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Get in Tune With CHORDS

Although measurement underlies quality improvement efforts within facilities, it does not enable examination of performance on a large scale, in comparison with peers. For that, benchmarking is essential. Such benchmarking is commonplace in community-based hospitals and health networks, which rely on these data not only for quality improvement but also to satisfy payor requirements.

To date, however, the correctional health care field has done very little benchmarking of health care performance, although it could greatly enhance quality and effectiveness of care. This is due, in part, to a lack of robust, uniform performance measures tailored to the unique correctional setting, as well as the absence of a way for facilities to share data.

These major obstacles will soon be a thing of the past. Building on a chronic disease data reporting program it initiated several years ago, NCCHC is now working with leaders of a variety of correctional systems throughout the country to establish a national performance measurement system called CHORDS (Correctional Health Outcome and Resource Data Set). Broadly speaking, CHORDS will consist of the following elements:

- Standardized performance measures, with an emphasis on effectiveness of care, availability of and access to care, use of services, cost of care and others
- A data repository to establish regional and national benchmarks for participants
- Data reporting capabilities to help correctional systems track, trend and compare data over time

This important effort has the potential to impel quality improvement in correctional institutions across the nation and, ultimately, benefit the public health. Stay tuned for updates as the project progresses.

Board Member Update

Carl C. Bell, MD, CCHP, became board chairman at the annual board meeting on Oct. 16 in Baltimore. Bell knows well the work of the National Commission: He is a founding member of the board of directors who served as chair in 1991. An expert in correctional psychiatry, he will focus on prevention as well as violence reduction in incarcerated populations during his term (see the next issue for a profile). He represents the National Medical Association on the board.

At that same board meeting, Judith Robbins, LCSW, CCHP-A, was selected as chair-elect. She has represented the National Association of Social Workers since it became a supporting organization in 2005. Robbins directs a statewide mental health program for pretrial youth through a contract with Connecticut's judicial branch and has been heavily involved with NCCHC's juvenile health committee.

Welcome to Two New Board Members

- Joseph Goldenson, MD, representing the American Public Health Association: Employed by the San Francisco Department of Public Health, Goldenson is the medical director of the San Francisco jail, a position he has held for 20 years.
- Ilse R. Levin, DO, representing the American Medical Association: Employed by Unity Healthcare, Levin is a staff attending physician at the Washington DC Department of Corrections and the Reentry Clinic, providing care to inmates and halfway house residents.

In Other News ...

New Position Statement and Guidelines for Disease Management

The policy and standards committee complete work on, and the board adopted, three documents in October. All are available at ncchc.org, Resources section.

- Position Statement: Management of Chronic Pain (see page 4 for 10 key points)
- Guideline for Disease Management: Adolescent Obesity
- Guideline for Disease Management: Adolescent Sickle Cell Disease

AMA Resolution on Correctional Health Care

The American Medical Association reaffirmed its support of correctional health care this year when it adopted a resolution titled Maintaining AMA's Commitments to Public Health and Correctional Health Care. The resolution was submitted by the American Association of Public Health Physicians. Both groups are supporting organizations of NCCHC and are represented on its board of directors.
Why Multicultural Awareness Is Important

by Mark Fleming, PhD

Over the years, the field of mental health counseling has become increasingly aware of the critical importance of not only recognizing diversity but also implementing multiculturally aware practices when working with clients.

In our attempts to be multiculturally aware, it is imperative to recognize that issues around diversity include not only race but also gender, disability status, residency status, sexual identity, geographical location, socioeconomic status, political affiliation and religious identity, to name a few. As practitioners, it is incumbent upon us to recognize the importance of multicultural awareness, be cognizant of the potential pitfalls from a lack of awareness and use appropriate practices to heighten awareness in ourselves, others and the systems in which we work.

Multicultural awareness in corrections is important for a variety of reasons. First, there has been an emergence for a greater attendance to an ever-increasing diverse population. In recent years, it has become more evident that the traditional theoretical orientations and assessments are inappropriate for clients from certain cultural backgrounds. As a result, the American Psychological Association published guidelines on working with ethnically and linguistically diverse populations.

Second, an increasing understanding of diversity increases a counselor’s repertoire of skills and perspectives by adding a fourth dimension to the three traditional helping orientations (psychodynamic, humanistic-existential and cognitive). This fourth dimension helps the counselor to understand the client in the context of the client’s cultural lens, thereby minimizing therapist projections and potential negative feelings of countertransference.

Third, awareness challenges the assumption that one approach to counseling is transferrable to all clients. As clinicians, we must engage in the daily practice of seeing each of our clients as unique individuals who must be accepted and respected. Awareness is critical in that unintentional isms are as serious and harmful as intentional isms. For example, if a therapist asks a male inmate if he has a wife, the therapist has engaged in heterosexism. A more appropriate question would be if the inmate has a significant other or partner.

When a practitioner lacks awareness of multicultural issues, there is a greater potential for harm to the client and to the therapeutic relationship. This harm may manifest in many ways, including the therapist forcing his or her worldview on the client, the therapist conceptualizing a patient through a culturally biased lens and the client feeling as if the therapist is culturally insensitive, with the result that the client does not fully engage in the process of therapy.

Without an active attempt to increase one’s awareness of diversity issues, biases can easily interrupt or undermine the therapeutic process. Without understanding the values and belief systems of our clients, we are destined to engage in treatment from our own worldview as opposed to the client’s worldview. Biases can impair a counselor’s ability to diagnose and plan appropriate interventions. Biases can also interfere with a counselor’s conceptualization of causes of and solutions to the client’s problems, or with the ability to accurately discern the difference between internal and external causes of the client’s problem.

Heightening Awareness

There are no quick ways to heighten awareness in ourselves, others or the systems in which we work. The most lasting ways are processes that must be initiated over time and gradually worked into the fabric of the individual or the system. There are several ways in which practitioners can begin the process of heightening awareness both at the individual and systemic levels.

Individually, practitioners must first and foremost engage in a journey of self-discovery regarding their own biases and assumptions and how these may play out in a therapeutic environment. Secondly, practitioners must be sure not to impose personal beliefs on the client or the system. Lastly, it is incumbent upon the practitioner to strive for an increased awareness into multiculturalism through trainings, seminars and classes.

In the correctional environment, one of the primary ways to heighten awareness is through a diversity mission statement. The system also must work diligently to recruit, retain and promote individuals from diverse backgrounds. The correctional system and all of its subsystems must foster a welcoming and inclusive environment. This can be achieved by building a tradition of inclusion even amid a history of exclusive practices. Having translators available, establishing policies that directly address employees who use discriminatory language and behaviors, and offering flexible benefits and service plans that meet the needs of all employees are other ways to heighten awareness.

As we move rapidly into the 21st century, an increased awareness of the importance of multiculturalism and diversity in correctional settings will be an ever-present issue. As individuals and systems strive to meet the needs of all cultural identities of inmates and employees, practices at both the personal and systemic levels must be fully integrated. Though the task may seem daunting, the journey can be achieved one step at a time.

Mark Fleming, PhD, is director of behavioral health services, Corizon, St. Louis, MO. He presented on this topic at three NCCHC educational conferences in 2011.
It is important to evaluate and manage inmates with chronic pain. NCCHC’s new position statement on the topic emphasizes that corrections clinicians should be knowledgeable and skilled in the management of this challenging problem and seek training as necessary. Below are the 10 key points of the statement. Find the complete document, including introductory information, at ncchc.org.

