAST YEAR, I HELPED OUR CLIENTS SAVE $15+ MILLION IN DRUG COSTS.”

“My team and I monitor medication usage trends and track best practices to give our clinicians better medication choices. We not only find ways to lower costs, we give savings back to you.”

Gregg Puffenberger, PharmD, MBA
MHM Director of Pharmacy Management

MHM is the leading national provider of correctional mental health. We provide value-added pharmacy management services to all of our clients to contain costs and improve outcomes.

Delivering correctional healthcare the right way costs less. Find out how by contacting Dr. Puffenberger at 800.416.3649 or gpuffenberger@mhm-services.com