Crisis Intervention Teams
Improving Outcomes for Inmates With Mental Illness

Legal Affairs: Special Diets, Special Problems

Constipation: Straight Talk on the Last Taboo Subject

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Carl Bell Steps Up (Again) As Board Chair

It was an auspicious day in 1983 when Carl Bell, MD, CCHP, agreed to join the inaugural board of directors of the newly minted National Commission on Correctional Health Care, formerly a program of the American Medical Association. Today, he is one of two original members still serving (along with Robert Hilton, RPh, CCHP), and after all these years he is as committed and active as ever. In fact, his leadership once again places him in the role of board chair, having first served in 1991. He is the board liaison to the National Medical Association.

During his 30 years on the board, Bell has served on most committees, but he has been particularly involved with accreditation and the executive committee. With experience on the policy and standards committee, he also has contributed to several editions of the NCCHC Standards, including the first-ever manual on correctional mental health services. He also contributed to NCCHC’s landmark The Health Status of Soon-to-Be Released Inmates report to Congress.

Public health is a passion for Bell, who is a prolific researcher, and his work very often addresses the intersection of mental health and public health. He has been involved with a vast array of issues, including suicide prevention, substance abuse and trauma, and populations of interest include both adults and youth. A common thread through much of his work is the topic of violence and how to prevent it. One potentially promising area, he says, is omega-3 fatty acids, which play a crucial role in brain function and may be linked to reduction of violence.

A Glimpse at a Highly Accomplished Career

Bell, a board-certified psychiatrist, is an internationally renowned mental health expert with a comprehensive CV of more than 200 pages, including hundreds of published works, lectures and consultations. His career cannot be distilled into a handful of bullet points but here are some highlights of his current work:

- CEO/president, Community Mental Health Council, a comprehensive mental health center in Chicago
- Director, Institute for Juvenile Research, Department of Psychiatry, College of Medicine, University of Illinois at Chicago
- Professor, School of Public Health, UIUC
- National Research Council’s Committee on Assessing Juvenile Justice Reform
- National Institute of Mental Health’s National Mental Health Advisory Council
- Institute of Medicine’s Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults
- Published more than 400 articles; wrote the first correctional psychiatry chapter for Sadock and Kaplan’s Comprehensive Textbook of Psychiatry

A key goal during Bell’s term as board chair is to strengthen awareness of the interrelatedness of public health and correctional health care. “Correctional health professionals are critically important to our nation’s quality of public health," says Bell. He calls on these professionals to keep that foremost in mind when working with patients because through their influence and care, they can help patients address issues that put them at risk for criminal behavior.

Preparing for Expanded Health Coverage for Jail Detainees

With health reform looming, counties need to know the law’s potential impact on their criminal justice systems. NCCHC has joined the National Association of Counties, Community Oriented Correctional Health Services and a broad array of other organizations in working groups to explore issues related to health coverage eligibility and enrollment for detainees, provision of care, billing, medical records, information technology and more. Meetings were held in January and February, with more to follow. Materials from these meetings are being posted online.

- Health Coverage for Your County Jail’s Pretrial Population — slide presentation and webinar; see Training Opportunities at http://admin.naco.org/programs/csd/pages/healthreformimplementation.aspx
- Medicaid Expansion and the Local Criminal Justice System — audio recording available at www.cochs.org/library/Michael_Dubose

Updates Conference Speakers Featured on Blog Talk Radio

Tune in to NCCHC Right Now for a preview of some of the speakers presenting at Updates in Correctional Health Care. While you’re at the site, browse past episodes for interviews with 2011 award winners and more. www.blogtalkradio.com/ncchc
Concern about public safety and taxpayer expense is stimulating widespread interest in improving success rates for people released from correctional facilities. The role of correctional health services can be significant as good physical and mental health are important in helping releasees reintegrate into the community and avoid recidivist behavior. Collaboration with community partners also is essential for effective discharge planning and continuity of care.

Updates 2012 features a special focus on this theme, along with an educational track being presented by Community Oriented Correctional Health Services, a nonprofit organization established to build partnerships between jails and community health care providers. Topics will include use of health information technology, legal issues and more. And, as always, Updates will provide a solid core of topics germane to all aspects of work in this diverse field.

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- Behavioral Health Challenges and Solutions for Inmate Reentry
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- Enhancing Health Care Processes in Jails: A CQI Approach
- Grievances: Changing the Paradigm
- Health Care Cost Containment, Risk Mitigation and Service Improvement Using Community-Based Partnerships
- A Tool to Assess When an Intoxicated Arrestee Requires Hospital Clearance
- Therapeutic Work With Youth Offenders and Their Families
- When an Inmate Death Leads to Litigation
- Women’s HIV Prevention and Reproductive Health Services

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Part of San Antonio’s extensive park system, the River Walk artfully connects downtown hotels, restaurants, boutiques, museums and historical venues. Recent expansion and improvements have nearly doubled its network, with 8 new miles of walk-and-bike paths plus many new shops and cafes.


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With an ideal location on the River Walk, the Grand Hyatt is a luxury hotel characterized by an exciting blend of modernism and Latin culture, featuring outstanding amenities and services. Reserve by April 20 to ensure availability and lock in the special rate of $189. To reserve online, visit the conference site at www.ncchc.org and click on the “Book Online” link. Or call 800-233-1234 and mention NCCHC.

REGISTRATION INFORMATION

Register by April 6 to save on the full conference registration fee. Register using our new online system and you will receive immediate confirmation and payment receipt. May 7 is the last day to preregister; after that date, please register on-site.

For more details about the conference or to register, visit www.ncchc.org.
TBI Rate 7 Times Higher in Prisoners
In U.S. prisons, about 60% of inmates have had at least one traumatic brain injury, and some systems have reported even higher prevalence. In contrast, about 8.5% of nonincarcerated adults have a history of TBI, and about 2% of the population suffers from a TBI-related disability. These findings were reported in the Feb. 4 issue of Scientific American. Because these injuries can cause behavioral problems that lead to incarceration, studies and programs are underway to understand how best to treat this inmate-patient population. Some of the best options so far include cognitive therapy for prisoners and education for correctional officers.

Juvenile Justice Reform Initiatives
Mental health services is a primary focus of a new $2 million effort to support innovative and effective reforms in treatment and services for justice-involved youth. In a private-public partnership, the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention and the John D. and Catherine T. MacArthur Foundation are funding organizations that will offer states and local governments training and technical assistance to improve mental health services for youth, reduce racial and ethnic disparities in the juvenile justice system and better coordinate treatment and services for youth involved in the juvenile justice and child welfare systems.

Guidelines for Field Triage of Injured Patients
When a patient sustains an injury, health personnel must determine its severity, begin management of the injury and decide whether hospital treatment is necessary. To assist with this field triage, the Centers for Disease Control and Prevention convened a national expert panel to revise the existing decision scheme last issued in 2006. The 2011 revision explains the modifications to the physiologic, anatomic, mechanism-of-injury and special considerations criteria; updates the schematic of the 2006 guidelines; and provides the rationale for these changes. The report is intended to help prehospital-care providers to recognize injured patients who are most likely to benefit from specialized trauma center resources and is not intended as a mass casualty or disaster triage tool.

New Statistics on Elderly Prisoner Population
Anyone who works in a prison is aware of the increase in the number of elderly inmates. But a new report from Human Rights Watch quantifies the trends:

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New Statistics on Elderly Prisoner Population
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• The number of U.S. state and federal prisoners age 65 or older increased by 63% between 2007 and 2010, compared to only 0.7% for the total prison population. There are now 26,200 prisoners age 65 or older.
• The number of prisoners age 55 or older grew by 282% between 1995 and 2010, vs. 42% for the total prison population. There are now 124,400 prisoners age 55 or older.
• Of state prisoners age 51 or older, 41% have sentences ranging anywhere between more than 20 years to life.
• Medical expenditures for older prisoners are three to nine times as high as for other prisoners, depending on the state.

Programs for Justice-Involved Women
The National Resource Center on Justice-Involved Women has developed a national directory of programs for women with criminal justice involvement. NRCJIW was established last year by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance in partnership with the National Institute of Corrections to provide guidance and support to criminal justice professionals and to promote evidence-based, gender-responsive policies and practices with the goal of reducing the number and improving the outcomes of women involved in the criminal justice system. Find the directory in the News section.

http://careers.correctionalhealth.org
Because suicide is a leading cause of death in juvenile facilities nationwide, NCCHC recommends an active approach to the management of suicidal juveniles. The 2011 Standards for Health Services in Juvenile Detention and Confinement Facilities brought noteworthy changes to the Suicide Prevention Program standard through a number of new compliance indicators.

Prevention Program Details
The compliance indicators for standard Y-G-05 go into more detail on what a suicide prevention program should entail. For instance, the responsible health authority should approve the facility’s suicide prevention plan, the training curriculum for staff, including development of intake screening for suicide potential and referral protocols; and the training for staff conducting the suicide screening at intake (CI #5).

Other compliance indicators specify that facility staff should identify suicidal juveniles and immediately initiate precautions, and that suicidal juveniles should be evaluated promptly by the designated health professional who directs the intervention and assures follow-up as needed (CI #1a, 1b). Treatment plans addressing suicidal ideation and its reoccurrence should be developed, and patient follow-up should occur as clinically indicated (CI #4).

The 11 key components of a suicide prevention program are outlined in compliance indicators #2a-k. Of note, the need to provide treatment is now explicit. Qualified mental health professionals should consider strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the juvenile’s suicide ideation. The strategies should include treatment needs when the patient is at heightened risk to suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.

Housing and Monitoring
Housing and monitoring are now combined into one component. Child care workers and health staff alike will need to be aware of and receive training in the major changes to this piece, which center on the monitoring of actively and potentially suicidal juveniles.

Actively suicidal juveniles express a state of acute thought of completing suicide associated with imminent risk. They should be placed on constant observation (CI #1c).

