University Correctional HealthCare

October 2009

Dear Members of the University Community,

I have important news regarding a decision by the University Board of Trustees at its meeting today (Sept. 15th). The Board voted to approve a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS). Under the terms of the CIA, UMDNJ agrees to adhere to specific requirements that will ensure that we are in compliance with all laws and regulations involving Medicare/Medicaid and all other Federal health care programs.

I am encouraging all of you to view the CIA as I do. Consider it a milestone in the University's ongoing efforts to demonstrate that we are conducting all aspects of our business in an ethically sound manner and in full compliance with all federal and state laws and regulations. The CIA is the *last major step* in a chain of measures taken against the University because of poor past business practices carried out by a tiny fraction of University employees who are no longer here.

A CIA is by no means unique to UMDNJ. Major hospital centers, global pharmaceutical companies, health insurers and individual health care providers have entered into a CIA to demonstrate sound compliance and to continue doing business with the Federal government. Our CIA is just one of many hundreds of such agreements now in effect.

I also want to underscore that the CIA is in response to old violations stemming from improper conduct dating as far back as 1993. One involves double-billing for Medicaid reimbursement -- the second, payments to cardiologists to refer their patents to UMDNJ.

Most of the reforms under the CIA are already in place. The most impactful requirement for you will be additional training in compliance matters. Otherwise, your routines are unaffected. This is not a Federal monitorship or Deferred Prosecution Agreement. Thanks to so many of you, we are truly a changed institution, committed to conducting all business matters in an ethical and legally compliant manner and with a zero tolerance policy for practices that fall short of those standards. We have a strong compliance program in place -- at least as stringent as any you might find at any major university, hospital center or academic medical center. So many of you have been going the extra mile to help restore public trust and confidence in our business operations. The CIA will allow us to validate just how far we've come.

I am confident that we will all do what's requested of us to meet the CIA's requirements. The first critical step is reading UMDNJ's revised Code of Conduct that each of you will be receiving in the coming days. The Code outlines the standards for ethical conduct in all workplace dealings. You will be receiving another message from me regarding what is expected of you concerning the Code. That and other details of CIA requirements will also be communicated to you by your managers. For those of you with additional questions about the Corporate Integrity Agreement and its implications for the University and for you as a University employee, please refer to Frequently Asked Questions regarding the CIA posted on my web page. For information about CIAs in general, I urge you to visit the website of the Office of Inspector General at the following link: www.oig.hhs.gov/fraud/cia

The CIA is a necessary and welcome directive vital to the University's strength as a valuable state-wide asset. The CIA will allow us to prove to the public what many of you already know: our house is in much better order and we are better poised than ever for an exciting and fruitful future.

Best regards,

William F. Owen, President

Ask Mechele

Dear Mechele,

I remember in a previous column there was a question dealing with a staff member being bullied by a co-worker. Well, what do you do when your boss is the bully? First, let me say that I have no problem doing my job and have encountered few obstacles that I can't navigate, but if I ever did have a problem, my supervisor is the last person I would ever go to for help. I have seen this person take a strong, competent individual and badger them to a point where they were literally running into the restroom so that we wouldn't witness their tearful humiliation. I don't assume to know the specifics of their dispute, but I have been present when the boss would refuse to listen to legitimate concerns or cut someone off at the first hint of a question to one of their dictates. It has reached a point where I would rather resign than to have to deal with this individual on a one-to-one basis…and I'm not the only one. No doubt supervision in a prison system can't be an easy job, but since when is it ok to treat the staff like they're nobodies? Oh, and in case you're planning to recommend that I take these concerns to the next level, know that this bully boss appears to have been trained to be this way by their supervisor, bully boss #2, so we've got double trouble. Like I said, I don't have any pressing problems right now, but I'm getting tired of being embarrassed when witnessing these diatribes and am sick to death of hearing folks complain about the poor morale resulting from this type of daily tension. What do you recommend?