**Position Statement**

1. Chronic pain is a distinct clinical entity, requiring an understanding of pain mechanisms, evaluation, and treatment options.
2. Because a fundamental knowledge of the correctional health care environment and their patients is needed, properly trained primary care clinicians are uniquely qualified to treat chronic pain in correctional settings.
3. Medical directors and other responsible health authorities should facilitate and encourage appropriate training covering the requisite skills to make reliable diagnoses, establish appropriate treatment plans, and monitor progress for patients with chronic noncancer pain.
4. Nationally recognized guidelines regarding the care and treatment of chronic pain should be referenced and adapted to the correctional environment.
5. Chronic pain should be addressed like other chronic medical conditions, in a systematic, objective, structured manner beginning with diagnosis and treatment planning and proceeding with structured and regular monitoring of progress.
6. Clinicians should establish measurable treatment goals for chronic pain and measure progress against them. Treatment goals should be discussed with the patient but determined by the clinician. They must be functional in nature, measured against the patient’s established baseline, and monitored. The elimination of chronic pain is usually not a realistic goal. Patient expectations must be addressed early. Patient self-report may not be completely reliable but should be included in the assessment.
7. Most chronic pain can be managed through primary care clinicians. However, an interdisciplinary team approach is often beneficial, and specialty care, including pain management, should be available for patients whose function and chronic pain are not improved with treatment and for patients requiring end-of-life care.
8. Accepted and evidence-based therapeutic options should be available when medically necessary. A multifaceted and biopsychosocial approach is optimal when possible. Policies banning opioids should be eschewed.
9. Medication use should be judicious. Benefits and risks for the patient (including abuse) and the facility (potential for diversion) must be considered, recognizing that problems with substance abuse, chemical dependency, and management of prescription medications are common in correctional populations.
10. Continuity of care planning is important, including consideration of resources and reentry into the community. Care coordination should be ensured to avoid interruption in pain treatment.
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### Table 7: Clinical Values Report on Subjects Receiving Aripiprazole or Placebo in Combination with Antidepressants/Tedostaurin Presentations in Subjects with Aripiprazole and CDF1

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**Means**: Mean ± SD

**N-Value**: Number of subjects per treatment group

**Subjects**: All subjects who received the study medication during the treatment period.

**Inclusion Criteria**: Subjects who received the study medication during both the placebo and the study periods.

**Exclusion Criteria**: Subjects who did not receive the study medication during both the placebo and the study periods.

**Subjects with Dystonia**: Subjects who experienced dystonia during the treatment period.

**Subjects with Impulsiveness**: Subjects who exhibited signs of impulsiveness during the treatment period.

**Measurement**: Measurement using the Aripiprazole Clinical Assessment Scale (ACAS) and the Clinical Global Impression (CGI) Scale.
Award Winners Take the Spotlight at NCCHC’s 2011 National Conference

The National Commission’s annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud the 2011 recipients of these prestigious awards, which were presented Oct. 17 during the opening ceremony of the National Conference on Correctional Health Care, held in Baltimore.

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

Steven R. Shelton, MD, CCHP-A
Now in his 27th year at the Oregon Department of Corrections, Dr. Steven Shelton is perhaps the longest tenured corrections medical director in the nation, having held that position for the past 18 years. His longevity is no fluke. Dr. Shelton is renowned for exceptional performance as a leader, innovator and advocate for correctional health care. His efforts benefit not only his own system but also, through education, information sharing and mentorship, systems across the country.

Dr. Shelton’s correctional career began in 1984 when he joined ODOC as staff physician. Formerly a nurse, he had attained an MD degree a few years earlier and was working in community settings, including his own urgent care clinic. In the early days he would see inmates in the morning hours when his private practice was closed. As the prison system grew, so did his involvement. Over time he became staff physician at two prisons and chief medical officer at two prisons, and in 1993 he became the system’s medical director.

Among his achievements, Dr. Shelton developed the concept known as therapeutic levels of care, which uses defined standards and case discussion to determine the medical necessity of various treatments. Because this approach was adopted by the state’s medical assistance program, it ensures that inmates receive a community standard of care. Dr. Shelton also developed nursing protocols for early first-line intervention. Both approaches have been used in many other systems. He also transformed processes—and attitudes—related to patient sick call and self-care.

The man behind these innovations possesses a rich combination of traits that has earned him the devotion of his staff and respect of his peers. One hallmark of his leadership is his success in building a staff of highly capable clinicians. He is committed to professional development and mentorship, and oversees a continuing education program that draws clinicians from county jails and neighboring states. He also nurtures strong relationships with specialty providers. “He is an exemplary role model. No staff members leave and they just keep getting better in their practices,” says a colleague. He also models creativity, empathy and, in every sense of the word, caring. Despite his high-level role overseeing health services for 14,000 inmates, Dr. Shelton continues to practice direct patient care.

With all 13 ODOC facilities accredited, Dr. Shelton is closely allied with NCCHC’s mission. He also strives to help the field. He lends his expertise as a physician surveyor for NCCHC’s accreditation program, and his educational presentations are too numerous to count. He fosters professionalism by serving on the Certified Correctional Health Professional program’s board of trustees. He himself has been a CCHP since 1993, earning Advanced status four years later. He also is a charter member of the Society of Correctional Physicians and has served as its president.

Overall, Dr. Shelton has organized an outstanding system of health services and staff development that has improved health care access, utilization and patient satisfaction. He gives generously to the correctional health community, sharing his knowledge at all turns. He excels at building alliances for the betterment of all.

B. Jaye Anno Award of Excellence in Communication
This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. The award is named after NCCHC’s cofounder and first vice president.

Fred Cohen, LLM
Correctional professionals who need to stay abreast of important court rulings—but don’t have time to pore over the arcane details of myriad lawsuits—know exactly where to turn: the Correctional Law Reporter. Launched 22 years ago by Fred Cohen, LLM, and his longtime collaborator William Collins, JD, this bimonthly newsletter, first produced at a kitchen table, soon grew into the most respected periodical of its kind. It also was the catalyst for the formation a year later of the Civic Research Institute, which continues today as an independent publisher of reference and practice materials for professionals in the social sciences and law.

A national authority on correctional health law, Mr. Cohen possesses special expertise in mental health law and is the author of the two-volume reference work The Mentally Disordered Inmate and the Law, now in its second edition, as well as executive editor of the Correctional Mental Health Report. He also has written numerous case books, treatises and articles on law and deviance.

Mr. Cohen’s vast knowledge of these topics developed over a long career that encompasses many aspects of corrections and the law. A graduate of Yale Law School, he has been a full professor at a number of leading law schools and is a founder of the Graduate School of Criminal Justice, State University of New York at Albany, where he developed the law component of its PhD program. He has been the court-appointed monitor in several lawsuits pertaining to correctional mental health, medical and dental care in...
Ohio, and has conducted investigations or served as a consultant in several other states, often on mental health topics. He also was a reporter to the American Bar Association’s Juvenile Justice Standards Project and served on the ABA task force revising correctional standards.

Characteristically, Mr. Cohen’s response upon notification of the award was humble and humorous: “I am surprised and honored to receive the Anno Award. Writing is an isolated activity and to learn in this fashion that someone is reading and applauding is wonderful.”

**NCCCHC Facility of the Year Award**

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

**Lehigh County Prison, Allentown, Pennsylvania**

This year marks 25 years since Lehigh County Prison attained initial NCCCHC accreditation, but this silver anniversary is not why the facility is being honored as Facility of the Year. Rather, it is in recognition of current excellence in health services delivery, continuity of care and staff professionalism.

Despite its name, Lehigh County Prison functions as a maximum-security jail and is surveyed under NCCCHC’s jail standards. Its latest accreditation survey found 100% compliance with applicable standards. That level of achievement is common for the facility, which has an average daily population of about 1,100 and annual admissions of about 5,600.

Since 2003, the facility has used a contract management company to provide integrated medical, dental and mental health services. Health staff are on site around the clock. The team has frequent meetings to discuss administrative, nursing and quality improvement issues, and someone from facility administration is always present and participates in problem-solving decisions.

With such a well-run operation, it is hard to single out specifics to highlight. Among the areas that receive high marks are chronic disease management, nursing care, diagnostic services, mental health, dental care, pharmacy services, infection control, emergency management and discharge planning. Receiving screening is always timely, and detainees are rapidly assessed for detoxification, suicidal ideation and medication needs. Likewise, initial health assessments are consistently timely. Each inmate also receives an annual examination. One way to assess performance is through customer satisfaction, and here Lehigh County Prison shines: The facility receives health care grievances from less than 2% of the population.

Such excellence doesn’t arise overnight. In this case, 25 years of continuous compliance with the standards has cultivated a workplace where staff pride and dedication to quality are the norm. This culture also depends on the example set by the warden and assistant warden, both of whom have served at the facility for more than 20 years. Under their strong, steady leadership, the facility has established a stable health services department with a solid history of performance.