Potentially suicidal juveniles are not actively suicidal, but express suicidal ideation and/or have a recent history of self-destructive behavior. They should be observed at staggered intervals not to exceed every 15 minutes, for example, 5, 10 and 7 minutes (CI #1d). In other words, potentially suicidal juveniles should be monitored on an irregular schedule with no more than 15 minutes between two checks. Note that precise 15-minute observation periods are not in compliance with the standard, nor are consistently recurring intervals (even “q1 checks” do not meet the intent of this standard). The idea is that the youth under watch cannot predict when the next check will occur.

If, however, the potentially suicidal juvenile is placed in isolation, constant observation is required. Unless constant supervision is maintained, a suicidal juvenile should not be isolated but should be housed in the general population, mental health unit or medical infirmary and located in close proximity to staff. All cells or rooms housing suicidal juveniles should be as suicide-resistant as possible (e.g., without protrusions that would enable hanging). Other supervision aids, such as a closed circuit television, can be used as a supplement to, but never as a substitute for, staff monitoring. The use of other juveniles in any way, including as companions or suicide-prevention aides, is not a substitute for staff supervision (CI #3).

Risk Factors
Recent research points out that adolescent suicides in correctional settings have different high-risk periods compared to adults. Although juveniles may become suicidal at any point during their stay, high-risk periods include immediately upon admission, after adjudication, after return to a facility from court, after the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one), prolonged stays in juvenile detention facilities and after suffering humiliation (e.g., sexual assault) or rejection. In addition, high risk of suicide has been identified for juveniles entering or unable to cope with segregation, other specialized single-room housing assignments or room confinements (e.g., time-out, quiet time, separation). Juveniles who are in the early stages of recovery from severe depression also may be at risk.

Signs of Prevention Success
Despite the differences in adult and juvenile populations, data from a recent study examining jail suicide underscore the importance of appropriate monitoring. In 2010, the National Center on Institutions and Alternatives released a major study called the National Study of Jail Suicide: 20 Years Later. Commissioned by the U.S. Justice Department’s National Institute of Corrections, the study found a dramatic decrease in the rate of suicide in county jails during the past 20 years.

In 1986, NCIA released a Justice Department commissioned study that reported 107 suicides per 100,000 inmates; strikingly, the 2010 study calculated the suicide rate in county jails to be 38 deaths per 100,000 inmates, with no more than 15 minutes between checks. This means that precise 15-minute observation periods are not in compliance with the standard, nor are consistently occurring intervals (even “q1 checks” do not meet the intent of this standard). The idea is that the youth under watch cannot predict when the next check will occur.

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which is a threefold decrease from 20 years earlier. This rate is still three times greater than that of the general U.S. population (11 deaths per 100,000 people), but as Lindsay Hayes, NCIA project director and author of the study, has said, “The recent decrease is extraordinary.”

The 2010 study identified 696 jail suicides in 2005 and 2006 combined, with 612 deaths occurring in detention facilities (housing individuals for more than 72 hours) and 84 in holding facilities (housing individuals for less than 72 hours). Various characteristics of the jail facilities were summarized in the findings. Notably, 93% provided a protocol for suicide watch, but less than 2% had the option for constant observation; most (87%) used 15-minute observation periods. It should be noted that precise 15-minute observation periods would not be in compliance with NCCHC’s standards on suicide prevention for juvenile facilities, jails or prisons.

**Corrective Action**

It is clear that much progress has been made with regard to suicide prevention in correctional facilities in the last 20 years, and NCCHC has been at the forefront of this movement in setting standards for suicide prevention. The Y-G-05 standard is intended to ensure that suicides are prevented if at all possible. When suicides do occur, appropriate corrective action should be identified and implemented to prevent future suicides.

To that end, in the event of a youth’s suicide, a psychological autopsy should be completed within 30 days. A psychological autopsy, sometimes referred to as a psychological reconstruction and usually conducted by a psychologist or other qualified mental health professional, is a written reconstruction of an individual’s life with an emphasis on factors that may have contributed to the death. The typical psychological autopsy is based on a detailed review of all file information on the juvenile, a careful examination of the suicide site and interviews with staff, juveniles and family members familiar with the deceased. (See Y-A-10 Procedure in the Event of a Juvenile Death.)

A continuous quality improvement root cause analysis should be conducted for all suicides and suicide attempts. Remedial action should be taken on identified policy, staff performance, environment or other system failures that allowed the event to occur. The remedial change(s) should be successful in preventing opportunities for future suicide attempts.

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

The NCIA National Study of Jail Suicide: 20 Years Later is available online at http://nicic.gov/Library/024308.
by Fred Cohen, LLM

Steve Collazo, an inmate at New York’s Great Meadow prison, sued the prison’s food services manager (and others) claiming improper denial of access to medically prescribed diets resulting in a violation of his Eighth and 14th Amendment rights. In Collazo v. Pagano (2d Cir. 2011), the district court’s grant of summary judgment for the defendants is upheld.

What Happened
On Jan. 22, 2003, Collazo was examined by Dr. Edmundo Nunez, a facility physician. Following some tests, Dr. Nunez concluded that Collazo’s triglyceride levels would benefit from a therapeutic diet low in saturated fats. Collazo remained on this diet for several months, but it was jeopardized on Sept. 15, 2003, when a corrections officer issued a misbehavior report to Collazo for allegedly throwing away his food after having an argument with a kitchen server. Collazo was charged with violating three prison disciplinary rules: refusing direct orders by not complying with his medical diet, wasting food by throwing away his special dietary meal and failing to comply with mess hall serving policies.

Defendant James Pagano, the director of food services at Great Meadow Correctional Facility, was informed of this incident by the corrections officer and a cook, both of whom said that this was the fourth time Collazo had thrown away his food. Accordingly, Pagano recommended to Dr. Albert Paolano, director of health services at Great Meadow, that Collazo’s special diet be discontinued. Dr. Paolano approved the request, and Collazo was notified on Sept. 17 that his diet would be discontinued as of Sept. 19.

At a disciplinary hearing on Sept. 18, Collazo was found guilty of refusing a direct order, but was found not guilty of wasting food and of failing to comply with mess hall policy. On Sept. 26, Collazo filed a grievance in order to have his special diet restored. On Oct. 10, Collazo’s request was granted, conditioned on his first visiting with Dr. Nunez.

Over the next few months, Collazo was a “no show” for several scheduled visits with Dr. Nunez. Collazo finally appeared for his scheduled appointment in April 2004. By July, Dr. Nunez had diagnosed Collazo with diabetes, and at that point recommended that he be placed on a new specialized diet. Subsequently, Pagano conducted a review in which it was discovered that Collazo had missed 18 of his special meals during the week of July 19, 2004. On this basis, Pagano once again recommended to Dr. Paolano that Collazo’s special diet be revoked, a recommendation Dr. Paolano once again accepted.

Upon further investigation, it came to light that Collazo had missed all of these meals because no one had informed him that he was once again eligible for a special dietary offering. Collazo was found not guilty at the resulting disciplinary hearing, and his special diet was restored since.

Legal Framework
The Third Circuit treats Collazo’s legal claim essentially as a denial of medical care. Thus, the issue is whether the denial of the medically related food amounts to deliberate indifference to plaintiff’s serious medical needs.

Deliberate indifference has two necessary components, one objective and the other subjective. Subjectively, the official must have acted with the requisite state of mind, the “equivalent of criminal recklessness.” The court finds there is nothing in the record that indicates that Pagano had this necessary intent either time he asked for Collazo’s special dietary status to be revoked. The first time Pagano asked that Collazo’s special diet be revoked, he was acting on the basis of information, provided to him by prison officials, that Collazo had been violating mess hall rules. The second time, Pagano acted after his own investiga-
tion revealed that Collazo had been routinely skipping his specialized meals. Collazo does not contest the fact that he had indeed missed these meals; once Pagano became aware that Collazo’s “violations” were the result of an innocent misunderstanding, the special diet was restored.

Thus, Collazo’s constitutional claim fails at the threshold of deliberate indifference.

Comment
In his 2009 book *Rights of Prisoners*, law professor Michael Mushlin, JD, writes:

> Given the serious harm that can occur as a result of a failure to provide a medical diet, it is apparent that a violation will be shown in cases where serious harm may occur, such as with diabetics, but will not be shown when the medical condition, or the consequences of not providing the diet, are less severe.

For diabetics, lack of an appropriate diet may cause blindness. As long as the medical condition is “serious” and the potential consequences potentially serious, the right to a medical diet is clear.

What happens, however, if the inmate willfully refuses food where the custodian may be required to force feed to save a life? Should reasonable efforts be made to have the recalcitrant inmate eat the medically indicated food?

While the answers to these questions are not clear, one thing in the area of inmate food is clear: Food cannot be withheld as punishment. The dreaded “loaf,” of course, is used as punishment but it has caloric value along with a disgusting appearance and flavor.

To the extent Collazo was punished by the withholding of the medically indicated meals, even though the violation itself is food related, there is the question of the legality of such diet change as punishment. I would argue that it is directly analogous to withholding needed medical or mental health care and impermissible. And, based on this decision, I would likely lose.

Fred Cohen, LL.M, is the coeditor of the *Correctional Law Reporter*. This article is in press for a future issue of CLR, ©2012 Civic Research Institute, Inc, and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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**Medical Diets in the Standards**

NCCHC’s Standards for Health Services (for prisons, jails and juvenile facilities) address medical diets in standard F-02. Compliance indicator #4 states that when inmates refuse prescribed diets, follow-up nutritional counseling is provided.

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Crisis Intervention Teams

Improving Outcomes for Inmates With Mental Illness

by Dean Aufderheide, PhD

Our nation’s prisons are confronted daily with substantial numbers of inmates with serious mental illness who are under our supervision. Correctional officers are typically the first to observe significant changes in an inmate’s routine or mental status. In the structured prison environment, bizarre behavior suggestive of mental illness, deterioration in self-care or an increase in aggressive or irritable behaviors tends to stand out. And when this behavior escalates to potential violence, correctional officers are often on the front line.