Ok, But Not Ok

Dear Ok But Not Ok,

Let me say from the door that you're probably not going to like some of my responses to your questions. But I have to give you credit for your guess that one of my recommendations would be to take it to the next level…you've clearly been reading my column and know my style. That being said, in my opinion, that recommendation is still the right one. Everyone reports to someone. So, even if you are dealing with a double dose of bully bosses, they too have to answer to someone. I've personally heard Jeff Dickert (VP UCHC) say on multiple occasions that he has an open door policy, so, that's always an option. However, since your only problem at this point is being an embarrassed bystander, what's to stop you from removing yourself when it appears that the situation is about to escalate? Just get out of the line of fire. If the boss asks why you left the vicinity, you now have an opening to alert him/her of your discomfort in such situations. I believe that we often give folks too much credit for being able to see and hear themselves, especially in tense situations. I was once dumbfounded when a high ranking DOC administrator lit into one of his staff in my presence. I immediately left the office. Later, when he asked why I made such a quick exit I explained that if I were the other person, I would have appreciated having some privacy during such a heated discussion. The administrator seemed surprised and said, "Was I that bad?" to which I responded, "Are you really asking for my opinion?" By answering his question with a question I managed to both provide him with an answer while also giving myself an out from getting involved in a touchy situation.

There's no easy solution to this problem, but I still believe that the best way to deal with a bully is head on. I have a history of letting people know they've offended or embarrassed me. If not, the problem is mine, not theirs. Now once they know, they may not care enough to change their behavior or to offer me an apology…fine. But, they can never say they didn't know how it made me feel. It saddens me to know that you would sooner leave your job than go to your supervisor with a problem. I personally could not work that way, because it's almost guaranteed that one day there will be a problem requiring your supervisor's intervention. I've worked for some people that I did not personally care for, but even then I managed to find a way to get what I needed to do my job well. So, let me close by saying that since your typical bully doesn't bully everybody, I think that I would plan on being the person who first tries stepping to the bully (respectfully) with my concerns and allowing them to respond…good or bad, at least you'll have an answer. If it goes well, things will likely improve, if not, that's what a chain of command is for…start climbing.

TO: All Faculty & Staff

FROM: Gerard Garcia
Acting Vice President for Human Resources

SUBJECT: YEAR 2010 HOLIDAY SCHEDULE

DATE: October 2, 2009

The holiday schedule for all faculty, staff and housestaff for the calendar year 2010 is as follows:

1.	January 1, 2010	Friday	New Year's Day Observance
2.	January 18, 2010	Monday	Martin Luther King, Jr's Birthday
3.	April 2, 2010	Friday	Good Friday
4.	May 31, 2010	Monday	Memorial Day Observance
5.	July 5, 2010	Monday	Independence Day Observance
6.	September 6, 2010	Monday	Labor Day
7.	November 25, 2010	Thursday	Thanksgiving Day
8.	November 26, 2010	Friday	Day after Thanksgiving
9.	December 24, 2010	Friday	Christmas Day Observance

STAFF RECEIVE SIX (6) FLOAT HOLIDAYS AND FACULTY REPRESENTED BY THE AAUP OR NJEA RECEIVE THREE (3) FLOAT HOLIDAYS.

Only full and part-time staff who are in active payroll status as of January 1, 2010, and full-time temporary staff who have been continuously employed for six (6) months as of that date, are eligible for six float holidays.

Staff hired between January 2, 2010 and July 1, 2010 will be credited with three (3) float holidays in July 2010. Staff who are on unpaid leave on January 1, 2010, but return from leave on or before July 1, 2010 will be credited with three (3) float holidays.

Float Holidays must be taken between January 1, 2010, and December 31, 2010, or they are forfeited.

Float Holidays shall be reported on the time sheets as "FH".

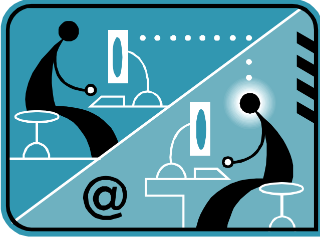
Regular part-time staff shall be paid for Float Holidays on a prorated basis in accordance with the length of their workweek.

Float Holidays, except in the case of personal emergencies, must be requested at least one week in advance. Float Holidays may be used for religious holidays.

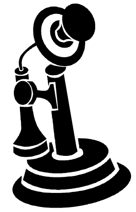
Supervisors shall only approve a Float Holiday if the staff member's absence does not interfere with University operations.

For staff members on a seven-day workweek schedule, a holiday falling on a Saturday or Sunday is observed on that day. Premium pay will be given only to staff members working the actual holiday.

Premium pay is not given for work performed on the Day after Thanksgiving or on Good Friday for non-exempt staff.



