



University Correctional HealthCare

April 2009

Opportunities in Correctional Health Care

Providing healthcare in a correctional setting is usually viewed as being exigent, complex and demanding. Day to day situations common in other environments often have to be negotiated, are generally time consuming and exhausting for most prison healthcare providers.

Certain facts inherent to correctional healthcare clearly place us in a different realm as compared to average medical providers. Among these facts is the diversity of the patient population in terms of race, ethnicity, and cultural traditions. In addition, the increased healthcare burden of a population generally lacking access to care prior to incarceration results in the progression of untreated chronic illnesses (HIV, hepatitis C, mental health disorders, substance abuse problems) and subsequently, additional challenges. This combination, along with the large volume of individuals diagnosed with these medical problems, creates an environment of extraordinary wants and needs.

Healthcare practices serving diverse populations with large numbers of patients with the aforementioned problems are also found in urban settings and community health centers throughout the country. However, one significant fact makes correctional healthcare unique. Our patients are under observation twenty four hours a day, seven days a week. They are watched while sleeping, eating, working, interacting with other inmates, exercising, etc. There are very few inmate activities that are not under close observation by the correctional staff (civilian and non-civilian). This reality provides those in correctional healthcare an opportunity to tap into a valuable resource which, when use appropriately, can facilitate maximizing the health of inmate/patients.

In order to fully appreciate this opportunity we need to consider the parameters of our role as healthcare providers. Consider this perspective. Collectively we are all resources of patient healthcare information; data that can help our inmate/patients meet their true needs. From the scheduler setting up appointments, the phlebotomist drawing blood for lab tests, to the physician/nurse practitioner/physician assistant who makes diagnoses and prescribes medications, we all have important functions necessary for the effective management of acute and chronic healthcare problems. But toward this end, we should ask our-

selves, do we give the patients what they want or do we have the responsibility to provide the patients what they need?

What should we know about our patients? Consider this perspective. Do we only need the information the patients share with us? Do we only need to know what they want? Do we take the time to really understand how they are living? It is helpful to know where your patients live, what foods they eat, the type of work they do, the activities they are involved in, what items they purchase, and how they interact with others (inmates/correctional staff/other civilian staff). Wouldn't it be helpful to know as much as you can? Wouldn't it be helpful to sort out what the patient wants vs. what they truly need? Isn't it our responsibility to utilize all the information we have available to us to successfully work with patients and help them understand what they really need?

This is where the twenty-four-seven constant observation is one of the real opportunities afforded to correctional healthcare. Seeking and obtaining information can be extremely helpful toward sorting out wants from needs. This can be accomplished in a variety of ways.

- Check with the housing unit officers
- Speak with the patients' job supervisor
- Touch base with nurses at the medications line
- Review the canteen list
- Take periodic walks around the facility
- Establish a relationship with the yard and gym officers
- Check-in with other healthcare staff

Hopefully these ideas will provide you with some options to consider when addressing patient requests. I think we should appreciate and utilize these unique opportunities that will allow us to continue to provide the most optimal healthcare to our inmate/patients.

Arthur Brewer, MD
Medical Director





Hey, I know a song...



It has been said, 'music can soothe the savage beast'. It has been said of some singers, 'They have the voice of an angel'. It has been said, 'music is therapeutic'. Music can soothe, calm, invigorate, agitate, bring one closer to God, connect us with nature, separate us from each other and bring us together. Music can get us through times of trial and tribulation. This week Riverfront State Prison began transferring staff to other facilities. These are some of the songs that have been coming to mind lately...

The Girl Scouts:

Make New Friends But Keep the Old.

Frank Sinatra:

And Now the End is Near and I Must Face the Final Curtain

Gladys Knight:

Neither One of Us Wants To Be the First to Say Good-bye

The Beatles:

You Say Good-bye; I Say Hello

I am sure there are many, many other songs that would fit this bill but these are the ones that first came to my mind. It is a sad day when friends part company regardless of the reason. It is sad to leave a site that has become more than just a workplace. Sure there are many ways to keep the lines of communication open...e-mail; snail mail; telephones; cell phones; heck, even X-Box Live (if you're in to that kind of thing) but none of these can take the place of the sense of community you find by coming together for a common cause and doing it face-to-face. I had often heard that Riverfront is a 'different' kind of jail and now I understand what that means.

Riverfront is a family, a group of people who truly care about each other. A group of people that take care of each other and when they say 'I've got your back,' they mean it. You know what? There is a song about that too, "We Are Family" by Sister Sledge. Being the new kid on the block (here less than six months) you might not think I would feel this way, but this 'family' has accepted me as one of their own. I may not be feeling the intense depth of loss the rest of the staff feels but I am feeling a loss just the same. In the past few weeks, I have seen a family in crisis. Mom and Dad (The State of New Jersey and the City of Camden) are getting divorced and us 'kids' (the RFSP employees) are being sent to live with relatives. Things will never be the same. Sonny and Cher are in my head singing to the kids, 'Say your prayers before you go to bed make sure you get yourself to school on time...'

A note to the receiving facilities:

When the orphans arrive at your door please think of Bill Withers' song 'Lean on Me' and extend the hand of support, compassion and friendship. This transition may be a bit difficult for some of us to endure, but endure we will. And on that note, I leave you with Gloria Gaynor, 'I Will Survive'.