**NCCCHC Program of the Year Award**

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

**“The Group” Weight Reduction Program Wyoming Honor Conservation Camp, Newcastle**

That sloped walk up to the health services building turned out to be a good thing for a couple dozen inmates at the Wyoming Honor Conservation Camp. After complaints by certain individuals about shortness of breath and sore legs, the warden concluded that their excess weight and overall poor health were the culprits. He asked the health services team to come up with a plan. Thus was born Self-HeLP (Healthy Lifestyles Program), an effort known as “The Group.”

Part of the Wyoming Department of Corrections, WHCC provides vocational, educational and other programming to an average daily population of about 300 men. Although exercise activities have long been offered, The Group was conceived in July 2010. It has evolved since the early days of informal meetings with a small group of inmates referred by health staff. As it became clear that many of the men did not understand the concept of self-care for chronic conditions or how lifestyle choices affect health, the education component became formalized. An important milestone occurred in September 2010, when health staff began to record participant weight, blood pressure and other health measures at each weekly meeting.

Another major step was in December, when the recreational activities specialist added structured exercise to the program. To ensure privacy, because some participants would have been reluctant to exercise with other inmates present, the warden approved use of the gym during count time. In addition, the food service department was enlisted to provide healthy choices for meals and snacks. These foods are available to all inmates.

Although the total number of participants is small, their results are impressive. A July 2011 report noted a total of 196 pounds lost since recording began. Looking at individual outcomes, some of these men have made astonishing improvements. One lost more than 40 pounds in three months. Another reduced his LDL cholesterol from a whopping 547 to 167. A diabetes patient is no longer dependent on insulin. Many participants reduced their blood pressure. A bonus: These inmates also benefit from greater self-confidence, reduced anxiety and better social skills due to the support they give each other.

Calling the program a “best practice for Wyoming corrections,” the DOC director is encouraging its implementation in other facilities.

To see more photos from the awards ceremony, visit our Facebook page, facebook.com/NCCCHC.
At Corizon, we work tirelessly to be the best provider of correctional healthcare. When our strength and dedication is paired with yours, we both find purpose. By working together, our collective vision becomes a reality. Innovations become customized solutions. Efforts become results.

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Always striving. Ever better.
As chief medical executive at Calipatria State Prison, a maximum security male facility, I oversee health care for more than 4,000 inmates. In 2008, I had an idea for improving care for patients with diabetes. I felt that inmates needed to increase their responsibility in controlling their diabetes, and that if I could provide glucometers for self-monitoring, they would have better control and outcomes. After obtaining approval from the California Department of Corrections and Rehabilitation and my warden, I initiated a pilot program.

Health program specialist Lita Martin and I spent many hours creating a local operating policy for the program. To determine what the policy needed to address, we considered all aspects of the program, such as choosing and issuing glucometers, dealing with damaged meters, exchanging supplies, patient refusals and parties responsible for program specifics.

The glucometer and lancet device were selected based strictly on safety issues and, for the lancet device, also from a public health angle. We chose a self-retracting six-lancet device, feeling that it was somewhat tamperproof and so small that it could not be used as a weapon or for tattooing very well. For the glucometer, we picked a 17-strip barrel device. The barrel housing was acceptable to custody and also seemed tamperproof. For medical, we like the number of strips as it lessens the number of exchanges.

During this process we also had discussions with custody about housing. Housing units typically rotate who is released first to chow. There had been complaints of delays in feeding after insulin was administered, leading to hypoglycemic events, and sometimes the insulin was given after chow instead of before. Given our concerns about irregular feeding times and delays in insulin administration, the warden approved my request that all diabetic inmates be housed in the same building on each yard and that they consistently be released first for meals. We believe this contributes to better control and fewer adverse outcomes.

Policy Details
The diabetes self-care program policy was approved in January 2009 and we announced our intentions to all staff. A team of health professionals educated medical staff affected by the program, explaining the details and expectations.

The policy has evolved over time, with a few revisions to make it more practical. These are some of the highlights:
- The primary care provider will issue a medical permit to each program participant allowing him to self-test and carry his diabetic supplies. The permit identifies the items that may be carried, such as glucometer, drums, cartridges, plastic carrying case, alcohol swabs, batteries, lancet device...
and self-test diary.

- Nursing staff conduct weekly logging of the glucometers and supplies distributed. The patient is assigned supplies based on the frequency of testing ordered by the primary care provider. Every Sunday, nursing collects all used drums and cartridges and distributes new ones (on a one-for-one basis) along with alcohol swabs as needed. They also inspect the glucometers for tampering or other problems.
- The patient may dispose of the used strips and alcohol swabs in the regular trash.
- Diabetic supplies are the property of the patient and will accompany the patient upon transfer to another institution or parole.
- The initial glucometer and the weekly distribution of supplies are provided at no charge. If a glucometer is deliberately damaged, the patient may be required to purchase a replacement.
- Custodial disciplinary action will be taken if any of the following occur:
  - Patient willfully damages or abuses the glucometer.
  - Patient tampers with the glucometer and/or diabetic supplies.
  - Diabetic supplies are missing.
  - A patient not enrolled in the program is found in possession of a glucometer or diabetic supplies.
- To ensure that their insulin is readily accessible, type 1 diabetes patients will not receive job assignments that are off the institution grounds.
- Any patient refusing to participate in the program completes a refusal of examination and/or treatment. The patient’s blood glucose levels will not be checked by nursing except when presenting with symptoms or prior to insulin administration.
- Our pilot facility was B yard, which has about 1,000 general population inmates. The goal was to enroll all 18 of the diabetic inmates into the program. To get started, a team of health professionals (chief physician, director of nursing, nurse supervisors, RNs, health program specialist, and senior lab technologist) met with the inmates in a classroom setting. They presented general education on diabetes (basic physiology, monitoring calories, signs and symptoms, red flags) followed by in-depth teaching on glucometer use.
- Two patients refused participation, but later accepted. All participants signed consents demonstrating understanding of program participation, expectations and how supplies would be distributed. On this same day, we gave them the glucometers, medical permits and supplies.

**Signs of Success**

Data collected three months into the program showed mild improvements in patient health. The participants’ average HbA1c level decreased to 6.60 from 7.01 before the pilot. A sample look at blood glucose checks for one participant found an average pre-pilot level of 233; this decreased to 120 during the pilot.

Analysis of the triage and treatment area log also suggests improved outcomes. In the 12-month period before the pilot, the 18 participants made 10 visits due to hypo/hyper-glycemic events; at the three-month assessment, no visits had been made. Diabetes-related emergency room visits also decreased.

At three months we also conducted a survey of the 16 original participants. All replied “yes” in response to questions regarding satisfaction with the program, improved knowledge, improved health condition and better awareness of the diabetes disease process. In addition, 12 assigned a top score of 5 on a satisfaction rating scale, with the other participants assigning a rating of 4.

The survey also yielded uniformly positive write-in comments from the patients, such as “Very good, thank you!”, “Glucometer helps [patient] control his diet, I dropped from 238 to 220 lbs!” and “Very happy to be part of program!”

Given the success of the pilot, in fall 2009 we expanded the program to all of the general population yards. At the time we had about 200 diabetes patients (the number is now about 120). Again we began with education. The consent forms were signed and the glucometers were issued. The program is second nature now; all general population diabetes patients receive the glucometer kit and weekly exchange of supplies based on their provider’s recommendations for self-testing. (The glucometers are not allowed in the administrative segregation units, but I understand that the San Quentin prison has a pilot program in ad seg.)

As far as more current data, this has been a bit difficult to obtain as only eight patients remain of the original pilot program. However, in October 2011 the average of all HbA1c levels in the general population was 6.81, reflecting an improvement from the average of 7.35 in 2008. Also, review of triage and treatment logs shows that the number of general population visits for hypoglycemic events was nine in 2006 but only one in 2010.

**What We’ve Learned**

I believe that the greatest benefit of the diabetes self-care program is the ability for the patients to take ownership of their chronic disease management. To self-monitor and manage their diabetes decreases their sense of helplessness and increases their autonomy. We were impressed to see the pride they took in the program, and to date we have had no reports of abuse. There have been very few refusals to participate; usually the refusals are from inmates who are in denial about their disease, and sometimes with time they accept and consent.