Technology Corner



with Leo Agrillo

"Where's that file, I know I was just working on it the other day." How many times have you said this to yourself or a colleague? I admit this has happened to me, but I've managed to keep this particular problem to a minimum by using good file naming practices. Electronic files need to be well-organized and labeled correctly so that they are easily identifiable and accessible to all employees. While basically no different than paper files, electronic files are much easier to manage. And by following a few simple rules when creating files, you'll be able to get to the information you need in record time. At UCHC we store most of our files on network servers so that they can be assessed by others; therefore, it is imperative that file names be meaningful to not just you the creator, but also to others that need file access.

Rule 1 – DON'T: Use special characters in a file name.
\/ : * ? " < > | [ ] & $, .

The characters listed above have special meaning depending on the computer operating system and should not be used as part of a file name. We are using the Microsoft Windows® operating system and the . (dot or period) has the special distinction of separating the file name from the extension. Never use the dot as part of a file name. The dot is automatically used to signify the file name from the extension. The extension is the three characters following the dot that tells the operating system what application to use to open the file.

Rule 2 – DO: Use underscores instead of periods, spaces or other special characters.

To make file names easier to read use underscore. Here are some examples:

Poor: File Naming.Convention's.doc

Good: File Naming_Conventions.doc

Rule 3 – DO: Keep It Simple - err on the side of brevity

In general, about 25 characters will capture the necessary information.

Rule 5 – DO: Include dates as part of the file name and use this recommended format.

The international standard date notations are: YYYY_MM_DD or YYYYMMDD. YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. This format allows ease in sorting and comparing files. Using the date in this manner prevents confusion with other date formats (especially in formats that use just two digits for the year).

The recommendation is to use YYYY_MM_DD_meeting_notes.doc and every month all that needs to change is the date. This makes files much easier to sort and find, especially when the same types of files are created on a recurring basis.

Rule 6 – DO: Include a version number for drafts of the same file

v01, v02, v03 can be added as needed to a file name. Here are some examples:

Example 1:
2009_09_21_meeting_notes_v01.doc

Example 2:
2009_09_21_meeting_notes_v02.doc

Rule 7 – DO: Be Consistent

There are two types of habits, good habits and bad habits. If we are consistent, our good habit of following these rules will make everyone's job easier; if not, we'll wind up spending a lot of valuable time searching.

These rules were condensed and modified from a document on file naming (referenced below) to meet our needs here at UCHC based on observations, user feedback and my experience in this area.

For more detailed information on file naming go to: http://www.records.ncdcr.gov/erecords/filenaming_20080508_final.pdf

If there is a topic you would like this column to address or have questions regarding technology feel free to email me at: agrillle@umdnj.edu

Revised Staff Directory

Updated 10/09

	Office	Cell	Pager	Email
Central Administration				
Jeff Dickert:	609-341-3093	732-580-1055		dickerje
Shirley Lee	609-633-2786			leesm
Melody Massa:	609-292-1247	201-407-3144		massamk
Sharry Berzins	609-984-4599			berzinsh
Jennifer Storicks	609-341-3093			storicjd
Medical Administration				
Arthur Brewer:	609-292-6878	609-313-4185	609-229-0689	brewerar
Rhonda Lyles	609-777-1660			lylesrc
Yasser Soliman:	609-943-4372	609-313-1980	609-229-0690	solimays
Hesham Soliman:	609-723-4221 x8229	609-238-0513	856-223-2262	solimahe
Jon Hershkowitz:	973-465-0068 x4677	732-570-5727	732-206-3157	hershkje
Johnny Wu	609-777-3755	609-238-0993	609-229-0675	wujo
Mental Health Administration				
Rich Cevasco:	609-984-6474	201-407-3114	732-396-6768	cevascrp
Mitch Abrams	973-465-0068 x4383	917-887-5206	732-396-6920	abramsmi
Marci Masker	856-459-7223	201-407-3097	732-396-6767	mackenma
Harry Green	609-298-0500 x1272	732-512-8846	609-229-0688	greenha
Psychiatry				
Rusty Reeves	973-465-0068 x4382	973-632-3194		reevesdo
Anthony Tamburello	856-459-8239	609-410-0266	609-324-3215	tamburac
Nursing Administration				
Magie Conrad:	609-633-6573	908-930-4025	732-302-6694	conradmm
Denise Rahaman	609-777-0440	609-923-1855	609-229-0694	rahamade
Dental Administration				
Man Lee:	609-777-1366	609-218-0697		leemp
Thomas Golden	908-638-6191 x7584			goldentf