Laurie Flynn, RN

Staff Nurse

RFSP



Ask Mechele



Dear Mechele,

I've often heard about kids bullying each other at school, but I never thought that adults would bully each other at work. I would like to share my experiences as an employee who is being bullied by a coworker. I work on a mental health unit in an office the size of a closet. My very first day on the unit a coworker told a particular officer (who shall remain nameless) that I had reported him/her to the Administrator for sleeping on the job. I was devastated when this was repeated back to me by another colleague. This meant that I was put in the position of having to repair my relationship with the officers; first of all because it was a lie, and also because I've worked in corrections long enough to know how gossip can make its way around the jail. Fortunately for me, officers who worked with me on another unit helped put the gossip to rest. When this person realized that the incident didn't faze me, the situation escalated into verbal insults in front of other workers. I spoke up (one-on-one) and let this individual know that their behavior was offensive to me, but they wouldn't stop...instead, it became worse. Friends and colleagues recommend everything from a beat down (no way, I need my job) to writing her up, to telling her supervisor. Right now, I'm just exhausted from all the drama and want the madness to stop. I need HELP!!!!

Too Grown To Be Bullied

Dear Too Grown To Be Bullied,

First of all, I'm so sorry that you've had to put up with this nonsense. It's my personal philosophy that the job itself is rarely the problem...it's the BS that surrounds the job that tends drives us crazy. I congratulate you on taking the initiative and going directly to this individual in an attempt to address the problem...most of the time this approach works. I once had an issue with an officer, nothing that got in the way of my job, but there was always this air of animosity directed at me for no apparent reason. Since I was rarely in his presence, I figured it wasn't worth the effort to speak on it. But one day I decided I'd had enough and just confronted him about the way he'd been acting. Initially, he denied there was a problem, but I was persistent. He finally and reluctantly admitted that I looked a lot like his ex-wife. On one hand I was dumbfounded, but I came to realize that there are not always logical reasons to explain why some folks act irrationally. Once this was out in the open, we were ok; and from that point on whenever I was around him, I used my most demanding voice and told him his alimony check was late and I was calling my attorney. It became our inside joke.

Now back to your situation. You need to get both supervisors (yours and theirs) involved as soon as possible. You tried the adult route to no avail. I would also advise you to document each incident naming anyone who witnessed the altercation(s). No one likes to have to "tell the boss," however; you're describing a pattern of escalating harassment so the time to nip this in the bud is now. And don't forget that we have an EAP that you can access at any time on your own. While my optimistic nature hopes for a happy ending, that may not be the final outcome, but sometimes that's just the way it is. Your co-worker may be in need of some professional help and this could be the catalyst that propels this individual into addressing their issues. Also, you deserve to work in an environment free of harassment (at least from your colleagues), after all, isn't being in prison stressful enough? So thanks for taking the time to share this difficult situation with us and good luck. Please let me know how things pan out.



Technology Corner

with Leo Agrillo



There's Novell, DOCNet, UMDNJ, Logician, Webct, E-mail, and each system/application has a different login and password. How do I know one from the other? Who do I contact when I can't login? When folks are not able to do their required training the number one problem is typically related to different logins and passwords. I would like nothing better than to tell you that I have a simple solution to this problem, but the fact is...there isn't one. We are limited by both technology and policies, and although there is some relief on the horizon, the issues related to having multiple logins and passwords will be with us for the unforeseeable future. But, understating the different systems will help, so at least when there are issues, you will have an idea as to where to start and who you need to call.

Personal computers in the facilities we serve are on the Department of Corrections Network (DOCnet). The login is of the format CMSxxxx where xxxx is usually the first four letters of your last name. This login is also referred to as your Novell login. Your supervisor provided you with your login and password information. In addition, there is a login and password for the Electronic Medical Record (EMR) also called Centricity™ or Logician. This too is a part of DOCnet.

The DOCnet password can be reset from the login screen by clicking on "Did you forget your Password?" and following the prompts. If you still cannot login or can login to DOCnet but cannot login to the EMR then you will need to notify the DOC help desk by calling (609) 984- 8288 or sending email to HELPDESK@doc.state.nj.us.

The next area requiring access is the UMDNJ network that is used for email, payroll and training. Accessing UMDNJ sites from DOCnet computers requires internet access from the DOC. To test if you have internet access open Internet Explorer from a DOCnet computer and enter <http://www.google.com>. If the Google search page appears, you have internet access, if you receive an error, you don't. If you do not have internet access, contact your local support staff who can determine if the correct forms have been submitted and if so, where they are in the process.

There are three different passwords currently being used within UMDNJ with the same login name. The three passwords are for (email) <https://mail.umdnj.edu>, (payroll, etc.) <https://my.umdnj.edu> and (training) WebCT. Your supervisor will have provided you with your login name and password. The convention used by UMDNJ to create logins is the first six letters of your last name, followed by the first two letters of your first name. For example:

Name: Leo Agrillo

Login: agrille.

My understating is that at some point in time these passwords will be automatically synchronized or only two will be needed as WEBct is scheduled to be replaced later this year. Until this occurs, my recommendation is to try to use the same password for all three.

The *my.umdnj.edu* password can be reset from the login screen by clicking on "Forgot Password?" and following the prompts. If you still cannot login or cannot login *mail.umdnj.edu* or WEBct then you will need to notify the IST help desk by calling (732) 743-3200 or sending email to isthelp@umdnj.edu.