Managing crisis situations with mentally ill inmates, therefore, requires correctional staff to have at least a working knowledge of mental illness, especially in special housing areas such as administrative segregation and inpatient units. It is imperative that security staff assigned to these housing areas be equipped with the knowledge and skills to respond effectively to the challenges associated with managing inmates with serious mental illness.

Crisis intervention team training is an effective way to enhance the knowledge and skills of correctional staff while aiding administrators in improving the management and care for this special population. Knowledge is power and, when urgency of response is paramount, being able to recognize psychiatric symptoms and knowing how to apply de-escalation techniques are powerful tools in calming disruptive and potentially violent behavior. This results in improved staff and inmate safety.

Adapting a CIT Training Program for Prisons

The first CIT was established in 1988 in the aftermath of a police shooting of a man with a serious mental illness. The Memphis Model, developed in a collaboration among the city’s police department, the local chapter of the National Alliance on Mental Illness and two local universities (including a medical school), is a prebooking jail diversion effort meant to improve outcomes of police interactions with people with mental illness. Today similar CITs exist in hundreds of communities.

The traditional CIT training for law enforcement is a program of information on community resources, referral processes and other topics that do not directly apply in the prison environment. However, CIT training can be modified to target the specific demands associated with managing the mentally ill in prison. The Oklahoma Department of Corrections, for example, has a two-day, 16-hour Correctional Crisis Resolution Training program designed to improve the outcomes of correctional officer interactions with offenders in crisis who also have a mental illness. 

“This specialized training is needed to equip staff with...
the knowledge and communication tools necessary to safely and effectively manage this population,” says Robert Powitzky, PhD, ODOC’s chief mental health officer.

In the Florida Department of Corrections, we targeted information and skills pertinent to our system to distill the training program into a one-day, eight-hour module. The module is strategically focused on frontline security staff acquiring (1) a working knowledge of mental illness, (2) an understanding of the challenges mentally ill inmates face in prison adjustment, (3) crisis intervention skills and (4) practical de-escalation skills and techniques. The goal is to avoid unnecessary uses of force.

Qualified correctional mental health professionals are the lead instructors in this training. With knowledge and experience in conflict resolution, crisis intervention and de-escalation techniques, they possess the expertise to adapt the educational content to the needs of the correctional institution. The training team also includes a correctional officer, who speaks to the effectiveness of CIT programs, and, when feasible, a representative from NAMI and a CIT-certified instructor.

The module is taught using a combination of didactic information, scenario-based role plays and immediate peer feedback. A distinctive feature of our program is an emphasis on understanding what it is like to have a serious mental illness. Using headphones, training participants listen to simulated auditory hallucinations while they are instructed to execute a series of assigned tasks. The correctional officers gain a perspective on the challenges that mentally ill inmates experience and learn skills that can be applied to a wide range of custodial situations.

**Challenges and Opportunities**

**Leadership Buy-In**
The first challenge is to get buy-in from the correctional leadership. To make any training effective, a top-down communication from the leadership that the training is important, has priority value and is a part of the core mission is essential. When the leadership endorses a CIT training, staff are motivated to participate.

The opportunity is to educate the leadership on the effectiveness of CIT training in accomplishing its core mission, improving staff and inmate safety, and how correctional officers can play an important role in interventions involving inmates who have mental disorders.

**Training Logistics**
The second challenge is the logistics of the training. Prison systems are highly structured environments with precise procedures and protocols. Security staff post assignments must be meticulously managed to ensure there is adequate staff to provide the appropriate supervision of inmates. Any training materials brought into the facility must be inspected and approved. When developing and scheduling a CIT training, therefore, it is critical to have a clear understanding of the system’s rules and regulations, the various offices and individuals from whom you will need authorization and the flexibility to schedule the training based on the availability of the security staff who will attend. This often means providing multiple trainings for smaller groups at the same facility.

The opportunity is to strengthen shared values in ongoing communication and cooperation, both formally and informally and at the level of both line staff and administrators. These interactions provide opportunities for the CIT trainers to become more sensitive to the concerns and perspective of the prison system and its correctional staff while providing the framework for ongoing cooperation and involvement in the CIT training.

**Staff Attitudes**
The third challenge is addressing staff attitudes toward the training itself. The correctional culture typically involves regimentation, universally applied rules, implicit authority of security staff and punitive sanctions for violations by inmates. Some correctional staff may view mental health providers as soft, gullible and coddling of inmates, or perceive mental health care as protecting inmates from the consequences of their behavior. It is important to note that correctional staff are professionals who are trained to be action-oriented and to quickly resolve problems that arise. So when faced with disruptive behaviors that can compromise the safe operation of a prison and divert staff time and resources, they must act decisively.

The opportunity is to help correctional officers to carry out an important role in interventions involving inmates who have mental disorders. There is no doubt that the authority to provide discipline and apply sanctions is important in managing and curbing maladaptive behaviors. But the tools of CIT are not meant to replace these traditional tools.

Rather, they are additional tools that correctional officers can use to solve a problem effectively and efficiently with the least amount of disruption. A knowledgeable officer equipped with CIT skills can effectively help a mentally ill inmate meet the demands of the correctional environment.

continued on page 12
It’s a win-win situation because dysfunctional behavior by inmates who have mental disorders not only impairs the ability of officers and administrators to operate safe and orderly facilities but also results in stress for correctional employees at all levels.

Interestingly, research shows that correctional officers identify the threat of violence by inmates as their most frequent source of stress, and the strain of dealing with mentally disordered behavior can add to the considerable inherent stress of the job.

Judith Evans, executive director of NAMI Florida, agrees. “Assisting individuals with coping with their mental illness can be very stressful. With the increased number of individuals with mental illness in our jails and prisons, it is more important than ever that correctional officers have the knowledge and skills to respond effectively to individuals diagnosed with a mental disorder.”

CIT Resources

Although a great deal of information is available on crisis intervention team training, very little focuses on its use in prisons. That’s why it is important to carefully consider your system’s characteristics and needs when adapting a training program.

- National Alliance on Mental Illness
  Crisis Intervention Team Resource Center — This site serves as a repository of information about CIT programs nationwide and promotes national networking to help standardize and expand the use of CIT. www.nami.org

- National Institute of Corrections
  Crisis Intervention Teams: A Frontline Response to Mental Illness in Corrections — This online training program applies to jails, prisons and community corrections agencies. It focuses on building capacity to implement a CIT program and the training for that program. http://nicic.gov/Training/12B3203

Also, if you are attending NCCHC’s Updates in Correctional Health Care conference, check out session 142 on Tuesday, May 22. “Crisis Intervention Team Training From the Streets to the Jail” will present the model used at the Cook County (IL) jail, one of the nation’s largest jails. See page 3 for meeting information.

Prevention

It also is important, however, to understand that the psychology behind a crisis is crucial to its successful resolution. It doesn’t matter how good we are at confronting conflict and difficult inmates if the crisis intervention strategy doesn’t include proven methods for not only resolving but also preventing and managing crises. Otherwise, we will face the same crisis problems over and over again, and CIT will stand for “continue intervention tomorrow.”

In managing crises associated with mentally ill inmates, we have the opportunity to implement proven methods that can safely defuse and de-escalate those crises. A modified CIT training is a proven method to equip correctional officers with the knowledge to recognize the symptoms of mental illness and apply the skills they have learned. Safety and security don’t just happen, and the knowledge and skills acquired from the CIT training can result in improved staff and inmate safety.

Dean Aufderheide, PhD, is the director of mental health for the Florida Department of Corrections, Tallahassee, FL.
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Constipation: Straight Talk on the Last Taboo Subject

by Jeffrey E. Keller, MD

After many years of dealing with complaints of constipation both in the ER and in correctional facilities, I have decided that bowel health is the last taboo subject. We all received “The Talk” (about sex and reproductive health) as adolescents. But nobody seems to talk about how to have a proper bowel movement. It is a subject that inevitably causes giggling and uncomfortable laughter. It is not spoken of in polite society. As a result many people do not understand how their bowels work.

I have found this to be a big problem in the jails I work in. Inmates complain of constipation when they are not really constipated. They are bowel-fixated when there is no reason for them to be. Often, they need education more than they need laxatives. To this end, I want to discuss several essential factors relating to understanding and treating constipation that may help make your correctional medicine practice a little easier.

1. The most common cause of constipation is too little stool, not too much stool.

This is a little counterintuitive, but very true and important to understand. The small intestine absorbs the nutrients from the food we eat and deposits the indigestible bits (mixed with a lot of water) into the colon. The job of the colon is to reabsorb most of the water and thus create feces. The indigestible bits are better known as fiber. The colon moves the mass of fiber and water along by means of peristalsis—the systematic contraction and relaxation of the wall of the colon. If the mass of stool is small, peristalsis has a much harder time moving things along.

You can demonstrate this by playing a game I used to play in grade school—the soap game: You take a wet piece of soap and squeeze it in your fist, causing it to shoot across the room (extra points if you hit your friend in the head). You will find that a larger piece of soap works much better than a small sliver of soap. With a larger piece, even a little squeeze will shoot the soap a long way. But if the soap is a small sliver, you have to squeeze very hard and generate a lot of pressure to make the soap move.

It is the same principle with your colon. For peristalsis to work efficiently there has to be enough stool. If there is too little, the colon has to generate high pressures to move it along and it moves inefficiently. This leads to constipation. The essential teaching point here is that to relieve constipation, the absolute most important thing we need is more fiber. The other remedies we will discuss are not even close to as important. Just about everyone with complaints of constipation should receive more fiber. Unfortunately, jail and prison diets are all too often deficient in fresh fruits and vegetables and whole grains. But you can supplement dietary fiber with fiber tablets or soluble fiber.