Utilization Review		Email
Christine Bartolomei	609-292-2353	bartolch
Eileen Hooven	609-984-5848	hoovenem
Dolcie Sawyer	609-984-5848	sawyerdo
Medical Records		
Cindy Romano	609-292-1393	romanoci
Statewide Ombudsperson		
Elizabeth Topol	609-292-9095	topolcl
Quality Improvement		
Lisa DeBilio:	609-292-5707	debilila
Debra Crapella	609-984-5843	crapelda
Debbie Pavlovsky	609-292-6478	pavolsde

Training Team		
Mechele Morris:	609-292-2252	morrisme
Stephanie Turner-Jones	609-292-2226	turnerst
Denise Gould	609-292-1340	goulddj
Infectious Disease		
Elliot Famutimi	609-292-3365	famutiel
Telemedicine		
Leo Agrillo	609-984-1725 609-413-6944 cell	agrillle
Scheduler		
Patti Ford	609-984-1012	fordpa
Jose Torres	609-292-6953	torresj9
Patti Reed	609-777-1510	reedp1
Rebecca Cozzens	856-459-8034	cozzenra
Samantha Pezzella	856-459-8453	pezzelss

Dear Members of the UMDNJ Community,

Recently the senior management team and I went down to the Occupational Medicine Clinic on the GA level of the Bergen Building to get a seasonal flu shot. Today, I want to urge all students, faculty, and staff at UMDNJ to do the same. As most of you are aware, this year we are challenged with having to protect ourselves and our patients from both seasonal influenza and 2009 H1N1 influenza (swine flu). Getting the seasonal flu vaccine is the first step in preventing a major outbreak of influenza on all of our university campuses. Free vaccine is available to all UMDNJ faculty, staff, and fee-paying students at ALL of the University's employee and student health services. Vaccinations will also be given in a number of clinical sites such as The University Hospital.

In the next few weeks I will also be urging many of you to get the 2009 H1N1 vaccine. We can't predict the impact of the 2009 H1N1 influenza virus yet, but we must be thoroughly prepared. I am taking this opportunity to let you know what UMDNJ's task force of healthcare professionals and administrators is doing to prevent and control H1N1:

- We have a dedicated website www.umdnj.edu/flu with current guidance information and a link to the comprehensive CDC website at http://flu.gov/
- Our NJ PIES is available 24 hours a day, 7 days a week at 1-800-222-1222 to respond to questions about influenza in general, signs and symptoms of flu, treatment and prevention.
- Our Occupational Medicine/Employee Health Services and Student Health Services will offer free to all employees and students, both the 1-dose seasonal flu vaccine and the 2-dose H1N1 vaccine as soon as they are available.
- We are increasing the availability of alcohol-based hand wash to help you protect yourself.
- We are increasing the availability of N-95 respirators and surgical masks for those working in clinical settings as needed.
- We are focusing our communication resources to help the UMDNJ community better understand influenza, the ways to prevent and control it and what to do if you become ill.
- Our Employee Assistance Program and Student Wellness Program have resources available to help address stress and anxiety as a result of a flu threat.
- We have developed plans to handle surges of patients and to ensure continuity of operations.
- We are continuing to work with public health officials and are carefully monitoring advice from the Centers for Disease Control and Prevention (CDC) about how best to respond to this virus.

These efforts alone aren't enough. In addition to getting a seasonal flu shot, all of us must take additional, very basic precautions. Remember, as a university and an academic health center we have a special obligation to protect our patients, our students and our fellow employees. Cover your coughs, wash your hands often and stay home if you are ill. According to the CDC, most of us who contract this virus and develop flu-like symptoms will fully recover after a brief period. Let me also remind you to encourage your family and friends to take the seasonal and H1N1 vaccines this year as well. Remember, you can't get the flu from getting a flu shot!

Please be aware that since this is a rapidly changing situation, the University may need to make adjustments quickly if circumstances warrant. We will distribute updated information as appropriate and www.umdnj.edu/flu will be kept current.

Thanks in advance for all your efforts in keeping our patients, colleagues, and yourselves healthy and best wishes for a healthy and successful academic year.