Please note that UMDNJ sites can be accessed with any computer having internet access be it from your home or a public computer. It is important that you always logoff when you are done working to prevent unauthorized access to your UMDNJ accounts. Also, be aware that it is against company policy and HIPAA regulations to store any patient information on a local computer.

Send your questions regarding technology to: agrille@umdnj.edu or uchccorectsvcs@umdnj.edu



AIVIRT ESIRPRUS



As the inpatient (IP) Clinician Supervisor at SWSP, I am always looking for ways to motivate, train and promote teamwork with my staff. Over the years with DOC and UCHC I've learned that you must read, re-read and sometimes re-read again, the UMDNJ Policies, UCHC Policies, DOC/HSU Policies/Procedures, the institutional Rules/Regulations and various other directives we are responsible for. Sometimes rules change, policies evolve, and after 19 years in this business, I must admit, I get confused at times what the current expectations are. I figure if I am unsure at times, I bet my staff are at least, equally unsure.

A few years ago I instituted an annual practice of requiring my staff to review all of the updated UMDNJ/UCHC/DOC/HSU Policies/Procedures. I would divide them up, give them so many per month, have them sign off on a form stating they read and understood them. They complied. They likely retained a small percentage of the information, but they signed their forms and returned them like good soldiers. How boring!

After the August 2008 updates to the DOC/HSU Policies I started the same process (with the exception of trying to save a few trees by requiring them to read everything on line rather than being given it on paper). Again, I thought, how boring. How can I shake it up? How can I make Policies interesting, a topic of discussion, and an exciting debate? Not an easy thing to do!! Eventually I came up with "Aivirt Esirprus". I know it's pretty hoakie, but hey, I never said I was the creative type. "Aivirt Esirprus" (Trivia Surprise) became an occasional topic on our Staff Meeting Agenda.

The game is simple; I ask questions about policy/procedure and the staff person who answers the question correctly first wins a prize. I don't know about you, but my staff can be a pretty competitive and rowdy bunch when they want to. Prizes, only items permitted within the institution, are offered as small tokens for correct answers. Prize items include things like snacks from the vending machines (i.e.: candy bars, chips, pretzels, bottled water or soda), Chap Stick, little bottles of Hand Sanitizer, packs of tissues, Hand Lotion, etc. Of course I spring for the prizes, but the small cost is worth the fun of this little game.

I mix it up a bit too by including questions about the DOC/HSU Policies, UCHC Policy, site specific policy, etc. Here are some

questions I've used:

1. Any DOC Custody/Civilian or UCHC Staff person may refer an IM for mental health services. The following are appropriate methods to refer a "non-emergent" case to mental health except?
 - a. Submit a MR-049
 - b. Call the MH Office and discuss the case with a clinician
 - c. Enter an EMR Order and route the referral to a provider/clinician
 - d. Submit a P-1 Liner (***)

2. When an IM is referred for transfer to a RTU or TCU from OP level of care, the IM is to be physically transferred within what timeframe?
 - a. Immediately
 - b. 24 hours
 - c. 48 hours
 - d. 72 hours (***)

3. You fall down the stairs injuring your back and leg while at a UCHC worksite. You should
 - a. First seek medical attention and second contact your supervisor or the designee (***)
 - b. First call UCHC Central Office and ask for a claim number and second go to the closest ER
 - c. First call your supervisor and second call UCHC Central Office for a claim number
 - d. First take down the names of any witnesses in the area and second call UCHC Central Office for a claim number

Sometimes it's the simple things that make the most impact. Staff will likely retain only a small percentage of the dry material they read (which may or may not pertain specifically to their job duties at that time), but they are likely to remember discussions on a topic sparked during a silly game.

Lisa D. Little, MA, LPC
Clinician Supervisor
SWSP IP

Revised

General Information

Revised

UCHC Leadership Staff



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Jon Hershkowitz:		732-570-5727	732-206-3157
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Marci Masker		201-407-3097	732-396-6767
Harry Green		732-512-8846	609-292-0688
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Training Team

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Cindy Romano	609-292-1393
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Pharmacy

Kyle Mason	609-292-1385
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SAYING "HOW!" TO WIKI HOW

Many people are familiar with Wikipedia, the on-line encyclopedia to which anyone can contribute. Less well known, but growing rapidly, is an online repository of information at www.wikihow.com. This is a collection of over 50,000 articles, with titles such as "How to Kiss," (1,527,568 readers), "How to Have Six-Pack Abs" (2,815,473 readers) – and, for kids, "How to Make a Secret Spy Fort." (22,766 readers) as of this writing, with dozens or hundreds of contributors to each one. But there are other articles, with fewer readers but greater relevance for



our purposes, such as, "How to Prevent a Suicide Among Prison Inmates," "How to Cope with Holiday Stress and Depression in Prison," "How to Define a Problem," "How to Build Self-Confidence," "How to Accomplish a Goal," "How to Meditate," and many more. By concentrating solely on their list of featured articles (marked with a star in the upper right-hand corner), you will limit yourself only to those offerings

which have been scrutinized and vetted by the editors.

Of course, since anybody can change an article at any time, Wiki-How will never replace the New England Journal of Medicine as a

peer-reviewed, professional journal of record. (But then, neither can you ever expect the New England Journal of Medicine to offer you practical hints on how to kiss, have six-pack abs, or build a secret spy fort!)

If you are willing to pick and choose from what is available on these pages, carefully weighing each piece of information upon the scale of your own professional judgment, you can probably find some good, practical information which you already know to be true, or which you can verify elsewhere. You are also likely to find spots where you can improve upon an existing article yourself, as well as ideas for articles you might enjoy writing in their entirety.