The second greatest benefit is the impact on nursing. This program has reduced greatly the nurses’ workload because they used to do the blood glucose checks as ordered by the primary care provider. They still check prior to insulin administration or for symptomatic patients, but not at any other times, even for those refusing glucometers.

The expenditure (about $10,000 per year) has not risen much because we used to give glucometers and supplies to diabetic inmates upon release; now it is an upfront cost. And we do see savings through reduced staff hours spent...
with these patients, fewer complications and fewer ER visits.

As far as program weaknesses, we would like the patients to be more faithful in keeping their diaries and bringing their glucometers or diaries to their clinic visits. Many only give recollections of their readings. We hope in the near future to add infrared readers to the providers’ computers; by waving the glucometer over the reader, all of the stored data will appear on screen for easier monitoring.

Also, for more than a year we have asked that all patients bring all medications to every chronic care visit. I feel this would help the provider and the patient in the management of chronic diseases, including diabetes, but this has been a struggle to implement.

But these glitches do not detract from the overall success and value of our diabetes self-care efforts. I recently gave a presentation on the program to a gathering of chief executive officers and chief medical executives from CDCR’s 33 adult institutions. The CDCR’s federally appointed receiver so applauded our innovative vision and implementation of the program that he directed all 33 institutions to follow our lead. Since then, I have been part of a statewide committee helping to formulate a policy for statewide use. It is predicted that by early 2012, all diabetic inmates in the CDCR general population will have glucometers, and improved outcomes will follow.

K. Ball, DO, CCHP, is the chief medical executive at Calipatria State Prison, part of the California Department of Corrections and Rehabilitation.

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**Reports From the Field Point to Success**

- Calls for diabetic care have changed from general to specific in nature. For example, instead of custody reporting that the inmate is not feeling well, the report may say, “The inmate said he is diabetic and his blood sugar is high; can you come and check him?”
- Noticing a low number in a patient’s diabetic log, an RN asked what happened. He replied, “I was feeling sick and anxious so I checked my blood sugar before calling the officer. It was low so I ate something and felt better. I checked it again later and it was normal so I went back to bed without needing intervention.”
- A patient reported, “I know that when I eat too much my blood sugar gets out of control for two or three days, so I’m paying more attention to what I eat.”
- Another patient said, “I check my blood sugar to see if the medication is working; this reassures me.”
- An RN observed that the patients do not see the glucometer as a toy but as an instrument that may help to save their lives. “I’m impressed with how carefully they treat the glucometer. I have not noticed any sabotage or tampering. I often perform the exchange of supplies and have no problems to report.”
- Custody reports no problems with the pilot program. In fact, the associate warden for health care said, “This pilot has been successful.”

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Those of us who practice medicine in jails frequently (Frequently? Daily) run into the thorny issue of our relationship to the doctors who care for our patients outside of the jail.

When patients are in our jails, we are responsible for them; they are our patients. But these patients also have doctors outside of the jail that perhaps they have been seeing for years. The inmate considers their outside physician to be their "real" doctor, not us. (Throughout this article, I am going to use the term "doctors" rather than the more generic "practitioners." I do not mean to slight nurse practitioners or physician assistants. What I say applies to them, as well.)

What brought this topic to mind is a case that occurred in one of my jails recently. A patient came to jail with a prescription pad filled out by his outside physician authorizing him to have a double mattress, an extra blanket and an extra pillow. (There was no note requiring us to feed him pizza every Friday night—he must have forgotten to ask for that.) So I was left in a little dilemma. What should I do about this note? Ignore it? Allow the inmate to have the extra comfort items?

Dealing with inmates' outside physicians can be tricky, but I have found (mostly through sad experience) that there is definitely a right way and a wrong way to handle these encounters. The right way involves recognizing three important points:

1. The outside physician is not authorized to write orders for patients in the jail; she does not have staff privileges in the jail setting.
2. Inmates like to pit the outside doctors against the jail doctors to get their way. It is a form of manipulation. It needs to be recognized as such.
3. The easiest and most time-effective way to defuse this situation is to speak to the outside physician directly and come to a joint decision of what will be done for the patient in jail.

Staff Privileges
The first core issue here that was misunderstood both by the patient and the outside physician is one of staff privileges. Just like hospitals, jails and prisons have a staff privilege system. If a patient of mine is admitted to the local hospital, I cannot write or call in orders. To be able to do so, I would have to formally apply for staff privileges at that hospital. Even then, I could not write orders for a patient at the hospital unless I was the admitting or attending physician. This staff privilege system is common to all medical establishments. I likewise cannot call in orders at the local nursing home or walk into the urgent care center across the street and start seeing patients.

It is the same thing at a jail or a prison. To practice medicine in a correctional facility, a physician must be granted staff privileges at that facility. Who grants these privileges? The person with legal authority to operate the facility. In the case of almost all jails, that would be the sheriff and the jail administrator.

What this means, of course, is that I, as the medical director of the jail, have no obligation to honor any outside physician's orders. In fact, the outside physician cannot make orders; she has no staff privileges. If I or the other jail medical providers think that an outside physician's recommendations are a good idea, we must rewrite the order; it has to come from us. On the other hand, if I, in my professional judgment, think that an order from an outside physician is inappropriate, I am under no obligation to follow it. I should, of course, document exactly why I made this decision so there is no question later.

Inmate Manipulation
But this does not solve the problem raised by this outside physician's orders and the patient's insistence that we have to follow them. What the patient is doing here is the classic and common inmate game of pitting two physicians against each other. This happens all of the time in jail. Inmates will say that their outside physician wants them to be on certain medications, have a special diet, wear their own shoes and so forth. If I, as the jail physician, say no to these requests, then the inmate feels that he or she has a legitimate grievance: "My outside doctor has prescribed X and you won't let me have it. My outside doctor is my real doctor and knows me and my medical problems way better than you do."

This is a very common and sometimes successful method of inmate manipulation. If I do not recognize this as a type of manipulation, the inmate ends up becoming a spokesperson for the outside physician.

Direct Communication
By far, the best way to deal with this problem is to call the outside physician by telephone and come to common ground. I have found this to be quite easy and pleasant for the most part. Inmates paint their outside physicians as fanatically insistent upon the inmate getting what the inmate wants. But that is not true most of the time. Outside physicians are, for the most part, thoughtful, reasonable and helpful.

And so it was in this case. I called the outside physician and explained the jail policy about extra mattresses and other comfort requests. She admitted that she didn't...
Three Key Principles

To summarize, there are three principles of dealing with orders of a physician outside of the jail system:
1. Recognize that outside physicians do not have privileges to practice within the jail. You as the jail doctor may agree with their recommendations or disagree, but you are the ultimate decider. It is important for the inmate and the outside doctor to understand this.
2. Inmates tend to pit their outside physicians against the jail doctor as a type of manipulation to get what they want. This must be recognized as manipulation.
3. The best way to counter this manipulation and to defuse the whole situation is to speak personally with the outside physician and come up with a joint treatment plan for the inmate while in jail.

Know much about jail medical procedures and that she had written that note only because the patient begged her to. I asked if she would support me in my determination of appropriate housing for this patient’s medical condition and, of course, she agreed. By the end of the conversation, we were chatting like old comrades. I gave her my personal cell phone number in case she had any questions about future patients who might end up in jail.

And finally, I could report to the patient that I had personally talked to his outside physician and that we had jointly developed a housing and treatment plan for him while he was in jail and this would not include an extra blanket, extra mattress or extra pillow. Problem solved. He is no longer able to play one doctor versus another.

Added Benefits

There are lots of added benefits to calling the outside physician in cases like this. It consumes much less time than fighting with the patient over the course of several clinic visits and grievances. It develops personal contacts in the outside medical community. If I have a question in this particular doctor’s field, I can call her for help. The doctor also knows more about the jail and jail medicine than she did before. We now have a rapport that will come in handy the next time one of her patients ends up in jail. The next time one of her patients asks her to authorize special treatment in jail, she will know not to do this (or at least to call me first).

Note that requesting medical records would not have achieved the same results. In fact, requesting medical records would have accomplished nothing and wasted time. The act of calling and speaking personally to the outside physician is the key.

As usual, this strategy worked wonderfully in this case. Once I told the inmate that his outside doctor and I agreed on the treatment he would receive in jail, he had nothing further to say. He never brought the subject up again. He never wrote a grievance. And this is such a common problem, I will probably use this strategy again tomorrow!