Similarly, another solution to constipation is to drink more water. Remember that the colon reabsorbs water from the stool given it by the small intestine. If you are dehydrated, the colon will absorb a lot of water, leaving the stool small and hard to pass. So, like a reflex, if you are my patient and you say “constipation,” I am going to say “fiber and water.” These are the single most important part of constipation therapy.

Incidentally, the “stool softener” laxatives like mineral oil and Colace work by making the surface of the stool more permeable to water, thereby attracting water back into the stool. This, of course, makes the final product moister and bigger. However, you can achieve the exact same effect by drinking more water. If you are not dehydrated, the colon will leave more water in the stool to begin with.

2. Bowel movements occur on a circadian rhythm.

By this I mean that we naturally tend to have bowel movements at approximately the same time every day, usually in the morning. Your body tells you when it is time to have a BM by giving you “the urge.” You can’t just have a bowel movement any time you wish. If you try to have a bowel movement at the wrong time of the day or when you are not feeling the urge, your body may not cooperate. This is very similar to another natural event that occurs in a circadian fashion—sleep. Our bodies have a signal that tells us it is time to go to sleep (we get tired) and this tends to occur at the same time each day. If you try to go to sleep at the wrong time of day when you are not tired, you will not tend to be very successful.

This fact—the circadian nature of bowel movements—becomes important when prescribing osmotic or stimulant laxatives. (These include Dulcolax, Milk of Magnesia, magnesium citrate, senna and others.) These laxatives work by stimulating the colon to contract. They are properly used intermittently to reestablish a natural rhythm of bowel movements. I know a doctor who liked to prescribe Dulcolax to be taken three times a day. This makes as much sense as prescribing Ambien to be taken three times a day. Also, just like sleeping aids, if you take laxatives every day, you can become habituated to them so that it becomes hard to go without them.

3. You cannot have a bowel movement if there is nothing in your rectum.

Simplified, the large intestine consists of two parts, the colon, which extracts water from the mass delivered to it by the small intestine and creates stool, and the rectum. The rectum is a stool storage place preparatory to evacuating it in a bowel movement. The rectum is analogous to the dumpster in my office complex. During the day, all the...
medical offices take their garbage out to the dumpster. Then once a day, the city garbage truck comes around and empties it. This is very much our large intestine—during the day, the colon adds finished stool to the rectum and once a day or so, the rectum is emptied.

But what happens if nobody put any garbage into the dumpster? Let’s say that you generally have a bowel movement every day but recently, well, you just have not been eating much fiber. It may be that your body has not created enough stool for a bowel movement this day. Or maybe, peristalsis slowed down somewhat for whatever reason and your rectum is empty. On that day, you will not feel the urge to have your normal daily bowel movement. That does not mean necessarily that you are constipated. It may mean that there is nothing in the rectum to evacuate right now; there will be tomorrow. Relax! You do not have to take a laxative. Once again, most likely the problem is that you are not eating enough fiber or drinking enough water.

Conversely, if you eat an unusually large amount of fiber, you may need to have two bowel movements a day.

4. You need to be able to identify those ‘red flag’ patients who are at high risk for true constipation problems.

In most patients, constipation is a nuisance rather than a bad medical problem. I mean by this that even if you don’t treat these patients with anything, they will eventually work things out themselves. I have not seen any patients in my jails explode from constipation.

However, certain patients can develop constipation so severe that it becomes a true and urgent medical problem. The most common way for this to happen is to develop a fecal obstruction so large that the patient literally cannot pass it. Think basketball sized. It is important to identify these high-risk patients. It is pretty simple:

- The elderly and infirm
- Debilitated patients, such as those with cancer or AIDS
- Patients with an inherited bowel disease, such as cystic fibrosis, that leads to constipation; these patients will tell you who they are
- Patients taking chronic narcotics (think Elvis)
- If you identify a high-risk patient, how can you tell if they have a fecal obstruction? Simple—you do a rectal exam. You will not miss the huge stool mass.

5. There are two objective tests to determine if a patient is truly constipated.

One of the problems with diagnosing constipation is that we have to take the patient’s word that they are not having normal bowel movements. Sometimes, especially in corrections, patients may not tell us the truth. When you run into a patient with repeated and incessant complaints of not having bowel movements or in whom nothing works, you can check the validity of the history in two ways.

The first is the rectal exam. If the patient is “set” to have a BM, you should be able to palpate a fecal mass in the rectum. You can also tell if there is a fecal obstruction. If the rectum is empty, the patient is not ready to have a BM. If the patient states she has not had a BM in five days, and the rectum is empty, well, these two things do not jibe.

If you are not sure whether a patient has serious constipation or not, a plain abdominal X-ray can give you the answer. The normal colon will have around two or three stool boluses visible on X-ray. The seriously constipated patient may have a solid mass of stool extending from the cecum to the rectum. You should not, of course, order an abdominal X-ray frequently, but occasionally it is a more efficient and less expensive way to evaluate persistent claims of constipation than is endless prescriptions of laxatives. If the bowel is empty, the most powerful laxative in the world will not produce a bowel movement.

Most patients with complaints of constipation in the correctional environment would benefit more from education than they would from laxatives. Once you have sorted out the rare serious cases of constipation, you can have “The Talk” with the rest of the patients and teach them to manage their bowel health on their own. Give them the tools they need to manage this problem on their own by placing simple constipation remedies like fiber and stool softeners on the commissary. If you need a protocol and educational materials to guide you, email me and I will share mine.

Jeffrey E. Keller, MD, is medical director of the Ada County Jail in Boise, ID, and the Bonneville County Jail in Idaho Falls, ID. He writes a correctional medicine blog at http://jailmedicine.com. Contact him at jkeller@badgermedicine.com.
Correctional Nursing Practice: What You Need to Know (Part 9)

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

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

Regulatory Oversight

Nurse Practice Acts, Boards of Nursing and Licensure
Regulation of nursing practice occurs at the state level. Each state’s legislature enacts a Nurse Practice Act that establishes licensure requirements and defines the scope of practice. This act is implemented by the state board of nursing. Boards of nursing function to protect the public’s health and safety by accrediting or approving nurse education programs, establishing practice standards and issuing licenses to practice. Depending on the state’s structure of government, some boards of nursing are independent while others report to a government agency such as the department of health, consumer affairs or education.

Individuals completing an accredited school of nursing may apply to the state board of nursing for licensure and entry into practice. Upon authorization, the nurse candidate may schedule to take the National Council Licensure Examination. Passage of the NCLEX allows for initial licensure. To ensure ongoing qualification to practice, licenses must be renewed periodically. This may entail documentation of continuing education, clinical practice, absence of criminal record and good moral character.

Nurses also may seek licensure in states beyond their primary license. This is done through endorsement or through interstate compact. Note that states vary in their laws, regulations and codes, and that nursing practice must be in compliance in each state in which the nurse is licensed.

Regulation and Disciplinary Action
Nurses are subject to review by state boards of nursing, which have statutory authority to take various types of action for violations. A review may occur when a complaint is reported to the board by a patient, family member, colleague or administration. Situations that lead to review generally involve omission or commission, gross negligence or unsafe practice. Disciplinary review may arise from professional misconduct such as failing to communicate change of address, repay student loans or pay child support; driving under the influence of drugs and alcohol; falsification of records; improper delegation; and diversion of substances. The level of review depends on the nature of the complaint. Informal reviews may involve a consent order (i.e., a negotiated agreement). Formal reviews generally involve a hearing. The outcome can range from closing the file if no violation is found to a letter of reprimand, orders of corrective action, licensure restriction or revocation of license. Depending on the violation and the board’s position, voluntary surrender of license may sometimes be an option.

In addition to the Nurse Practice Act, other laws, rules and regulations at the federal, state and local levels may be pertinent to nursing practice and may subject the nurse to legal action. A nurse who is notified of board review or legal action should seek immediate legal counsel by a nurse attorney.

Scope of Practice
Again, each state’s Nurse Practice Act specifies scope of practice. Over the years the scope of nursing has evolved and expanded. The current health care climate suggests that it is likely to expand even more.

The practice of nursing in corrections is consistent with practice standards for nurses in any setting. However, many states recognize the unique challenges of nursing in the correctional setting and tend to have a broader view of practice for these professionals. This in no way implies that correctional nurses can or should practice beyond the scope of their respective practice acts. In fact, all of the nursing specialties, correctional nurses are most vulnerable to practice issues. This is in part due to the environment; especially if the institution lacks strong, competent nursing leadership.

It is important for the correctional nurse to have a good understanding of scope of practice. Following policies and procedures is useful in meeting standards, but the institution’s policies and procedures cannot conflict with state practice acts. In facilities that hire competent, well-educated chief nurse administrators who function at advanced leadership levels, policies and procedures usually comply with the scope of practice.

Nursing Standards
Nursing excellence is fostered through standards, code of ethics and professional development, which includes credentialing and lifelong learning. Standards for nursing are developed by the American Nurses Association.

Professional standards are authoritative statements that describe the responsibilities for which the nurse is accountable. The standards reflect the values and priorities of the profession. They provide guidance and direction for practice, as well as a framework for evaluating practice within the standards. The nursing process is the framework around which all nursing practice is based.

Standards of practice also exist for specialty areas of nurse...
ing. For corrections, these encompass use of the nursing process (e.g., assessment, problem diagnosis, identifying desired outcomes, planning, implementing and evaluating).

The correctional nurse is also expected to meet standards of professional performance. These relate to quality of care, performance appraisal, professional knowledge, professional environment, ethics, collaboration, research and resource utilization.

Other resources to help nurses understand their practice and related responsibilities and accountabilities include the Code of Ethics for Nurses and the Nursing’s Social Policy Statement, both from the ANA. These documents foster compliance with the nursing contract to the profession and to the public.