What I like most about WikiHow (in addition to the fact that it is fun to browse) is that it gives us an opportunity to share information not only with others in the corrections community, but with anyone in the world who might happen to find it useful.

Don Gibbons, PhD
Forensic Mental Health Clinician
NJSP



Call me!

The recent historic election of a man admired for his uplifting and eloquent oratory to our nation's highest office, should remind us of the power of communication...the sway of the written and spoken word. Its scope is ubiquitous. Facebook. MySpace. Cell phones. Text messages. Email. Our means of communicating with one another has grown ever more abundant, ever more diverse. The impact of this trend is evident in the work we do. As correctional health care providers, we have come to take for granted the ability to readily access and electronically update a medical record, order/change medication, seek consultation, or refer a matter to a colleague. Few would argue that these greater powers of communication are positive developments both for our society, and for our work. Let us remember, however, that as the technology grows, so must our attention to how it is being used.



With so many new and convenient *means* of communicating, one might suppose that communication itself would improve. This is not always the case. Too often, difficult and confusing cases have been made more so, not by poor clinical reasoning, but by a lack of adequate communication. At times, we have found ourselves being lulled into the false sense that the new technologies have adequately replaced the old ones. Our use (or perhaps misuse) of flags provides one such example.



Flagging a colleague about a clinical matter is often a convenient method of communication. It saves time and sometimes, aggravation. No need for small talk, conflict, or unpleasant feelings, just type away and send away. Time and aggravation, however, may not be all that is lost. Flags, while frequently useful and necessary are, in many cases, not at all sufficient. A flag that is unclear, read too late, or viewed by the wrong person can, and does, lead to problematic outcomes.

Many are the crises that can be averted by a simple phone call; un-electronic and old school to be sure, but effective. The unexpectedly transferred, the diagnostically confusing, and the difficult to manage...yet a few of the situations where such antiquated devices as say...the land-line telephone, may be the more effective tool, even when put up against technologically superior devices. Admit it, in many cases one simple "heads up" over the telephone, can and has successfully communicated the richness and complexities of a case better than a hundred flags or emails.

It is worth remembering that in our lives and work, the words we use may one day condemn, or in fact, deliver us. Let us not, in this burgeoning information age, forget to use the first and simplest method of human communication... the spoken word.

Harry A. Green, Psy.D.
Clinician Administrator
Central Region

Now Available to the
NJ Dept. of Corrections:
Technical Customer Service



For Routine Inquiries, Monday-Friday 8:30AM to 4:30PM

Primary Contact *Jeannie McCullough*,
Phone: 800-633-5221 X 7029
Email: mcculr1@labcorp.com
Fax: 302-428-8096

Backup Contact *JoAnna Hassano*
Phone: 800-633-5221 X 7059
Email: hassanj@labcorp.com
Fax: 302-427-5629

Other LabCorp Contact Numbers

General Customer Service	800-631-5250, option 6
Supplies	800-631-5250, option 4
Pickup and Stats	800-631-5250, option 3
Genetics Customer Service	800-345-GENE

Senior Marketing Executive *Marie Orlando*
Phone: 800-631-5250 X 4315
Email: orlandm@labcorp.com
Fax: 215-355-6924

Please have your account number and specimen number ready for inquiries

Quality Improvement News

With Lisa DeBilio



PI Teams...

Everything you need to know but don't have time to ask.

What is a PI Team?

PI stands for Performance Improvement. A PI team is a small group of co-workers (3-8), working together for a period of time, (e.g. 3 to 6 month) to improve specific processes or conditions related to their work environment.

Why bother with PI Teams?

First, because you care about your inmate/patients and want to provide them with the highest quality services possible. Also, because UCHC is an organization that wants its staff to continue to grow, improve, and be the best that they can be.

Does a PI team have to be facility based?

No, some issues are more relevant to the organization as a whole, so in those instances there would be a central PI team. However, in general, the people closest to the process needing improvement are best equipped to pull together a team of players who will generate creative, workable ideas for fixing problems.

Who can start a PI team?

Anyone who cares about the inmates, their work environment and/or their fellow workers can initiate a PI effort. There sometimes might be a need to prioritize areas of concern so that scarce resources are utilized wisely, but in theory, anyone can bring attention to a problem and suggest the best ways to solve it. Just remember to always consult with your local QI committee when starting up a PI effort.

How do I know what areas are likely to need improvement?

The possibilities are endless. Information can be directly drawn from staff experiences, anecdotal evidence or inmate/patients. Managers recognizing some business practices or care processes that are not as efficient or effective as they could be can offer project suggestions. Upper level management might identify a problem that cuts across different levels of the organization. Custody staff may point out areas that could benefit from a tune-up. This is your chance to ID a problem and do something about it...our motto is, "If it's broke, let's fix it!"

However, one of the best ways to find a problem in need of a PI solution is to review some existing objective data. Where? Look at routine performance measures, audits or simply just consult with your local QI committee members. Examples can be found in your Monthly Briefing Books, and posted HSU data.

How do I start a PI team?

Talk to your coworkers, supervisor and members of your site's QI committee. Find out who shares your concerns and is willing to invest some time and effort in the PI process. Once you identify potential group members, decide who is best suited to be the group facilitator and schedule your first meeting. Make a review of the QI model your first meeting's agenda

Who runs the QI meeting?