Jeffrey E. Keller, MD, is the medical director of the Ada County Jail in Boise, ID, and the Bonneville County Jail in Idaho Falls, ID. He also is a frequent speaker at NCCHC conferences. Contact him at jkeller@badgermedicine.com.
Correctional Nursing Practice: What You Need to Know (Part 8)

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 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 and exam at www.ncchc.org/cchprn.

Regulations, Standards and Policies

To be identified as a profession, a discipline must meet criteria that include having established standards of practice and regulation of the practice. In the profession of nursing, regulation is an important component in ensuring safe and competent practice. Nursing consistently ranks No. 1 of all professions in Gallup’s annual honesty and ethics survey. Confidence is supported when nurses thoroughly understand and comply with all regulations and standards.

As in the larger health care industry, correctional health care systems are subject to regulation. Importantly, laws and rules that pertain to nursing in the community also apply in the correctional setting. However, issues related to regulations, standards and compliance with nurse practice acts and scope of practice are not always well understood by correctional nurses and sometimes do not gain the expected level of knowledge, compliance and value.

Because nursing practice has a significant impact on health care delivery, patient safety and patient outcomes, regulation of the profession and individual nursing practice is necessary. The practice of nursing is regulated at the state level through administrative rules (laws) and civil procedures. Licensure is one method of validating knowledge and competence. Individual states license and regulate the profession through their nursing boards, while the National Council of State Boards of Nursing works to create uniformity and consistency in nursing practice and standards.

Many other government agencies—federal, state and local—also issue regulations, standards and guidance to assure safe and appropriate nursing care. At the federal level, the U.S. Department of Health and Human Services is the principal agency for protecting the health of citizens. HHS regulates through 11 divisions, including the Centers for Disease Control and Prevention, the Food and Drug Administration and the Office of the Inspector General. At present the Centers for Medicare and Medicaid Services has little impact on correctional health care, except, for example, when a facility receives federal funding, such as reimbursement for dialysis. However, that may change as provisions of the health care reform law are implemented.

Correctional health systems and their employees are expected to comply with applicable laws and regulations. The monitoring and oversight of these systems may not be as visible as in health care settings in the community. Nevertheless, these functions are important. Correctional facilities have a federal mandate to provide appropriate health care for individuals detained and incarcerated. If a facility fails to ensure safety and fails to meet the serious medical needs of those incarcerated, this likely will lead to litigation and court monitoring.

Several nongovernmental organizations also issue useful standards and other guidance. With respect to health care, the National Commission on Correctional Health Care’s Standards are the most recognized and well-accepted. Many facilities strive to meet these standards for accreditation even if they are not accredited because compliance improves quality and limits liability risk. Other organizations, such as the American Public Health Association, the American Nurses Association and the American Psychiatric Association, also publish standards and recommendations on aspects of health care in corrections. The correctional nurse must understand these standards and ensure that nursing practice is consistent with them. In all cases, measuring and monitoring systems is essential.

Nurses must also understand and comply with the policies and procedures established at their facilities. Policies and procedures provide guidance, standardization and consistency in practices, and failure to comply places the nurse, patient and institution at risk. For example, the patient may be at risk of endangerment, while the nurse and institution may be subject to litigation if poor patient outcomes occur.

Policy topics are wide ranging. Applicable laws and standards should be incorporated into institutional policies, procedures and protocols for the correctional nurse. For example, they should reflect federal and state regulations for reporting public health concerns, conditions of abuse, rape, communicable diseases, trauma, unexpected and expected deaths and care of the mentally ill. Regarding standards, NCCHC standards address topics such as access to care, quality improvement, grievance mechanisms, patient and staff safety, medication services, screening and assessment, patient restraint and much more.

When developing policies, nurses are expected to know and understand the American Nurses Association’s standards for nursing practice, administrative nursing and the specialty of corrections nursing. Nurses and their leadership are held accountable to these standards as well as the nursing social policy statement and code of ethics.

Mary V. Muse, MS, RN, CCHP-RN, CCHP-A, is chief nursing officer, Wisconsin Department of Corrections, Madison. This column is coordinated by Lorry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media; she is based in Pennsylvania. For correspondence, write to editor@ncchc.org.
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• 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.


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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, pimozone, 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% 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.

Rash
• Mild-to-moderate rash is a common side effect of efavirenz. In controlled clinical trials, 28% of subjects treated with efavirenz experienced new-onset skin rash compared with 17% of subjects treated in control groups. ATRIPLA should be discontinued in patients developing severe rash associated with blistering, desquamation, mucosal involvement, or fever

Hepatotoxicity
• Liver enzymes should be monitored before and during treatment in patients with underlying hepatic disease, including hepatitis B or C infection, in patients with marked transaminase elevations, and when ATRIPLA is administered with ritonavir or other medications associated with liver toxicity. A few of the postmarketing reports of hepatic failure, including cases in patients with no pre-existing hepatic disease or other identifiable risk factors, were characterized by a fulminating course, progressing in some cases to transplantation or death. Liver enzyme monitoring should be considered for patients without pre-existing hepatic dysfunction or other risk factors

Decreases in Bone Mineral Density
• Bone mineral density (BMD) monitoring should be considered for patients who have a history of pathologic bone fracture or are at risk for osteopenia. Decreases in BMD have been seen with tenofovir DF. Cases of osteomalacia (associated with proximal renal tubulopathy and which may contribute to fractures) have been reported in association with the use of tenofovir DF

Seizure
• Use ATRIPLA with caution in patients with a history of seizures. Convulsions have been observed in patients receiving efavirenz, generally in the presence of known medical history of seizures

Immune Reconstitution Syndrome
• Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including the components of ATRIPLA

Fat Redistribution
• Redistribution/accumulation of body fat has been observed in patients receiving antiretroviral therapy

Adverse Reactions
• In Study 934, through 144 weeks, the most frequently reported Grades 2-4 adverse reactions reported in ≥5% of subjects receiving efavirenz + emtricitabine + tenofovir DF were diarrhea (9%), nausea (9%), fatigue (9%), depression (9%), dizziness (8%), sinusitis (8%), upper respiratory tract infection (8%), rash event (7%), headache (6%), insomnia (5%), anxiety (5%), and nasopharyngitis (5%)
• The most common adverse reactions (incidence ≥10%, any severity) occurring in Study 934 include diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, abnormal dreams, and rash
• Skin discoloration, associated with emtricitabine, may also occur

Drug Interactions
• Coadministration of ATRIPLA with didanosine should be undertaken with caution. Patients receiving this combination should be monitored closely for didanosine-associated adverse reactions
• Lopinavir/ritonavir has been shown to increase tenofovir concentrations. Patients on lopinavir/ritonavir plus ATRIPLA should be monitored for tenofovir-associated adverse reactions. ATRIPLA should be discontinued in patients who develop tenofovir-associated adverse reactions
• Coadministration of ATRIPLA and atazanavir is not recommended. Efavirenz and tenofovir DF have been shown to decrease concentrations of atazanavir. Atazanavir has also been shown to increase tenofovir concentrations
• Saquinavir should not be used as the only protease inhibitor in combination with ATRIPLA

See Full Prescribing Information for complete list of drug-drug interactions.

Hepatic Impairment
• ATRIPLA is not recommended for patients with moderate or severe hepatic impairment because of insufficient data; use caution in patients with mild hepatic impairment

Dosage and Administration
• The dose of ATRIPLA is 1 tablet (containing 600 mg of efavirenz, 200 mg of emtricitabine, and 300 mg of tenofovir DF) once daily taken orally on an empty stomach. Dosing at bedtime may improve the tolerability of nervous system symptoms. ATRIPLA is not recommended for use in patients <18 years of age or in patients with CrCl <30 mL/min
Nursing Mothers: The Centers for Disease Control and Prevention recommend that HIV-1 infected mothers not nurse their infants. However, in the 1990s, refrigerated milk banks became available in the United States. Initial studies showed that infected milk did not transmit HIV when fed to human infants in a controlled setting. The transmission rate was estimated to be 0.2%. It is unclear whether infected milk can still be transmitted today. In 2012, the FDA published new guidelines for processing milk to reduce the risk of transmission. These guidelines recommend that milk be pasteurized at 165°F (74°C) for at least 2 minutes before use. Additionally, the milk should be stored at 41°F (5°C) or below until consumption. These steps significantly reduce the risk of transmission, making it safe for human infants to receive milk from infected women. Therefore, refrigerated milk banks can safely provide milk for human infants even if the women who donate the milk are HIV-1 infected (see [Warnings and Precautions]).