Correctional nurses deal with numerous issues that have important ethical and legal considerations (for example, delegation, staffing, involuntary medication administration). On some difficult issues, professional standards are clear. For instance, nurses should not participate in executions, nor support, participate in or fail to report abuse and neglect of which they are aware. Nurses should not participate in the collection of forensic information. Nurses have an obligation to view inmates as patients, and to promote patient advocacy while maintaining professional boundaries.

A nurse will be well-equipped to use critical thinking skills and to act appropriately at all times if he or she possesses a solid knowledge of the NCCHC Standards, correctional nursing standards and nursing practice standards, as well as applicable laws and regulations.

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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**CCHP-RN Certification Review Seminar**

If you are planning to pursue CCHP-RN specialty certification, you should consider attending the day-long preconference seminar taking place on Sunday, May 20, at the Updates in Correctional Health Care conference.

Taught by two members of the CCHP-RN task force (Susan Laffan, RN, CCHP-RN, CCHP-A, and Jerri McGinnis, BSN, MBA, CCHP-RN), the intensive review course will cover all content areas of the exam, using examples and case studies to illustrate the concepts. Practice questions will be provided for each content area. Tips on preparing for, studying for and taking the exam will be shared. This seminar can also serve as an overview course for the nurse new to corrections.

See page 3 for conference information. To learn more about certification, visit www.ncchc.org.
Complete Therapy in One Single Tablet for Treatment-Naïve Adults With HIV-1

Indication
COMPLERA is indicated for use as a complete regimen for the treatment of HIV-1 infection in antiretroviral treatment-naïve adults. This indication is based on Week 48 safety and efficacy analyses from 2 randomized, double-blind, active controlled, Phase 3 trials in treatment-naïve subjects comparing rilpivirine to efavirenz.

The following points should be considered when initiating therapy with COMPLERA:

- More rilpivirine-treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure compared to subjects with HIV-1 RNA less than 100,000 copies/mL at the start of therapy.
- The observed virologic failure rate in rilpivirine-treated subjects conferred a higher rate of overall treatment resistance and cross-resistance to the NNRTI class compared to efavirenz.
- More subjects treated with rilpivirine developed lamivudine/emtricitabine resistance compared to efavirenz.

COMPLERA is not recommended for patients less than 18 years of age.

Important Safety Information
BOXED WARNING: LACTIC ACIDOSIS/SEVERE HEPATOMEGALY WITH STEATOSIS AND POST TREATMENT ACUTE EXACERBATION OF HEPATITIS B

- Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including tenofovir disoproxil fumarate, a component of COMPLERA, in combination with other antiretrovirals.
- COMPLERA is not approved for the treatment of chronic hepatitis B virus (HBV) infection and the safety and efficacy of COMPLERA have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV-1 and have discontinued EMTRIVA® (emtricitabine) or VIREAD® (tenofovir disoproxil fumarate), which are components of COMPLERA. 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 COMPLERA. If appropriate, initiation of anti-hepatitis B therapy may be warranted.


Please see additional Important Safety Information for COMPLERA on following pages.
Put These Benefits Within Reach for Your Patients

Proven viral suppression through 48 weeks (HIV-1 RNA <50 copies/mL)\(^{1,2}\)
- Proven non-interior viral suppression to efavirenz: 83% with rilpivirine + emtricitabine/tenofovir disoproxil fumarate (N=550) versus 81% with efavirenz + emtricitabine/tenofovir disoproxil fumarate (N=546)\(^{1,3}\)
- Incidence of virologic failure: 13% with rilpivirine + emtricitabine/tenofovir disoproxil fumarate (N=550) versus 8% with efavirenz + emtricitabine/tenofovir disoproxil fumarate (N=546)\(^{1}\)
- More rilpivirine-treated subjects with HIV-1 RNA greater than 100,000 copies/mL at the start of therapy experienced virologic failure compared to subjects with HIV-1 RNA less than 100,000 copies/mL at the start of therapy\(^{1}\)
- The observed virologic failure rate in rilpivirine-treated subjects conferred a higher rate of overall treatment resistance and cross-resistance to the NNRTI class compared to efavirenz\(^{2}\)
- More subjects treated with rilpivirine developed lamivudine/ emtricitabine associated resistance compared to efavirenz\(^{2}\)

Demonstrated safety through 48 weeks\(^{1}\)
- The most common adverse drug reactions (Grades 2-4, ≥2%) were insomnia and headache\(^{1}\)
- Low rate of discontinuation due to adverse reactions (2% with rilpivirine + emtricitabine/tenofovir disoproxil fumarate versus 5% with efavirenz + emtricitabine/tenofovir disoproxil fumarate)\(^{1}\)
- Smaller mean changes in fasting lipid levels (rilpivirine + emtricitabine/tenofovir disoproxil fumarate versus efavirenz + emtricitabine/tenofovir disoproxil fumarate)\(^{1}\): Total cholesterol (0 mg/dL versus 25 mg/dL), HDL cholesterol (3 mg/dL versus 9 mg/dL), LDL cholesterol (–2 mg/dL versus 13 mg/dL), triglycerides (–11 mg/dL versus 8 mg/dL)\(^{1}\)

Additional information: Pregnancy Category B\(^{1}\)
- There are no adequate and well-controlled studies in pregnant women\(^{1}\)
- COMPLERA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus\(^{1}\)
- To monitor fetal outcomes of pregnant women exposed to COMPLERA, an Antiretroviral Pregnancy Registry has been established and healthcare providers are encouraged to register patients by calling 1-800-258-4263\(^{1}\)

A complete once-daily, single tablet regimen\(^{1}\)
- The recommended dose of COMPLERA is one tablet taken orally once daily with a meal (in excess of 400 kcal)\(^{1}\)
- Because COMPLERA is a fixed-dose combination, it should not be prescribed for patients requiring dose adjustment such as those with moderate or severe renal impairment (creatinine clearance below 50 mL/min)\(^{1}\)

For more information, please visit

www.complera.com

*Study designs: The efficacy of COMPLERA is based on the analyses of 48-week data from 2 randomized, double-blind, controlled studies (C209 [ECCHO] and C215 [THREVE] in treatment-naive, HIV-1-infected subjects (N=1368). The studies were identical in design with the exception of the BR. Subjects were randomized in a 1:1 ratio to receive either rilpivirine 25 mg (N=686) once daily or efavirenz 600 mg (N=682) once daily in addition to a BR. In the ECCHO study (N=690), the BR consisted of a NNRTI, emtricitabine/tenofovir disoproxil fumarate (300 mg/200 mg), or abacavir + lamivudine (150 mg/300 mg). The median baseline plasma HIV-1 RNA was 5 log copies/mL (range 2-7). The primary endpoint was non-interior viral suppression to efavirenz through 48 weeks [HIV-1 RNA <50 copies/mL]).\(^{1,2}\)

BR=background regimen; NNRTI=non-nucleoside reverse transcriptase inhibitor; NNRTI=non-nucleoside reverse transcriptase inhibitor.
Important Safety Information for COMPLERA (cont)

Please see previous page for Boxed WARNINGS about lactic acidosis, severe hepatomegaly with steatosis, and exacerbations of hepatitis B upon discontinuation of therapy.

CONTRAINDICATIONS
COMPLERA should not be coadministered with the following drugs, as significant decreases in rifampirina plasma concentrations may occur due to CYP3A enzyme induction or gastric pH increase, which may result in loss of virologic response and possible resistance to COMPLERA or to the class of NNRTIs:

- the anticonvulsant carbamazepine, oxcarbazepine, phenobarbital, phenytoin
- the antmycobacterials rifabutin, rifampin, rifapentine
- proton pump inhibitors, such as esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole
- the glucocorticoid systemic dexamethasone (more than a single dose)
- St. John’s wort (Hypericum perforatum)

WARNINGS AND PRECAUTIONS
New onset or worsening renal impairment
- Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hyperphosphatemia), has been reported with the use of tenofovir disoproxil fumarate. Assess creatinine clearance (CrCl) before initiating treatment with COMPLERA. Monitor CrCl and serum phosphorus in patients at risk for renal impairment, including patients who have previously experienced renal events while receiving HEPSEERA® (adefovir dipivoxil). Avoid administering COMPLERA with concurrent or recent use of nephrotoxic drugs. Patients with CrCl below 50 mL per minute should not receive COMPLERA

Drug interactions
- COMPLERA should be used with caution when given with drugs that may reduce the exposure of rifampirina
- COMPLERA should be used with caution when coadministered with a drug with a known risk of torsade de Pointes

Depressive disorders
- The adverse reaction depressive disorders (depressed mood, depression, dysphoria, major depression, mood altered, negative thoughts, suicide attempt, suicidal ideation) has been reported with rifampirina. During the Phase 3 trials (N=1568), the incidence of depressive disorders (regardless of causality, severity) reported among rifampirina (N=686) or efavirenz (N=682) was 8% and 5%, respectively. Most events were mild or moderate in severity. The incidence of Grade 3 and 4 depressive disorders (regardless of causality) was 1% for both rifampirina and efavirenz. The incidence of discontinuation due to depressive disorders among rifampirina or efavirenz was 1% in each arm. Suicide attempt was reported in 2 subjects in the rifampirina arm while suicidal ideation was reported in 1 subject in the rifampirina arm and in 3 subjects in the efavirenz arm. Patients with severe depressive symptoms should seek immediate medical evaluation to assess the possibility that the symptoms are related to COMPLERA, and if so, to determine whether the risks of continued therapy outweigh the benefits

Decreases in bone mineral density
- Bone mineral density (BMD) monitoring should be considered for patients who have a history of pathologic bone fracture or other risk factors for osteoporosis or bone loss. Cases of osteomalacia (associated with proximal renal tubulopathy and which may contribute to fractures) have been reported in association with the use of VIREAD® (tenofovir disoproxil fumarate)