An HSU representative will facilitate the QI meetings.

Who is expected to attend?

A representative from each department including, administration, custody, psychiatry, physicians, mental health, nursing, dental, and site PI team facilitators.

What should be reported on at these meetings?

One week prior to your site's QI meeting, please send an e-mail to your HSU facilitator with any agenda items. This would include new PI initiatives, and any area out of compliance or in need of improvement. Please refer to all routine data collection reports and summaries that are posted on the NJDOC I drive prior to the QI meeting. During these meetings be prepared to provide an overview of the items below compliance and any improvement efforts initiated as a result. Please refer to the QI schedule to determine what and when the various aspects of care need to be reported in addition to the posted data (ID: M&M; etc). Also, be prepared to discuss follow up items from previous meetings.

Where can we get PI training?

In the near future, Drs. Conrad, DeBilio, Morris, and Masker and will be providing training to multiple PI teams at each site. This training will include a review of the QI model, PI tools, reporting requirements and guidelines for attending QI meetings.



Spotlight: Medical Records

The Medical Record Department (MRD) at UCHC consists of a team of twenty medical record clerks (MRC) and a Director. Our department is responsible for Release of Information (ROI), which involves providing record copies to inmates. We also complete requests from other sources such as outside providers, lawyers, etc.

Other duties include: creating new charts, processing incoming charts, forwarding charts for transfers, filing documents into the medical reference file, sending charts to classification upon parole/Max outs, archiving, x-ray filing/purging, and chart auditing.

The Medical Record team met in November for the first time under UCHC. In addition to the various topics discussed (revised policies & procedures, chart archiving, truck mail...) and a team building exercise, our meetings provide an open forum for questions and concerns as well as brainstorming solutions to a variety of problems we may have encountered. At our next meeting (in a few months) we are planning to have guest speakers from other UCHC disciplines and possibly from the DOC.

The department is focusing on improving the ROI process, as this is our most important responsibility. We began by ensuring that each department was tracking the ROI and are now shifting our attention to include standardizing the tracking sheets in or-



Notice to UCHC Staff Regarding Litigation

Litigation, unfortunately, is commonplace in prisons. Most litigation against staff comes to naught. However, they all require attention.

In such matters, you should be directly served a summons or complaint. Supervisors, peers, and support staff are not authorized to accept service/sign off on an Affidavit of Service on behalf of another employee. Rather, supervisors should assist to arrange a meeting with the individual being served a summons or complaint.

If you receive notice that you are named in a lawsuit or other legal action, immediately:

der to insure that we are all collecting the same data. Eventually, this tracking will be streamlined with a conversion to Excel spreadsheets. Also, by collecting the tracking sheets on a monthly basis and reviewing the data, I anticipate being able to utilize information for even more improvements down the road.

In addition to their other duties, the MRCs have been hard at work purging outdated x-rays. This job includes physically looking through each x-ray jacket and extracting only the outdated films which are then recycled.

At the last medical provider meeting, it was noted that occasionally we (UCHC medical staff) have experienced difficulty receiving records from outside hospitals. I would like to offer my assistance in securing these records and can be reached by phone (609) 292-1393 or email romanoci@umdnj.edu.

I would like to thank both the Regional and Nurse Managers at the sites who work closely with me and the MRDs to accomplish our mutual goals. Please stop by the MRD at your site to say hello to the staff, who are sometimes a forgotten, but nevertheless an integral part of inmate healthcare. Also, feel free to contact me with any concerns or suggestions for improvement of the MRD at your site or in general.

Cindy Romano
Medical Records Director



1) Alert UCHC Central Office at (609) 341-3093 and fax the legal papers to my attention at (609)-341-9380 &

2) Contact UMDNJ Risk and Claims at 973-972-6277.

UCHC Central Office and/or Risk and Claims will forward the complaint as well to our Legal Department and inform you which attorney will represent you in this matter.

Call that lawyer, get the lawyer's name, explain the case, and make sure you understand what you should do. Denial or non-chalance will not serve you. Educate yourself about the case. Do not assume that the attorney knows the case as you do. Do not be afraid to suggest strategy to the attorney. If you have questions, or wish to speak about ongoing litigation, you may contact me Jeff Dickert 609-341-3093 or via e-mail (dickerje@umdnj.edu).

INFECTIOUS DISEASE PREVENTION & CONTROL IN CORRECTIONAL FACILITIES

The prevalence of infectious diseases among inmates is disproportionately exorbitant. Not surprisingly, significant numbers of inmates belong to high risk populations and engage in high risk behaviors prior to and during incarceration. Infectious diseases with high incidence in correctional facilities are: HIV/AIDS, Hepatitis C, Hepatitis B, Chicken Pox, Shingles, Scabies, Sexually Transmitted Diseases (STDs) and Methicillin Resistant Staphylococcus Aureus, (MRSA). Prevention and control of infectious diseases, while posing unique challenges, are of paramount importance for the following reasons:

- Disease prevention in prison will alleviate infectious disease in the general population.
- Since for many inmates incarceration is a revolving door, the cost of infectious disease treatment upon returning to prison can be lessened if there is adequate treatment initially.
- Curtailing intra prison transmission of infectious diseases will lessen inmate/patient suffering, reduce medical costs and reduce the risk for litigation.