Additional Information: For additional information about ART, visit the following websites:

- National Institutes of Health: https://emedicine.medscape.com/article/188960-overview
- Centers for Disease Control and Prevention: https://www.cdc.gov/hiv
- WHO: https://www.who.int/hiv/en/

References:

Emtricitabine - No postmarketing adverse reactions have been identified for inclusion in this section.

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Small Jail Makes Big Strides in Care

by Jaime Shimkus

It was a cause for celebration at the San Miguel County Detention Center when it achieved NCCHC accreditation last July. The warden, Patrick Snedeker, even arranged a special meeting with the county commissioners during which the accreditation certificate was presented by NCCHC cofounder B. Jaye Anno, PhD, CCHP-A.

Snedeker, who has been warden for eight years, had long set his sights on this goal for the jail, which is in Las Vegas, NM. “The people we serve are residents of our community and we are entrusted with a great deal of responsibility for them,” he says. “Health services is a critical component, so we want to reflect the best practices and national standards.”

The fact that the jail is a small facility, with an average daily population of about 113, was no deterrent. In fact, its small size and limited internal resources have been the catalyst for several innovative achievements aimed at improving care in a cost-effective manner.

The accreditation process was set in motion about two years ago when a nonprofit agency, Health Care Partners Foundation, was contracted to assume full responsibility for provision of health services. (Mental health services are provided by the Behavioral Health Institute, a state-owned psychiatric hospital.)

HCP had handled certain health management services for several years prior, but, says HCP president and CEO Rita Torres, “When we gained complete control of the medical units, we were able to establish policies and procedures based on NCCHC’s standards. We could then ensure that everything was being done appropriately.”

At that time, Deborah Johnson, PA-NP, came on board as the facility’s medical care provider. She had been through the NCCHC accreditation process twice before while working at the New Mexico State Penitentiary and helped in bringing the jail into compliance with the standards. The whole team embraced the idea of becoming accredited, says Johnson. “We work really hard to deliver quality care.”

Quality Through Collaboration

Another way the jail is striving to improve quality is through creative partnerships. Case in point: Project ECHO, a telemedicine program offered through the University of New Mexico School of Medicine. The program was created to provide specialty care for chronic and complex diseases for community health clinics in rural and underserved areas, but Snedeker saw its value for incarcerated patients. Program officials agreed and now the jail has technology that enables access to telepsychiatry and about a dozen medical specialties, including hepatitis C. “It is difficult to provide specialty care in a small facility,” says Torres. “Project ECHO makes a tremendous difference in managing those high-risk cases, and it doesn’t cost us anything.”

Better yet, case review by specialists has decreased costs by having expert opinion on what is medically appropriate. As an example, Johnson says that substituting pricey antipsychotics for older medications when appropriate has led to dramatic reductions in pharmaceutical expenditures. Also related to Project ECHO is an inmate peer assistance program being developed for jails with San Miguel serving as the pilot. It involves two types of activities. In one, inmates are trained to educate their peers on how to reduce hepatitis C and HIV risks related to injection drug use. In the other, inmates provide continuous suicide watch in the interim between checks by a corrections officer.

The partnerships don’t stop at the state line. Due to a shortage of medical providers in New Mexico, Torres and Johnson have worked with Colorado State University, Pueblo, to develop a two-year residency and fellowship for its graduate nurse practitioner students. In the program, which began this year, students spend the first year in rotation through correctional facilities, including San Miguel, and the second year in a fellowship at a single site. The students will receive specialty training (including the NCCHC standards) through a community college near the jail.

The Bottom Line

The jail met yet another goal this year when it completed its transition to electronic medical records. “This will assist with continuity of care,” says Torres, “and will make it so much easier for maintaining accreditation.”

As a whole, these efforts to improve quality of care also pay off financially. According to a June 2011 report on medical services, the medical budget has not increased in any of the past seven years and is actually below the 2004 level. In fact, cost savings have enabled the addition of services and staff, with an increase in patient medical visits for better continuity of care.

Explaining the motivation for these forward-thinking efforts, Torres says, “We believe that with vulnerable populations such as inmates, if you have good continuity of care and good community partnerships, you can attain cost savings and good quality of care based on accreditation standards and best practices.”

Jaime Shimkus is the editor of CorrectCare. Contact her at editor@ncchc.org
Minors Drug Offenders Diverted From Seattle Jails
A pilot program designed to reduce crime and save public safety dollars in Seattle will also reduce the number of drug offenders, many of them repeat offenders, booked into jails and sentenced to prisons. Launched in October in a downtown neighborhood, “law enforcement assisted diversion,” or LEAD, gives police officers the discretion to take nonviolent offenders engaging in low-level crimes such as public intoxication or drug possession straight to treatment in the community. King County’s prosecuting attorney says this approach is an evolution of the drug court model that takes the justice system out of the equation. The program will undergo evaluation to gauge its success. About 90% of arrests made by Seattle police are for possession or selling of small amounts of drugs so, if implemented citywide (or beyond), LEAD’s impact on jails could be significant. Grants from five private foundations are providing $4 million over four years to pay for services such as substance abuse treatment, housing assistance, job training and education.

Primary sources:
• stateline.org/live/details/story?contentId=612828

Florida Bill Targets Restraint of Pregnant Inmates
Florida legislators have introduced a bill that would regulate the shackling of incarcerated pregnant women. Titled the Healthy Pregnancies for Incarcerated Women Act, SB 524 prohibits use of restraints on an inmate known to be pregnant during labor, delivery and postpartum recovery except in “an extraordinary circumstance.” Other provisions require that the accompanying corrections official remove all restraints at the request of the treating health care professional, and that the corrections official explain the extraordinary circumstance in writing within 10 days.

A similar bill failed in the last session. The Department of Corrections said it already has guidelines for restraint of pregnant women and prohibits restraint of those in labor. Jails in the state, however, do not uniformly have such policies, according to an article in the Florida Independent, citing jail standards promulgated by the Florida Sheriffs Association.

This topic has received much national attention in the news media and in reports by organizations such as the ACLU and the Rebecca Project for Human Rights, which has examined state policies on shackling and advocates for an end to this practice. NCCHC’s position statement calls for avoiding use of restraints during pregnancy, particularly labor and delivery, with eight specific recommendations.

• Primary source: floridaindependent.com/56211
• Position statement: ncchc.org/resources

Violence Reduction Through Knitting
Yes, knitting, as in needles and yarn. And focused concentration, goal setting and accomplishment in a communal setting. Started by a retired community volunteer, a weekly, two-hour knitting group at the Jessup Pre-Release Unit, a male minimum-security penitentiary in Maryland, has seen success that surprised administrators. There’s a waiting list to join the group, in which inmates have learned how to make woolly hats and stuffed dolls. Ground rules for participation keep the men on their best behavior and, anecdotally, the warden has noticed reduced rates of violence. “My mind is on something soft and gentle,” said one inmate.

• baltimoresun.com/features/bs-ae-knitting-behind-bars-20111111,0,2032786.story
Odontogenic pain (toothache) is common among inmates and often leads to requests for urgent care. However, scope of dental care provided varies widely as some facilities do not have dental clinics or dental professionals on site at all times. “It is critical that midlevel providers and physicians triage and manage these patients until a dentist can resolve the problem,” write Jay Shulman, DMD, MSPH, and Donald Sauter, DDS, MPA, in the January 2012 issue of the Journal of Correctional Health Care.

The article presents the etiology and diagnosis of toothache along with the authors’ opinion of the standard of care for patient management and several recommendations. Key points are summarized here.

Common nontraumatic causes of tooth pain are tooth fractures, pulpitis (inflammation of living tissue within the tooth), decay through the enamel, abscess and cellulitis (diffuse inflammation of connective tissue caused by a spreading bacterial infection below the skin surface).