Coadministration with other products
- COMPLERA should not be administered concurrently with other medicinal products containing any of the same active components, emtricitabine, rifampirina, or tenofovir disoproxil fumarate (EMTRIVA® [emtricitabine], EDURANT™ [rilpivirina], VIREAD, TRUVADA® [emtricitabine/tenofovir disoproxil fumarate], ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate]), with medicinal products containing lamivudine (EPIVIR® or EPIVIR-HBV® [lamivudine], EPZICOM® [abacavir sulfate/lamivudine], COMBIVIR® [zidovudine/lamivudine], TRIZIVIR® [abacavir sulfate/lamivudine/zidovudine]), or with adefovir dipivoxil (HEPSEERA)

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

Immune reconstitution syndrome
- Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including the components of COMPLERA. Further evaluation and treatment may be necessary

ADVERSE REACTIONS
- The most common adverse drug reactions to rifampirina (incidence greater than or equal to 2%, Grades 2-4) were insomnia and headache
- The most common adverse drug reactions to emtricitabine and tenofovir disoproxil fumarate (incidence ≥10%) were diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, abnormal dreams, and rash

DRUG INTERACTIONS
- COMPLERA should not be used with drugs where significant decreases in rifampirina plasma concentrations may occur (See CONTRAINDICATIONS)
- COMPLERA is a complete regimen for the treatment of HIV-1 infection; therefore, COMPLERA should not be administered with other antiretroviral medications
- Drugs inducing or inhibiting CYP3A enzymes. Rifampirina is primarily metabolized by cytochrome P450 (CYP) 3A, and drugs that induce or inhibit CYP3A may thus affect the clearance of rifampirina. Coadministration of rifampirina and drugs that induce CYP3A may result in decreased plasma concentrations of rifampirina and loss of virologic response and possible resistance to rifampirina or to the class of NNRTIs. Coadministration of rifampirina and drugs that inhibit CYP3A may result in increased plasma concentrations of rifampirina
- Drugs increasing gastric pH. Coadministration of rifampirina with drugs that increase gastric pH may decrease plasma concentrations of rifampirina and loss of virologic response and possible resistance to rifampirina or to the class of NNRTIs
- Drugs affecting renal function. Because emtricitabine and tenofovir are primarily eliminated by the kidneys, coadministration of COMPLERA with drugs that reduce renal function or compete for active tubular secretion may increase serum concentrations of emtricitabine, tenofovir, and/or other renally eliminated drugs. Some examples include, but are not limited to, adefovir dipivoxil, cidofovir, ganciclovir, valacyclovir, and valganciclovir
- QT prolonging drugs: There is limited information available on the potential for a pharmacodynamic interaction between rifampirina and drugs that prolong the QTc interval of the electrocardiogram. In a study of healthy subjects, supratherapeutic doses of rifampirina (75 mg once daily and 300 mg once daily) have been shown to prolong the QTc interval of the electrocardiogram. COMPLERA should be used with caution when coadministered with a drug with a known risk of torsade de Pointes

DOSAGE AND ADMINISTRATION
Adults: The recommended dose of COMPLERA is one tablet taken orally once daily with a meal.

Renal Impairment: Because COMPLERA is a fixed-dose combination, it should not be prescribed for patients requiring dose adjustment such as those with moderate or severe renal impairment (creatinine clearance below 50 mL per minute).

Please see brief summary of Full Prescribing Information for COMPLERA on following pages, including Boxed WARNINGS about lactic acidosis, severe hepatomegaly with steatosis, and exacerbations of hepatitis B upon discontinuation of therapy.

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COMPLERA®
emtricitabine 200mg/rifampirina 25mg/
tenfovir disoproxil fumarate 300mg tablets
Dugs with No Observed or Predicted Interactions with COMPILERA

We did not identify drug interactions that have been observed between entecavir and benzodiazepines, tricyclic antidepressants, disulfiram, lithium, cytochrome P450 3A4 inhibitors, and other medications, or transformations in studies conducted in healthy volunteers.

No drug-drug interactions between diazepam and entecavir were noted in entecavir phase II clinical trials in patients with chronic hepatitis B. We did not observe drug-drug interactions with benzodiazepines, tricyclic antidepressants, disulfiram, lithium, or other medications that are metabolized by cytochrome P450 3A4. Therefore, caution should be used in patients with chronic liver disease who are taking medications that are metabolized by cytochrome P450 3A4, such as quinidine, diazepam, or any medications that are metabolized by this enzyme system.

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**Refresher on Communicable Disease and Standard Precautions**

By Sue Lane, RN, CCHP

Note: This is adapted from an article written for Cuff Links, a newsletter for jail officers. It can serve as an educational tool for correctional staff or a refresher for health services staff.

Working in corrections brings a challenge to facility staff in recognizing and protecting themselves from communicable diseases. These infectious diseases can be transmitted from one individual to another through airborne, contact, ingestion and sexual transmission. Since we are unable to see the organisms, we have to take reasonable precautions to prevent spreading diseases. The type of precautions taken depend on the way the virus or bacteria are transmitted, so it is important to know the route of transmission and to take appropriate precautions.

**Standard Precautions**

The Centers for Disease Control and Prevention recommends use of standard precautions to decrease disease transmission. These are guidelines regarding blood, body fluids, secretions and excretions (except sweat) whether or not they contain blood, nonintact skin and mucous membranes (inside nose, mouth, eyes). They should be used automatically by everyone.

Proper hand washing is one of the most effective preventive measures to reduce the risk of getting sick. Proper hand washing includes rubbing hands together under warm water with soap and warm water as soon as possible. 

Avoid coughing into your hand as this can spread germs and viruses to anything you touch and, if you must, wash your hands before touching anything else.

Contact precautions are intended to prevent transmissions that are spread by direct or indirect contact with a person who is infected. Common contact diseases include conjunctivitis (pink eye), ectoparasites (body, pubic and head lice) and skin infections, including MRSA.

Droplet transmission of viruses and bacteria mostly comes from the droplets that a person exhales. Droplets usually fall within three feet of the source. Using cough etiquette will decrease transmission. In addition, having the patient put on a surgical mask will trap the droplets.

Airborne precautions prevent transmission of infectious agents that may travel long distances when suspended in the air, such as when the droplets become aerosolized. Common droplet/airborne diseases include flu, chicken pox, measles and tuberculosis.

Knowing the correct personal protective equipment to use is important in decreasing the chance of exposure. Wear disposable gloves to prevent contact with skin, clothing, blood, etc., and wash your hands immediately after removing gloves. Surgical masks are placed on a patient with suspected droplet transmission.

Security staff should watch for signs and symptoms of illness, such as skin wounds, coughing and rashes, and notify health services. It is important to consult health staff as many conditions or diseases can look the same to untrained personnel. Below is a chart of some diseases common in correctional settings. Because of its complexity, tuberculosis is omitted here.

_Sue Lane, RN, CCHP, is utilization manager/infection control coordinator, Armor Correctional Health Services, Pompano Beach, FL._

<table>
<thead>
<tr>
<th>DISEASE, ILLNESS OR ORGANISM</th>
<th>INCUBATION PERIOD</th>
<th>SIGNS AND SYMPTOMS</th>
<th>HOW IT SPREADS</th>
<th>MOST CONTAGIOUS STAGE</th>
<th>NO LONGER CONTAGIOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox (varicella zoster virus)</td>
<td>10 to 21 days (usually 14 to 16 days)</td>
<td>Slight fever, eruptive lesions on body (look like tiny blisters)</td>
<td>Airborne or direct contact with droplets from nose, mouth or skin lesions or with freshly contaminated objects</td>
<td>From 2 days before skin lesions develop until all lesions are crusted</td>
<td>When all lesions are crusted</td>
</tr>
<tr>
<td>Body/head lice (parasite)</td>
<td>Life cycle 6 to 10 days</td>
<td>Head: Small cocoon-looking areas on shafts of hair; lice are small and white. Body: Usually where clothing is close to body such as waist, underarms, top of legs, pubic hair</td>
<td>Direct contact or sharing of patient’s personal items</td>
<td>Until lice are treated</td>
<td>Once treatment is complete</td>
</tr>
<tr>
<td>Flu (influenza virus)</td>
<td>1 to 3 days</td>
<td>Varies depending on type of flu. General: From mild to extreme aching, tired feeling, headache. Respiratory: Cough, sneezing, possible nausea and vomiting</td>
<td>Contact with droplets from nose, eyes or mouth of infected person; virus may live on surfaces (e.g., tissues, doorknobs) for several hours</td>
<td>Variable, from the day before symptoms until the first 7 days of illness</td>
<td>After 24 hours without fever and symptoms are improving</td>
</tr>
<tr>
<td>Measles (rubeola virus)</td>
<td>7 to 18 days (usually 8 to 12 days)</td>
<td>May start with flu-like symptoms, runny nose, cough, headache</td>
<td>Airborne or direct contact with droplets from nose, eyes or mouth of infected person</td>
<td>From 4 days before until 4 days after the rash begins</td>
<td>At least 5 days after start of rash</td>
</tr>
<tr>
<td>MRSA (methicillin-resistant Staph aureus bacteria)</td>
<td>Variable, occasionally initially mistaken as spider bite</td>
<td>Direct skin contact with infected person, wound drainage or contaminated wet surfaces</td>
<td>Skin boils, abscesses, scalded skin appearance (unrelated to injury)</td>
<td>Most contagious and should be covered at all times</td>
<td>Draining wounds are well-contained under a dressing, no longer draining</td>
</tr>
</tbody>
</table>
Study Explores Rifampin for Latent TB

Treatment of latent tuberculosis infection is critical to overall TB control efforts, but successful treatment of jail inmates—a population at high risk for progression to TB disease—is often stymied by inmate release before completion of therapy and lack of follow-up in the community.

Although isoniazid is the preferred treatment for LTBI, its nine-month treatment regimen exacerbates adherence problems among those passing through jails. Isoniazid also presents concerns about hepatotoxicity in some patients.