William F. Owen, Jr., MD
President

MUSIC THERAPY

Music Therapy can be described as the intentional use of sound and music in therapy and healing with people of all ages, with varied needs or developmental disabilities. Music therapy is a creative process, one which encourages positive growth and change. It involves the interaction of a person(s), the therapist and the music. A music therapy session is a creative working environment where a person can feel safe to express and explore all facets of themselves while also learning about others. The music or the musical activity can range from listening, singing, composing, playing instruments, or movement to stories represented in music. Expressing one's self and communicating by these means are nurturing and pleasant experiences that generate feelings of success and well being for all people. They are motivating and positive forces in the process of learning and personal growth.

Music therapy and the musical experiences within groups of 6-8 participants, frequently result in a heightened awareness of others and the experience of appropriate social interactions. Some examples of the goals and objectives reached in these sessions are as follows:

1. Increased socialization and awareness of others
2. Spontaneous and sustained interaction with others Increased eye contact and attention to tasks
3. Increased ability to model and copy appropriate social and play behaviors
4. Intentional and expanded use of the voice
5. Increased functional and related speech as well as improved articulation,
6. Improved fine and gross motor coordination
7. Improved impulse control and an understanding of social boundaries
8. Relaxation and calming techniques
9. A heightened sense of musical awareness and the enjoyment of engaging with peers

Music therapy can be a powerful asset in the prison mental health program. Why? As stated by well known contemporary artist Bono, "Music can change the world because it can change people."

Yanal Kazan, MA
Recreational Therapist, NSP

Pharmacy Savings Estimated at $3.5 Million

Pharmacy is the second largest expense in the medical budget, just after staffing. It had been estimated that pharmacy costs would be just under $2 million per month for both medical and mental health medications, based upon prior costs. For the first three months, however, the bills averaged $2.15 million. Annually, this increase would cost an additional $2 million. As a result of this overage, the pharmacy and therapeutics committee and the University of Medicine and Dentistry of New Jersey purchasing department were charged with taking steps to get us back on budget. Both groups responded to the challenge to reduce costs, while also insuring that the inmates would continue to have all pharmaceuticals that were medically necessary. Their joint actions resulted in monthly expenses dropping to an average of about $1.7 million over the next six months. Within our cost-based agreement, this should result in a $3.5 million annual savings to the New Jersey Department of Corrections (NJDOC), assuming we do not exceed any other budget items. Actions taken included:

- Re-negotiating pricing with Maxor Pharmaceuticals from an average wholesale basis to a cost-based agreement
- Instituting systems to assure the use of generic substitutions
- Shifting to less expensive atypical antipsychotic medications and away from atypical antipsychotic medications prone to misuse within prison settings
- Crushing generic medications instead of ordering more expensive quick dissolving brand medications
- Using half tablets or multiple tablets to achieved a prescribed dosage when cost favorable
- Establishing controls on stock levels at the sites

The efforts of four individuals were noteworthy in making these changes. They are: from purchasing, Hal Moeller, our mental health/psychiatry team, Rusty Reeves, MD, and Tony Tambarello, MD, and Deleca Barnes from Maxor Pharmaceuticals. Their leadership allowed our purchasing department and pharmacy and therapeutic committee teams to achieve these substantial savings. They deserve special recognition and appreciation for keeping the overall costs of inmate health care within budget.

Jeff Dickert, PhD
Vice President

Power of the Team

It is said that insanity is doing the same thing over and over again and expecting different results. Fortunately, we at UCHC are far from that. It takes a special kind of team to go beyond the perceived obvious and step forward to achieve the impossible.

It's not enough to say that this is the way things are and have always been, or to ask," What else can we do?" Successful teams step up to the plate and go beyond the self resignation of accepting the status quo. It begins with the leadership and runs down to everyone else involved in the organization. This is not a trickledown effect which can take a long time to achieve the goal. In times of crisis, action must be immediate and everyone has to be involved to make a successful intervention.

This played out recently when we saw our emergency room (ER) runs and hospitalization numbers rise beyond our expectations in July and August. A critical analysis of the data suggested that certain interventions were necessary. This, however, did not negate the clinical analysis, for the latter will always supersede the former when medical intervention is deemed medically necessary. After all, we are clinicians first; healing is our profession and nothing will interfere with that. More and more, we are realizing that the medical decision-making we learned is not always evidenced based, but rather, based upon practices that were taught to us by our predecessors, without the data to back it up.