All inmates experiencing dental pain should have access to timely and definitive dental treatment. Patients complaining of a toothache should be examined by a midlevel provider, physician or dentist within 24 hours. All facilities should have a triage protocol to assist nondental clinicians. The nondentist clinicians need to receive training by a dentist in how to conduct a competent, well-documented oral examination. From this information, the clinician can then separate patients who need expedited evaluation by a dentist from those who can be stabilized using analgesics and antibiotics and then given a regular dental appointment. A consulting dentist should be available to assist in the triage when necessary.

While palliation is appropriate at the time of the initial complaint, treatment by a dentist is necessary to resolve the problem. The article also provides guidance for treatment, including oral infections. Importantly, when the physical examination suggests no infection or a localized infection, antibiotics should not be given.

Patients who are given antibiotics should be treated by a dentist while there is a therapeutic blood level of the antibiotic. A patient who returns with complaints after two days of antibiotic therapy needs immediate reevaluation by a midlevel provider, physician or dentist to determine if the infection is progressing to cellulitis or spreading to fascial spaces.

Finally, progress of patients awaiting a dental appointment should be monitored with frequency consistent with the differential diagnosis.
Clinical Briefs

Tooth Scaling May Reduce Heart Attack, Stroke
In a study of more than 100,000 people in Taiwan, those who received tooth scaling by a dentist or dental hygienist had a 24% lower risk of heart attack and 13% lower risk of stroke compared to those who never had a cleaning. Protection was greatest in those who received scaling at least once a year. None of the participants, who were followed for an average of seven years, had a history of heart attack or stroke when the study began. Professional tooth scaling appears to reduce inflammation-causing bacterial growth that can lead to heart disease or stroke, according to a cardiology specialist quoted in Dentistry IQ’s article on the study, which was presented at the American Heart Association’s Scientific Sessions in November.

• dentistryiq.com/index/display/article-display/666867567/articles/dentistryiq/hygiene-department/2011/11/scaling-heart_health.html

Hepatitis C Deaths Exceed HIV Deaths
Analysis of death statistics from 1999 through 2007 found that the hepatitis C death rate surpassed that of HIV in about 2006, a function of death rates declining for HIV but rising for hepatitis C. The findings were reported by a Centers for Disease Control and Prevention researcher at the annual meeting of the American Association for the Study of Liver Diseases in November. These data probably underreport HCV mortality because many infections have not been diagnosed. Another study presented at the meeting suggested that as many as 800,000 new cases could be diagnosed under a proposed screening approach that uses universal testing by birth cohort (1945-1965).

• medpagetoday.com/MeetingCoverage/AASLD/29552

‘Epidemic’ of Prescription Painkiller Overdoses
Deaths from overdoses of prescription painkillers have more than tripled in the past decade, according to a Nov. 1 report from the CDC. Overdoses involving narcotic pain relievers like hydrocodone, methadone, oxycodone and oxymorphone kill more Americans than heroin and cocaine combined, the CDC director said. Key factors are increased use of such painkillers for nonmedical reasons along with growing sales. The CDC also released an issue brief highlighting key public health issues related to prescription painkiller overdoses and science-based policy actions that can be taken to address them. These issues are recognized in NCCHC’s new position statement on the management of chronic pain in correctional settings.

• Report: cdc.gov/vitalsigns/PainkillerOverdoses
• Issue brief: cdc.gov/homeandrecreationalsafety/rxbrief
• Position statement: ncchc.org/resources

Promising Treatment for Rx Painkiller Addiction
Sustained treatment with Suboxone (a combination of buprenorphine plus naloxone) reduces opioid abuse in people addicted to prescription painkillers, according to research by the National Institute on Drug Abuse, part of the National Institutes of Health. Published in the Archives of General Psychiatry, this was the first randomized large-scale clinical trial using a medication for the treatment of prescription opioid abuse. Results show no added benefit from the addition of intensive opioid dependence counseling. Unfortunately, patients had a high rate of relapse once the medication was discontinued, indicating a need for more research on how to sustain recovery.

• nida.nih.gov/newsroom/11/NR11-08.html

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Psychological First Aid for Youth

The application of first aid for medical injury is ubiquitous. There is a well-established consensus for response to physical crisis. Unfortunately, says psychiatrist Carl Bell, MD, CCHP, the same is not true for mental crisis. But Bell would like to change that, and he thinks juvenile justice settings are optimal places to establish policies and procedures for psychological first aid.

It’s not that the concept is unknown, says Bell, who has been writing about and presenting on the topic for at least a decade. Often psychological first aid is used in large-scale disasters or crises. But it is not applied routinely in juvenile settings, where so many youth are victims of trauma. According to a 2009 study of more than 26,000 adults in five states, 59% reported at least one adverse childhood experience (see Morbidity and Mortality Weekly Report, Dec. 17, 2010), and 9% reported five or more. This study excluded incarcerated people, and among that group prevalence of childhood trauma is most likely higher, Bell says.

Based in Chicago, Bell is the director of the Institute for Juvenile Research and a clinical professor of psychiatry and public health at the University of Illinois School of Medicine. He also is president and chief executive officer of the Community Mental Health Council and Foundation. A founding member of the NCCHC board of directors, he has long served on the NCCHC juvenile health committee.

Just as correctional staff receive regular first aid training, they also should be given training on psychological first aid, including how to recognize symptoms of trauma, Bell recommends. Upon being admitted to the facility, every youth would be screened for history of mental health trauma. Staff would also be on the alert for symptoms, both during screening and throughout the youth’s stay at the facility.

When a youth in crisis is identified, the staff member would apply first aid based on guidelines for age and symptoms. “It is not counseling, not in-depth psychotherapy. It is very simple,” says Bell. For example, if a fifth-grader is disturbed by grief after witnessing a family member being killed, the response would be to help the child retain positive memories as he or she works through the more intrusive traumatic memories.

Values apply first aid based on guidelines for age and symptoms. “It is not counseling, not in-depth psychotherapy. It is very simple,” says Bell. For example, if a fifth-grader is disturbed by grief after witnessing a family member being killed, the response would be to help the child retain positive memories as he or she works through the more intrusive traumatic memories.

Guidelines for psychological first aid are available from the National Child Traumatic Stress Network. Although they are designed for disaster and crisis situations, the principles apply to other settings, Bell says. In 2007 he served as an expert panel member in development of the Mental Health First Aid Guidelines Project for Traumatic Events of the ORYGEN Research Centre, University of Melbourne, Victoria, Australia.

“Psychological first aid absolutely should be implemented routinely in juvenile justice settings—and all community settings, too,” says Bell. “It really does help.”

Resources

- Mental Health First Aid Guidelines, ORYGEN Research Centre, University of Melbourne, Victoria, Australia
- Psychological First Aid Field Operations Guide, National Child Traumatic Stress Network
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The buildup to the CCHP anniversary celebration was exciting, and now that it’s over we can sit back and enjoy the memories. Held during the National Conference on Correctional Health Care in October, activities included contests, prizes and a special luncheon featuring a stirring talk by NCCHC cofounder Jaye Anno, PhD, CCHP-A. With great knowledge, insight and humor, she recounted a brief history of NCCHC and the Certified Correctional Health Professional program and highlighted the importance of professional certification in this challenging discipline. By the end of her talk, every attendee was even more proud to be a CCHP.

That sense of accomplishment and pride was heightened with the screening of the winning entry in the “I Am a CCHP” video contest. Submitted by Patrick Vance, MPA, CCHP, the two-minute video is expertly produced and beautifully synthesizes Vance’s personal journey in this field and the larger lessons about the value of CCHP certification. Vance is a health services administrator at the Oregon Department of Corrections. His prize: free registration to the 2012 Updates conference. See his inspiring video at facebook.com/ncchc.

Several drawings took place before the National Conference. The biggest prize—free registration to the conference—was set aside for a random drawing from the August group of CCHP examinees. Congrats to Matthew Meehan, LPN CCHP! In addition, 15 CCHPs won gifts such as dayplanners and business card holders with the CCHP logo. Find their names at ncchc.org/cchp/20years.html.

Finally, those remarkable CCHPs who have participated in the program continuously for 20 years received a special enhancer to adorn their CCHP pin and let the world know of their accomplishment.