To investigate whether rifampin, which entails a four-month regimen, could serve as an alternative, researcher Mary White, PhD, MPH, RN, and colleagues conducted an open-label randomized trial comparing isoniazid to rifampin on toxicity and completion in a jailed population. Their article about the study appears in the April issue of the Journal of Correctional Health Care.

The sample consisted of 360 inmates in the San Francisco County Jail diagnosed with LTBI at jail entry. Among those excluded were inmates with a history of treatment-limiting reaction to isoniazid or rifamycins, pregnancy or breast feeding, AST or ALT more than three times the upper limit of normal, bilirubin more than two times the upper limit of normal, platelets less than 150 K/mm3 or taking protease inhibitors or nonnucleoside reverse transcriptase inhibitors.

Treatment began in the jail, by directly observed therapy. After release, field workers at the county TB clinic gave medication by DOT using clinic protocols, including incentives and a case management team throughout the course. Study methods accounted for patients who were no-shows or reincarcerated. To identify possible drug toxicity (e.g., hepatitis, peripheral neuropathy, arthralgia, rash, memory loss), symptom reviews and liver function tests were conducted periodically and adverse events were recorded.

Results show that 33% of study participants receiving rifampin completed therapy compared to 26% receiving isoniazid. Rifampin also resulted in fewer elevated liver function tests and less toxicity requiring medication withdrawal. The study authors conclude that, “With careful monitoring rifampin is a safe and less toxic regimen, and appears to be a reasonable alternative because of its shorter duration, allowing more people to complete treatment behind bars.”

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Substance Use and Sexual Behavior Among Men Prior to Parole Revocation: Prevalence and Correlates — David Wyatt Seal, PhD, Michelle Parisor, MA, and Wayne DiFrancesco, MA

Food Allergies: The Implications for Correctional Facilities — Robin Hunter Buskey, DHSc, PA-C, CCHP, Robert Macky, PharmD, and Nakisha L. Brown, RD, LDN

Contraceptive Use and Barriers to Access Among Newly Arrested Women — Flynn LaRochelle, Cynthia Castro, PhD, Joe Goldenson, MD, MPH, Jacqueline P. Tuls, MD, Deborah L. Cohan, MD, Paul D. Blumenthal, MD, MPH, and Carolyn B. Sufin, MD

Chlamydia and Gonorrhea Screening Using Urine-Based Nucleic Acid Amplification Testing Among Males Entering New York City Jails: A Pilot Study — Woodman B. Franklin, Monica Kasyal, ID, MPH, Reena Mahajan, MD, MHS, and Farah M. Parvez, MD, MPH

Isoniazid vs. Rifampin for Latent Tuberculosis Infection in Jail Inmates: Toxicity and Adherence — Mary C. White, PhD, MPH, RN, Jacqueline P. Tuls, MD, Ju Ruey-Juan Lee, PhD, Lisa Chen, MD, Joe Goldenson, MD, Joanne Spetz, PhD, and L. Masae Kawamura, MD

Prevalence of Psychiatric Disorders in the Texas Juvenile Correctional System — Amy Jo Harzke, DrPH, Jacques Bailargeon, PhD, Gwen Bailargeon, MS, Judith Henry, PhD, Rene L. Olivera, MD, MPH, Ohiana Torrealday, PhD, Joseph V. Penn, MD, CCHP, and Rajendra Parikh, MD

Commentary: Disseminating Innovations in Correctional Health: A Necessary Step to Recognition by Academe — Warren J. Ferguson, MD

Each issue has a self-study exam that offers continuing education credit. Academy of Correctional Health Professionals members receive JCHC (print and online) as a benefit of membership. To learn how to obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
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AAP Policy Statement Addresses Health Care for Youth in Juvenile Justice System

An updated policy statement by the American Academy of Pediatrics discusses the health needs of youth in the juvenile correctional system and presents recommendations for provision of health services as well as areas of focus for advocacy efforts. Titled Health Care for Youth in the Juvenile Justice System, the statement was published in the December 2011 issue of Pediatrics.

The statement outlines the epidemiology of juvenile offending, reviewing findings related to gender, race, socioeconomic status, custodial placement and more. Although the fundamental health needs of youth in confinement align with those of youth in the community, greater needs are seen in areas affected by high-risk behaviors such as violence, substance use and sexual activity as well as by the living environment (e.g., socioeconomic conditions) and other factors. A literature review summarizes the relatively few (and, unfortunately, not recent) quantitative studies on physical and mental health problems and health needs of confined youth. The document reviews current practices in screening and assessment for mental health and substance abuse disorders, as well as on-site provision of psychiatric and substance abuse services. Continuity of care is often challenging, it is noted, but it is essential for successful transition back to the community and access to needed follow-up care, especially given that many youth had poor care before their involvement in the justice system.

Because national standards are valuable for understanding both the minimal and ideal health care that should be provided to incarcerated youth, the position statement highlights important recommendations from NCCHC’s Standards for Health Services in Juvenile Detention and Confinement Facilities.

Recommendations
Based on the findings noted above, the AAP policy statement makes recommendations in five categories. Key points are summarized here.

Delivery of Medical Care
Incarcerated youth should receive the same level and standards of medical and mental health care as their peers in the community. Health services should be equivalent to those recommended in AAP guidelines to the extent permitted by length of stay. This section highlights the importance of identifying health, mental health and substance use problems, and provides specific recommendations for screening, assessment, treatment, preventive services, exercise and diet. Facilities are encouraged to comply with NCCHC’s Standards for juvenile facilities and, ideally, to become accredited.

Developmentally Appropriate Confinement Facilities
Youth should be housed in facilities that are able to address their specific developmental needs. Health care policies and procedures should be developed in consultation with professionals knowledgeable about juvenile health. Staff should be trained to deal with the unique needs of this population. Youth housed in adult facilities must likewise have a developmentally appropriate environment and be separated from the adult population.

Integration of Available Systems of Care
This section focuses on the need for coordination between health care providers in the justice system and those in the community to ensure continuity of care. Given the growing use of electronic medical records, ideally correctional health care staff would have access to their patients’ community-based EMRs. Eligibility for health insurance benefits (both Medicaid and private) should not be terminated or suspended, and uninsured youth should be able to enroll in Medicaid while incarcerated.

Treatment and Intervention
Evidence-based mental health and substance abuse treatment interventions that reduce recidivism should be adopted to improve long-term outcomes. In an effort to prevent delinquency, investments should be made to improve risk factors related to juvenile delinquency and overall health. Given the lack of nationally representative data concerning health needs of justice-involved youth, funding is needed to collect such data to inform decisions about programming and cost-effective interventions.

Advocacy
Clinicians should advocate in several areas: (a) legislation and funding to provide for medical, educational and behavioral health needs of juvenile while confined and upon reentry; (b) adequate health insurance for medical and behavioral health during and after incarceration to support continuous care; and (c) interventions in the community that address risk and protective factors in order to reduce the number of incarcerated youth.

A supporting organization of NCCHC, the American Academy of Pediatrics is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

Find the policy statement online at http://pediatrics.aapublications.org/content/early/2011/11/22/peds.2011-1757.
New System Makes Recertification a Snap!

Good news, CCHPs! You may now complete recertification online and receive instant confirmation of doing so. At the site you also can update personal and address information. Simply visit www.ncchc.org/CCHP/continuingcert.html and click on the link. This page also links to step-by-step instructions, which are summarized here.

There are four certification cycles. Depending on which cycle you are in, recertification materials are due March 31, June 30, Sept. 30 or Dec. 31.

Step 1. Go to orders.ncchc.org/Recertification.aspx and create an account. (If you already have one, simply log in.)

Step 2. If creating an account, please enter all information requested, then select a password and answer three security questions. Passwords must be at least six characters and have at least one digit and one letter. Note that passwords and security answers are case sensitive.

Step 3. A verification screen will appear. Verify that the information shown (first name, last name, email address) is you, then click on “Select.”

Step 4. The system will send you an email with the subject line “NCCHC: Password Reset.” Open this message and click on the link to reset your password. If you don’t see the email, check your junk mail. Then add orders@ncchc.org to your safe senders list.

Step 5. The password reset screen will appear. Answer the security questions from Step 2, then create a new password or use the one you created in setting up your account.

Step 6. An overview screen will appear where you can view and update your personal information, address and account settings.

Step 7. From the overview screen, click on “Recertification” to reach the CCHP recertification application. Here, verify and edit your personal information and address if you have not already done so. Verify that recertification requirements are met by clicking on the appropriate boxes. When the form is complete, click on “Add to Cart.”

Step 8. The shopping cart screen will appear. Confirm the payment amount and indicate the email address where the order confirmation is to be sent. Click on “Next.”

Step 9. The checkout screen will appear. Enter your payment information then click on “Next.” You will have another opportunity to review payment before your credit card is charged.

To avoid a late fee, complete the recertification process within 30 days of the CCHP expiration date.

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 21 &amp; 24</td>
<td>Boise, ID</td>
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<tr>
<td>May 20</td>
<td>San Antonio, TX</td>
</tr>
<tr>
<td>June 29 &amp; 30</td>
<td>Phoenix, AZ</td>
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<tr>
<td>August 18</td>
<td>Multiple regional sites</td>
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<tr>
<td>October 21</td>
<td>Las Vegas, NV</td>
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</table>

We are seeking additional sites for regional exams as well as CCHPs to proctor the exams. If you would like to participate, contact the CCHP manager at 773-880-1460 or cchp@ncchc.org. Learn more at ncchc.org/cchp.

In Other News . . .

In the last issue we reported that Carol Shepard, BSN, CCHP, won the 2011 election to the board of trustees. In addition, two of the appointed seats have been assigned. Welcome to the new trustees:

• Pauline Marcussen, RHIA, CCHP, is serving as vice chair of the board. She is interdepartmental project manager for the Rhode Island Department of Corrections.

• Esmael Porsa, MD, CCHP, is medical director at Parkland Health and Hospital System, which provides health services to the Dallas County (TX) jail.