It is the responsibility of the Infectious Disease Department to be not only pro-active in disease prevention and control but also to engage in the following:

- Education of inmates about infectious diseases common in their environment at intake.
- Provide those inmates with an untreated infectious disease who are leaving prison with a discharge plan that includes referral information on relevant community resources.
- Provide discharging inmates with an adequate supply of medication and a follow-up appointment with a community medical provider.
- All inmates (long/short term, pending release) need continuous health education including ways to refrain from risky behaviors that predispose them to acquiring infectious diseases.
- Whenever possible, identify those inmates most likely to have an infectious disease. These individuals should be consistently monitored and encouraged to play an active role in the management/treatment of their illness.
- Apply the principles of an epidemiological trial in identifying potentially infectious agents. When conducting an investigation the priority will be to do whatever is necessary in order to answer the five epidemiological questions: when, where, who, how and what.
- Those with serious, highly infectious diseases require isolation in order to prevent the spread to other inmates. Concurrently, those in contact with a confirmed case should be quarantined and observed.
- Personal hygiene, such as simple hand washing education, is key to preventing infectious diseases. Warn officers that their leather gloves, often used for direct inmate contact, are not effective barriers against microorganisms that can easily be transported home to family members. Latex disposable gloves should be recommended.
- When there is a case of infectious disease, take a proactive approach which will include inspection to be followed up with terminal and environmental decontamination.



In conclusion, disease control and prevention follows the dynamic epidemiological triads, the host, agent and environment. All must interact for any disease to occur. Remember, environment plays a significant role in the contraction of disease in general, and especially in the case of infectious diseases.

Are Our Patients Ready to Stop Smoking?

Tobacco sales remained relatively flat between calendar year 2007 and 2008, dropping no more than 0.65%. Despite Statewide training and several Performance Improvement (PI) groups (five presented at PI Fairs 2007 & 2008), the use of tobacco products in prison has remained relatively flat while the inmate population has dropped almost 5% (a high of 26,746 to 25,436). Health professionals have been reminded to educate inmates on steps to improve their healthcare outcomes by maintaining a healthy weight, regularly exercising, and not smoking. A recent study found that it makes a difference (1 to 3%) when doctors take a few minutes to talk to patients about their smoking. However, when it comes to helping patients successfully quit smoking, the same does not appear to be sufficient enough to impact upon inmate smoking habits in prison.

(See: Stead LF, Bergson G, Lancaster T. Physician advice for smoking cessation (Review). Cochrane Database of Systematic Reviews 2008, Issue 2.)

With a high percentage of inmates having a substance abuse history coupled with the lack of availability of addictive drugs during incarceration, convincing them to stop or reduce their use of tobacco appears to take more than education. Furthermore simply, telling patients what to do and what not to do has not been shown to motivate most to change. Inmates in particular, have been told frequently by the criminal justice system to change, without success.

However, an approach taken from motivational enhancement therapy and a harm reduction model may make a difference. Rather than simply telling our patients what to do and what not to do, we ask them a few questions:

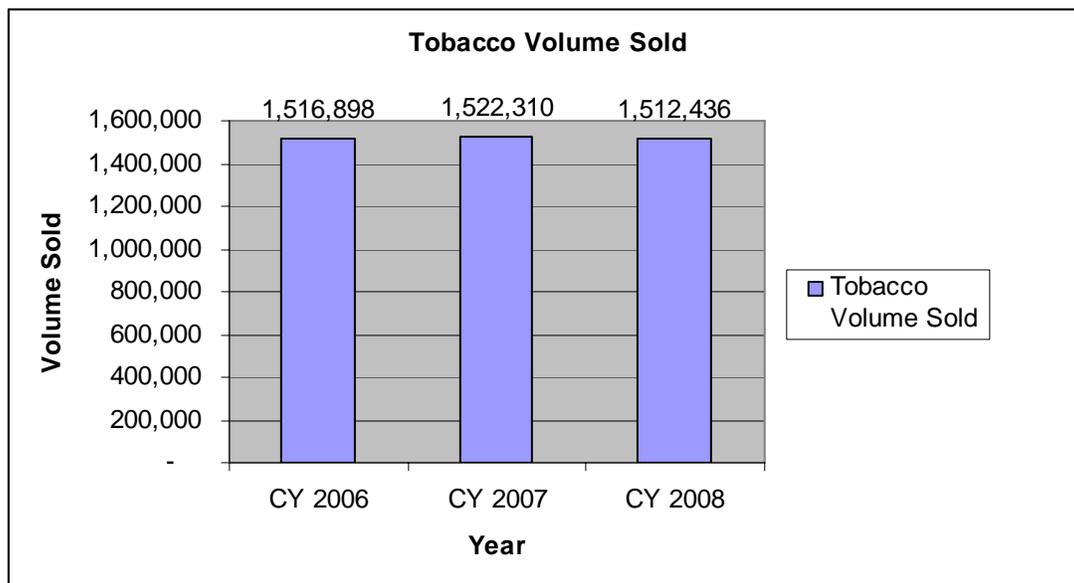
- What they you willing to do to improve your health
- Are you ready to make a change
- What stage of change are you in

Are you willing to move up one step in the Stages of Change

The attached brochure can help guide this discussion. Though designed for physical health related issues, it can also be applied to mental health. Please consider this in your next patient discussion. Find out what your patients are willing to do to improve their health and overall ability to function. It never hurts to ask.

Jeff Dickert, PhD

Vice President



What are you willing to do to improve your health?