**CCHP Exam Dates**

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<tr>
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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 ncchc.org/cchp.
Board Member Receives Multiple Honors

NCCHC board member Ryung Suh, MD, MPP, MBA, MPH, is enjoying a successful year. Suh, who joined the board in October 2010 representing the American College of Preventive Medicine, is CEO of a health care consulting and research firm based in Washington, DC; among other work, he also holds senior faculty positions at Georgetown University and other institutions.

- He received the William Kane Rising Star Award at ACPM’s annual meeting in February. The award honors a member of ACPM who has demonstrated a commitment to preventive medicine and the potential to make significant contributions to the field of preventive medicine.
- In June, Suh and Atlas Research cofounder Mark Chichester together were named the 2011 Small Business Person of the Year by the DC Chamber of Commerce. They were honored for their successes and commitment to the District of Columbia’s business community, and in particular their commitment to civil service and work to address health equity.
- Also in June, Suh was elected to the board of trustees of the American Association of Public Health Physicians. AAPHP is a supporting organization of NCCHC.
- Visit the “News” section at atlasresearch.us

NCCHC Surveyor Receives Pharmacy Award

Charles Lawrence, Sr, RPh, PD, CCHP, was honored by the Washington DC Pharmaceutical Association for outstanding community service. Lawrence developed and implemented policies and procedures in the DC Department of Corrections to ensure that its pharmacy services met all federal and local pharmaceutical codes.

One of the most prestigious awards in the field of community pharmacy, the Bowl of Hygeia Award is presented annually by state pharmacist associations, including that in DC. It is sponsored by the American Pharmacists Association Foundation and the National Alliance of State Pharmacy Associations. Lawrence has served as a surveyor for NCCHC’s accreditation program since 1995.

Past SCP President Receives Start Award

Lynn Sander, MD, FSCP, CCHP, is this year’s recipient of the Armond Start Award, the highest honor a correctional physician can receive. It is presented by the Society of Correctional Physicians for leadership in correctional medicine, with criteria that include adherence to the highest ethical standards and dedication to research, publication and training. Sander has been involved in correctional health care for 25 years, serving as the medical director of the Denver County Jail and as a federal health monitor for the U.S. Department of Justice. A national advocate for the rights and health care of incarcerated patients, Sander is known for excellence in patient care and high standards in education and research. As president of SCP from 2005 to 2007, she brought the organization to a position of leadership. The award is named for the late Armond Start, the physician who founded SCP. In the photo above, Sander is pictured with SCP president Michael Puerini, MD, CCHP-A.

Stay Informed With the Academy Insider

The Academy of Correctional Health Professionals is launching a new resource. The Academy Insider is a weekly e-news brief that delivers timely, relevant news about correctional health care and related topics directly to your inbox. The Academy Insider is also available as a mobile application. For Apple iPhone and iPod Touch, go to the App Store, search for “MultiBriefs,” download the app free of charge and then add the Academy feed. Android phone users may access the app by searching for “MultiBriefs” at the Android Marketplace. In addition, a complete archive of past issues enables users to search for news on topics of interest and to explore the most popular past articles.

New Name for American Dietetic Association

Effective January 1, the ADA will become the Academy of Nutrition and Dietetics. Founded in 1917, the ADA is the world’s largest organization of food and nutrition professionals. In announcing the change, the organization’s president cited consumer confusion about where to find the most qualified nutrition expertise. “An academy is ‘a society of learned persons organized to advance science,’” said Sylvia Escott-Stump, MA, RD, LDN. The new name “promotes the strong science background and expertise” of the members, who are primarily registered dietitians. “Nutrition science underpins wellness, prevention and treatment... Adding ‘nutrition’ communicates our dedication to improving the nation’s health”
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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.
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Source: The Center for Exhibition Industry Research (CEIR)

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• 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 Updates conference provides the perfect opportunity to 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. To obtain an Exhibitor Prospectus with details and a reservation form, email NCCHCexhibits@ncchc.org or call 773-880-1460.
MARKETPLACE

Special Savings! 10% discounts are offered for Academy members (single copies) and bulk purchases of a single title. (Excludes already-discounted items.) To order or for a catalog, visit www.ncchc.org or call 773-880-1460.

Standards for Health Services in Juvenile Detention and Confinement Facilities (2011)

This edition is modeled after the 2008 Standards for jails and prisons but takes into account the issues unique to juvenile settings and populations. The Juvenile Standards address nine general areas: health care services and support, inmate care and treatment, special needs and services, governance and administration, personnel and training, safety, health records, health promotion and administration, special needs and services, governance and administration, personnel and training, safety, health records, health promotion and medical-legal issues. This edition features a user-friendly format; standards on current issues such as patient safety and clinical performance enhancement; clear compliance indicators that define expected outcomes and aid in self-assessment; guidelines for facilities of various sizes; best practices recommendations; and appendices on legal obligations, quality improvement and more. Glossary and index. Published by NCCHC. Soft cover. $69.95

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 ncchc.org.

• CCHP Pin Enhancer to mark 5, 10, 15 or 20 years of participation in the program. $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 (2012 refills: $9)

CCHP Items

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About CorrectCare™

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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.

ADVERTISER INDEX
Defining ‘Isolation’ in Suicide Prevention

Q There has been some debate as to the interpretation of the Suicide Prevention Program standard (Y-G-05) in the new 2011 Standards for Health Services in Juvenile Detention and Confinement Facilities. Compliance indicator #1d states: “Potentially suicidal juveniles are monitored on an irregular schedule with no more than 15 minutes between two checks. If, however, the potentially suicidal juvenile is placed in isolation, constant observation is required.”

Our debate comes in understanding what is meant by “isolation.” Is it used to refer to those youth on suicide precautions in a room by himself/herself or does it refer to more of a punitive status, as in the youth was placed in isolation for behavioral issues in addition to suicide precautions? I contend that it is the former and the latter is generally referred to as “segregation” rather than “isolation.” Another option is that both interpretations are incorrect. Either way, we want to ensure that we have the correct interpretation.

A This is a great question. You are correct that the standard is referring to the first interpretation of isolation. When a youth is placed on suicide precautions in a room alone, then constant observation should be conducted.

Opioid Treatment Programs

Q We are thinking about starting a methadone program in our jail, but we don’t know where to begin. What advice can you give us?

A If you are considering an opioid treatment program using methadone, by federal law, OTPs based in correctional facilities must obtain certification from the Substance Abuse and Mental Health Services Administration. To become certified, the OTP first must be accredited by a federally approved body—which NCCHC is, and we offer OTP accreditation. The NCCHC Standards for Opioid Treatment Programs in Correctional Facilities are based on federal regulations but address the special nature of care provided in correctional facilities as well as the necessarily limited focus of such treatment in this setting. For more information, including how to obtain the Standards, visit our website: ncchc.org/accred/OTP.html.

Inmate Orientation Information in Spanish

Q I am helping a jail get ready for its accreditation survey. I am told that there is not really a Spanish-speaking population in this community. In that case, do they still need to have the inmate orientation information in Spanish as well as English?

A Standard J-E-01 Information on Health Services does not state that inmate orientation information must be written in Spanish. The third compliance indicator says, “Special procedures ensure that inmates who have difficulty communicating (e.g., foreign speaking, developmentally disabled, illiterate, mentally ill, deaf) understand how to access health services.” Therefore, if there isn’t a community need to pre-print information in Spanish (or other foreign language), at least there should be a procedure in place so that appropriate efforts are made to ensure that inmates understand how they can access health services. For example, a language line or local translator might be available in the event a Spanish-speaking inmate arrives. Keep in mind that if the bulk of your population speaks only Swahili, then you should accommodate these inmates.

Transfer Screening Time Frame

Q Standard E-03 Transfer Screening says that “qualified health care professionals review each transferred inmate’s health record or summary within 12 hours of arrival.” Does it mean within 12 hours after the inmate arrives at the new jail and is in housing? Or does it mean within 12 hours of the chart’s arrival at the new jail?

A The standard intends that within 12 hours of the inmate’s arrival at the facility (emphasis added), a qualified health care professional should be reviewing the health record or summary to ensure continuity of care.
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Sharen Barboza, PhD, pictured with John Wilson, PhD, members of MHM’s Clinical Operations Team

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