Like us on Facebook and join the certification conversation! facebook.com/CHH4U
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

Carl Bell, MD, CCHP

In addition to stepping up as NCCHC board chairman in October (see page 2), Bell was honored as recipient of the American Psychiatric Association’s annual Solomon Carter Fuller Award at the APA’s 2011 Institute on Psychiatric Services in October. The award honors “a black citizen who pioneered an area which has significantly benefited the quality of life for black people.” At the event, Bell also delivered a lecture titled “Public Health Efforts: Successes and Failed.” An article about the lecture appeared in the Dec. 2 issue of Psychiatric News; search for “Carl Bell.”

• http://psychnews.psychiatryonline.org

OJP/SAMHSA Task Force on Restraints

Two federal agencies—the Office of Justice Programs and the Substance Abuse and Mental Health Services Administration—have formed the National Task Force on the Use of Restraints on Pregnant Women under Correctional Custody. The purpose is to develop a best practices statement as well as a set of tools, resources and strategies to support dissemination and implementation of policy and practice change in this area. NCCHC board member Patricia Reams, MD, CCHP, is representing the Commission on the task force.

In 2010 NCCHC issued a position statement on restraint of pregnant inmates that provides eight recommendations. It is available at the NCCHC website.

• http://ncchc.org/resources/statements/intro.html

American Nurses Association

The ANA has convened a workgroup of correctional nurses to review and revise its publication Corrections Nursing: Scope and Standards of Practice, which was last revised in 2007. The workgroup will be responsible for describing trends and issues that are important for this specialty, as well as identifying standards of practice and professional performance, and applicable competencies. The review process will last about 12 months and will include a public comment period.

Among the workgroup participants are two NCCHC board members, Patricia Blair, JD, CCHP (liaison to the American Bar Association) and Patricia Voermans, MSN, ANP, CCHP-RN (liaison to the ANA). Both are featured in an article about correctional nursing that appeared in the Dec. 5 issue of The American Nurse, along with Mary Muse, MSN, CCHP-RN, CCHP-A, who serves on NCCHC’s task force for specialty certification for registered nurses.

• www.chemericannurse.org/index.php/2011/12/05/ensuring-standards-are-standard-behind-bars

Blogs, Blogs, Blogs!

Correctional health care is a lively, congenial field, and now several blogs have emerged to share practice information and insights and to spark conversation. Here are three in different disciplines. If you know of others, please contact editor@ncchc.org.

• CorrectionalNurse.net: An early entrant into the correctional blogosphere, this site “is dedicated to making visible the challenging profession of nursing in a correctional environment.” It is the brainchild of Lorry Schoenly, PhD, RN, CCHP-RN, a correctional nurse educator and consultant who is a regular contributor to CorrectCare and also serves as NCCHC’s social media consultant. Sample blog title: “Risky Business: Pre-Pour Meds in Jails and Prisons.”

• JailMedicine.com: Blog author Jeffrey Keller, MD, is a board-certified emergency physician who is the medical director of two county jails in Idaho. He also writes frequently for CorrectCare and is a popular speaker at NCCHC conferences. Despite its name, the blog aims to discuss all aspects of medicine practiced in jails, prisons and juvenile facilities. Sample blog title: “Since When Did Antibiotics Become the One and Only Treatment for Acne?”

• Corrections/Addictions Counseling: Part of a larger multiauthor blog hosted by the American Counseling Association, the segment dealing with corrections counseling began in February. It is written by Nancy White, LPC, an NCCHC board member (as liaison to the ACA) for nearly 20 years who has extensive experience with mental health and substance abuse counseling. First blog: “Concern for a Friend Leads to a Lifelong Career.”

Public Health Accreditation Board

PHAB president and CEO Kaye Bender, PhD, RN, was interviewed for the American Public Health Association’s Public Health Newswire, discussing the voluntary accreditation program that was launched last September. She discusses the benefits of using national, evidence-based accreditation standards and measures as a road map to quality improvement. Although no public health departments have been accredited yet, some 50 applications are in the pipeline.

• www.publichealthnewswire.org/?p=2573

Have You Subscribed to the Academy Insider?

The Academy of Correctional Health Professionals has launched a weekly e-news brief that delivers timely, relevant news about correctional health care and related topics to your inbox. An online archive enables users to search for news on topics of interest and to explore the most popular past articles. The Academy Insider is also available as a free mobile application. For Apple iPhone and iPod Touch, go to the App Store, search for “MultiBriefs,” download the app and then add the Academy feed. For Android phones, search for “MultiBriefs” at the Android Market.

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www.ncchc.org Winter 2012 • CorrectCare 29
Correctional health professionals of all disciplines will convene in Alamo City, a perennial favorite conference destination, for Updates 2012. The meeting will feature a broad array of health topics plus a special series on the role of correctional health services in reentry programming and prevention of recidivism. Our highly motivated attendees come to advance their knowledge, earn continuing education credit and network with colleagues. They also come to connect with the many companies that can help them meet the challenges of providing quality care to incarcerated populations, exploring new ideas and proven solutions for managing the complex operational and clinical demands of health care delivery to inmates.

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

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

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

Exhibitor Benefits
• Three days of exhibit hall activities
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Enhance your presence and maximize marketing dollars through these outstanding opportunities.
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• Final proceedings: Marked with your company’s name, the digital proceedings enables attendees to continue their learning with the speakers’ PowerPoint presentations.
• Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
• Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
• Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

Registration Information
The 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.
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The Oklahoma Department of Corrections is seeking applicants for Staff Physician at our correctional facilities statewide. The state of Oklahoma offers a competitive salary and benefits package which includes health, dental, life and disability insurance, vision care, retirement plan, paid vacation, sick days, holidays and malpractice insurance coverage. For more information and a complete application packet contact: Becky Raines, 2901 N. Classen Blvd., Suite 200, Oklahoma City, OK 73106-5438, (405) 962-6185, FAX (405) 962-6170, e-mail: braines@doc.state.ok.us. EEO

Medical Director, Cook County Jail
Cermak Health Services of Cook County, the health care provider at the Cook County Department of Corrections, Chicago, IL, is seeking a Board Certified Internist or Family Practitioner for their Medical Director. Salary Negotiable. Applicants may send resumes to: David Goldberg, M.D., Executive Medical Staff, John H. Stroger Jr. Hospital of Cook County, 1900 West Polk, Chicago, IL 60612.

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

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

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

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

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The Legal Health Record: Regulations, Policies, and Guidance, 2nd Ed.
This important book explains, from a manager’s perspective, how to create health records that are better organized and offer better legal defensibility, and how to lead teams through the processes necessary to clearly understand and organize strategies and workflows. As health records migrate to electronic environments, this book will assist in meeting the related challenges. The tools and strategies straddle the legal and record management/information technology arenas. Key features:
- expanded explanatory information; components of the legal health record; customizable forms and templates; litigation response and subpoenas; EHR system attributes that affect the legal health record; details about e-discovery, federal rules of civil procedure and uniform rules. By William Kelly McLendon, RHIA, & Michael R. Lowe, JD. AHIMA Press (2011). Soft cover, with CD-ROM, $59.95

CCHP Logo Items
If you are a certified correctional health professional, show off your accomplishment with the CCHP logo, such as a business card case, executive organizer and coffee cup and coaster set. Find product descriptions and order via the online catalog at www.ncchc.org/pubs.

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Expert Advice on NCCHC Standards

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

Custody Information in the Medical Record

Q My question relates to the J-I-03 Forensic Information standard. Upon inmates’ admission, our security staff provide health staff with a document that includes demographic information and all criminal charges. This document becomes part of every health record. Will this practice cause us to be out of compliance with this standard?

A No, but information about criminal charges is not necessarily appropriate for the health record and should be separate from clinical decision making. Standard J-H-03 Access to Custody Information states that qualified health care professionals should have access to information in the custody record when it may be relevant to the inmate’s health and course of treatment, but placing such information in every health record is not necessary or even advisable. In addition, this forensic information could be inadvertently copied and sent outside of the correctional system when responding to requests for copies of medical records. We recommend the facility reconsider its policy.

Inmate Translators

Q We are considering training Spanish-speaking inmates to interpret for newly arrived Hispanic inmates. I can’t find a specific prohibition from doing so in the prison standards; is this OK?

A Unless it is a dire emergency, this is not appropriate. The responsible health authority should not use inmates in place of interpretation services. The standard on inmate workers, P-C-06, indicates that inmates should not be substitutes for regular program staff.

Too Intoxicated to Screen?

Q The nurses who do receiving screening at our county jail need guidance on “when is an inmate too intoxicated to screen?” We know that we need to get a set of vitals and ask if there is any significant medical history or allergies, but there are varying thoughts on doing the actual screen. When inmates are intoxicated you really don’t get an accurate screen because they just want to go to sleep.

A You raise an interesting problem, but one that has a clear solution. The first step in the receiving screening (see J-E-02) is medical clearance, which assesses whether the person should immediately go to the hospital. If you decide to accept him or her into the jail, and since you really do not know what health conditions this person has, you should isolate the individual from the rest of the intake population, but be sure that he or she is closely monitored by custody and health staff. Many deaths of intoxicated individuals occur in jails. Of course, a good detoxification protocol should be implemented as clinically indicated.

If the person is medically cleared, there are two aspects to the receiving screening: asking questions and observation. If the inmate is too inebriated to reliably answer questions you might have to hold off until he or she becomes more responsive. You should duly note that. However, the observations section still should be completed. The receiving screening is performed to ensure that the individual is not contagious or has a larger medical or mental health problem, and thus determines the appropriate health services that need to be provided. Health staff should still collect the information, whether immediately or later when the person is more responsive, and make a professional judgment about the inmate. Health staff must care for their patients despite barriers to communication, whether intoxicated, mentally retarded or deaf and nonverbal.

Send your question to accreditation@ncchc.org.

NCCHC Standards

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Jennifer E. Snow, MPH, CCHP is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Send your question to accreditation@ncchc.org.
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