- Stop using tobacco
- Lose weight
- Get fit
- Deal with substance abuse problems
- Follow your treatment plan to better control your
 - blood pressure
 - diabetes
 - other health condition: _____
 -
- Take medications as advised

Chances are, you will be more successful at making a healthy change if you:

- Know which stage of change you are in.
- Take steps best suited for the stage before you go on to the next one. In time, the change will be part of your regular habits.

What Stage of Change Are You In?

"The only reason for time is so that things don't happen at once."

-Albert Einstein

LIST A CHANGE THAT YOU WOULD LIKE TO MAKE. Common examples are listed below.

Are You Ready to Change?

Five Stages of Change:

1. Not Yet Ready to Make a Change
 2. Thinking About Making a Change
 3. Preparing to Make a Change
 4. Taking Action
- Making the Change Last

Examples of Healthy Changes

- Stop using tobacco
- Lose weight
- Get fit
- Deal with a substance abuse problem
- Follow your treatment plan to better control your blood pressure, diabetes, or psychiatric symptoms, or other health condition
- Take medications as prescribed.

Then, decide which one of the following statements apply to you, if at all:

1. I have no plans to make this change in the next 6 months.
2. I am planning to make this change in the next six months.
3. I am planning to make this change in the next four weeks.
4. I have been making this change for less than six months.
5. I have been making this change for longer than six months.

If you chose:

#1: You are in Stage 1: Not yet ready to make a change.

To learn about steps best suited for this stage

go to: Stage 1. NOT YET READY TO MAKE A CHANGE.

#2: You are in Stage 2: Thinking about making a change. To learn about steps best suited for this stage go to: Stage 2: THINKING ABOUT MAKING A CHANGE.

#3: You are in Stage 3: Preparing to make a change. To learn about steps best suited for this stage go to: Stage 3: PREPARING TO MAKE A CHANGE.

#4: You are in Stage 4: Taking Action. To learn about steps best suited for this stage go to: Stage 4: TAKING ACTION.

#5: You are in Stage 5: Making the change last. To learn about steps best suited for this stage go to: Stage 5: MAKING THE CHANGE LAST.

Stage 1: NOT YET READY TO MAKE A CHANGE

Examples of Common thoughts for Stage 1:

- I have no desire to stop smoking. I feel healthy.
- I have no plans to lose weight. I like to eat.
- I'm not even thinking about doing regular exercise. I don't enjoy it.
- I feel fine. I don't think I need to get regular checkups. I wish people would not bother me with these appointments.
- I've tried to stop smoking in the past, but I failed. I give up.
- Making a change is more hassle than it's worth.
- I do not know how this change will help me.

Steps Best Suited for Stage 1

You may not be ready to make a healthy change, but start to think about how it could benefit you. Find out how the same behavior change has helped people you know.

- For example, persons who do regular exercise say they have more energy to get things done during the day and they sleep better at night. Others say they have lost weight and their blood pressure has been lower since they started to exercise every day.

At the start of a race, you hear:

On you mark ...

Get ready ...

Get set ...

Go ...

Training for a race gets you ready for it. Being ready is important, too, when you want to make health changes in your life. When you are ready to make a change, you are more likely to do it. An when you see the benefits of the change, you are more likely to make it a part of your lifestyle.

This guide can help you decide if you are ready to make healthy changes and what to do when you are. This step-by-step method has helped many people and is called the five stages of change.

1. Not yet ready to make a change
 2. Thinking about making a change.
 3. Preparing to make a change.
 4. Taking action.
- Making the change last.

- Taking steps in stage 1 gets you closer to stage 2 – Thinking about Making a Change. What would it take for you to move to stage 2? Focus on this.

* * *

Stage 2: THINKING ABOUT MAKING A CHANGE

Examples of Common Thoughts for Stage 2

- I think it would be good for me and people around me if I stopped smoking, but I'm not sure how to do it and if I can.
- I think I should lose weight because my clothes are getting tight.
- I keep hearing about how healthy it is to eat a balanced diet and limit my snacks. I think I should cut back on snacks.

Steps Best Suited for Stage 2

Make a list of things (cons) that keep you from making a change. Examples are:

- I'll gain weight if I stop smoking
- I don't have enough space to exercise.
- I feel fine. Why should I be concerned about my blood pressure?
- I feel hungry between meals

Look at the pros, not just the cons for making change. Examples are:

- If I stop smoking, I will save a lot of money and I will be able to breathe better.
- Walking in place in my cell is something that I can do and will help to pass the time.
- If I lose weight, not only will my clothes fit better, but I will lower my risk of getting type 2 Diabetes.
- Eating a balanced meals and limiting my snack intake at the Commissary will save me some money and help me to lose weight.

Make a pledge or commitment to prepare to make a change. Write this down. Post it in a place where you can see it often. This will remind you of your commitment.

Find out about ways to help you make the change. For example:

- See if your site offers a STOP SMOKING

GROUP.

- Ask your medical provider about the heart healthy diet now provided to all.

Let others know you are thinking about exercising during recreation period and would like to do this with someone. You may learn that others are and you can join them during recreation period.

Taking steps in stage 2 gets you closer to stage 3 – Preparing to Make a Change. What would it take for you to move to stage 3? Focus on this.

"Our destiny changes with our thought; we shall become what we wish to become; do what we wish to do, when our habitual thoughts corresponds with our desire."

-Denis Waitley

* * *

Stage 3: PREPARING TO MAKE A CHANGE

"If you don't know where you are going, your might wind up somewhere else."

-Yogi Berra

Examples of common Thoughts for Stage 3

- I want to stop smoking.
- I am ready to do regular exercise
- I am determined to get my blood sugar under control.

Steps Best Suited for Stage 3

Make an action plan for the change you want to start making. For example:

- Talk to your physician or health care professional about prescribed obtaining medications to help you stop smoking. Find out, too, about tobacco cessation programs. Set a quit date.
- Choose a physical activity you want to do. Learn about the proper way to get started and how to progress so you don't get injured, burned-out or bored.
- Schedule the activity in your daily or

weekly calendar.

- Get your blood sugar checked. Find out (or review things you need to do to keep your blood sugar under control. These include an eating plan, an exercise plan and medication, if needed.

Tell friends about your plan.

- Doing this reinforces your commitment to change. Let them know if you need their support.

Have a backup plan for times when your first plan doesn't pan out.

- Set a short term goal. Make sure the goal is one that is clear, measurable and achievable. Write down your goal. An example is, "I want to be able to walk in place for 30 minutes straight, three times per week in three weeks."

Taking steps in stage 3 gets you closer to stage 4 – Taking Action. What would it take for you to move to stage 4? Focus on this.

* * *

Stage 4: TAKING ACTION

"One way to get started is to quit talking and begin doing."

-Walt Disney

Examples of Common Thoughts for Stage 4

- I can fit 15 minutes of walking in place in the morning in my daily activities.
- I believe I can live without smoking cigarettes. I was able to do this before. I can make it stick this time.

Steps Best Suited for Stage 4

Post notes. Give yourself reminders. For example:

- Post a list of healthy foods in your cell.
- Put a note by the TV that states, "Move, don't sit when I watch you."
- Make a "To Do List." Feel empowered when you check off items you complete.

SUMMARY

Keep a log of the steps you are taking and the benefits you notice. Doing this helps you see the positive steps you are making in the process of change. It lets you read what you have done and can be proud of. Give yourself rewards for small achievements.

Review your backup plan. Use as needed. If this does not bring desired results, use another plan.

Keep talking to and being with people who support your efforts at making a change. Let them know what they can do to help.

Taking steps in stage 4 gets you closer to stage 5 – Making the Change Last. What would it take for you to move to stage 5? Focus on this.

* * *

Stage 5: MAKING THE CHANGE LAST

"We must become the change we want to see."

-Gandhi

Examples of Common Thought for Stage 5

- Since I stopped smoking. I can climb stairs without getting out of breath.
- I have more energy than I did before doing yoga on Mondays, Wednesdays and Fridays.
- I look forward to my morning walks.

Steps Best Suited for Stage 5

Keep reminding yourself of the benefits from making the change that has started to become a habit. Figure out ways to prevent relapse. For example:

- Set an upper limit of what you are willing to weigh or what clothing size you do not want to exceed. If you find that you are getting closer and closer to these limits, be more mindful of portion sizes and/or kick your activity level up a notch.
- Control your environment to avoid past relapse triggers. If you have stopped smoking avoid hanging out in the "designated smoking areas".
- Develop non-smoking friends.
- Manage stress. Do physical exercise. Do a relaxation exercise, such as deep breathing or meditation.

"What you get by achieving your goals is not as important as what you become by achieving your goal."

-Zig Ziegler

Moving from one stage to the next is a process.

It may not be as simple as going from:

stage 1 → stage 2 → stage 3 → stage 4 → stage 5

You may go back and forth through the stages:

stage 1 ⇌ stage 2 ⇌ stage 3 ⇌ stage 4 ⇌ stage 5

This is normal. It does not mean you have failed.

It's okay if you slip up. Don't dwell on this. Just get back on track.

Success starts with knowing which stage of change you are currently in, taking steps best suited for that stage and then moving on to the next one.

When you feel successful, you build momentum to advance.



General Information



Test your pager on a routine basis - any problems should be reported to Melody Massa at 609-341-3095



ADDRESS

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c/o NJ Department of Corrections
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P.O. Box 863
Whittlesey Road
Trenton, NJ 08625
609-341-3093
609-341-9380 - fax



UCHC has an email mailbox.
You can forward your newsletter articles to: uchccorectsvcs@umdnj.edu

Please welcome Tony Tamburello, MD, to his appointment as UCHC Associate Director of Psychiatry. Dr. Tamburello is an excellent clinical psychiatrist who has demonstrated an aptitude and interest in administrative psychiatry. In this half-time position, Dr. Tamburello will assist me in my duties as Director of Psychiatry; however, he will also continue to provide treatment as a staff psychiatrist at Southwoods State Prison. Any information that has been forwarded to me in the past will continue, and I will delegate those items determined to be appropriate, to Dr. Tamburello.

Rusty Reeves, MD, UCHC Director of Psychiatry



Please join us in welcoming Rhonda Lyles, Secretary 1 to the UCHC family. Rhonda, a UMDNJ employee who transferred from the Cancer Institute of New Jersey, will be working with Dr. Arthur Brewer, UCHC Medical Director. If you have a moment, stop by the Bates Building 2nd Floor to welcome Rhonda to the UCHC team.

Sharry Berzins, Office Manager

Please welcome Nicholas Lamberti, PsyD as the Clinician Supervisor at Southern State Correctional Facility.

Marci Masker, Clinician Administrator, Southern Region



Submit your articles by May 26th for the June newsletter