In our case, when ER trips increased by more than 30% over two consecutive months, we found that certain things had occurred which allowed our system to lose control of medical decision-making and medical oversight of our structure. From this, we may have started to accept the status quo. Nevertheless, critical analysis of the data through our utilization review processes and quick action by our statewide and regional medical directors stopped the hemorrhage. Armed with the data, Dr. Brewer convened a hastily scheduled meeting with me and the regional medical directors, Dr. Hesham Soliman and Dr. Jon Hershkowitz that bore fruit. Dr. Soliman recommended that the regional medical directors take control of the ER decision-making, with my oversight. By doing this, both the ER runs and the number of hospitalizations were managed much more effectively. Dr. Wu, who could not be at the meeting, also concurred and joined in this effort, which brought about better control of our medical system. By reporting any possible ER runs directly to the regional medical directors, the process became much less of a hassle for our nursing staff and reduced decision making time by eliminating the need to call the first on-call doctor. We also reinforced our capabilities behind the wall by allowing our medical providers and nursing staff to practice their professional skills more effectively. With additional training, supplies and medications being made available in-house, everyone's clinical skills and capabilities will be kept current and sharp.

The medical leadership and our entire clinical staff are to be commended for a job well done in a relatively short period of time in implementing this effective intervention that will help manage our system and provide the best possible care for our patients. The numbers speak for themselves as ER trips went from approximately 90 in the prior two months to 35 once the process was implemented in the beginning of September. We as a team truly went beyond the perceived obvious and achieved the impossible. My sincere thanks go out to everyone on our staff for their efforts in this outstanding achievement.

Yasser Soliman, MD
Statewide Associate Medical Director
Director of Utilization Management

Confidentiality

An elderly gentleman walks into his doctor's office and loudly tells the receptionist he needs to see the doctor because he's unable to urinate. He uses some colorful language and several waiting patients are shocked and embarrassed by his bluntness. The receptionist says to the gentleman, "Sir, you can't say that in here." He asks, "Why not?" The receptionist answers, "It's impolite and people don't wish to hear those personal details. You should come in and tell me you want to see the doctor for something else and then address the personal issues with the provider in private." The man straightens himself a little and begins again. "Ma'am, I need to see the doctor for my ear," he informs her with a wink. She smiles, this time pleased, and replies, "What's wrong with your ear, sir?" Loudly he blurts, "I can't pee out of it!"

This illustration though humorous, points out the difficulties that come with working in the field of healthcare. As a healthcare team of doctors, nurses, administrative personnel and officers within the department of corrections (DOC), we encounter numerous situations that can open the door to unwanted and even unintended breaches of patient confidentiality. We must keep in mind that while each individual involved with the patient has, to a certain extent, a "need-to-know" the personal information of that individual, the information to which we have access is to be guarded and used for specific, official purposes only. All medical information about a patient is considered confidential. We are responsible as employees to respect patient privacy and to protect the confidentiality of our patients' records. Maintaining this confidentiality contributes to the high professional standards held by this office and the integrity of the University of Medicine and Dentistry of New Jersey (UMDNJ).

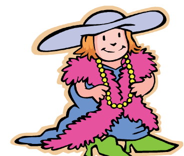
Those having access to Personal Health Information (PHI) must remember that each individual's information must be guarded carefully. A discussion between two healthcare providers about an individual while walking down a hallway, in a lunch line or in an elevator can end up causing a disclosure of personal information that may embarrass or confuse the owner of that information if the conversation is overheard or if a partial conversation is misinterpreted and gets back to that individual. Situations like this can also lead to malpractice.

Sometimes, we may think that we have removed enough PHI from a conversation to discuss a case without the patient's identity being divulged, such as using an ID number, specifics about an uncommon medical condition, or situational details which may be unique to that patient. If we do not take the individuals within earshot into consideration and the relationship they may have to the patient being discussed, we may end up divulging information to a friend, family member, coworker, supervisor or other individual with a connection to the patient, without the patient's permission. PHI should not be discussed in a public area where the conversation may be overheard. Be careful never to leave test results (positive or negative) on an answering machine, voice mailbox, or email without a patient's permission. Sign-in sheets should be kept out of sight of other patients. Whenever possible, log a patient in yourself rather than allowing another individual access to a list of patients. Computer monitors can sometimes be seen by individuals who are not authorized access to PHI. Ensure your screen is guarded from the view of unauthorized personnel. Notify an intended recipient that you are sending a fax BEFORE you send it, use a cover sheet including a confidentiality statement, and never send PHI via fax without the permission of the patient. In your work area, ensure that confidential faxes are not left unattended on a fax machine and be sure to take all papers from the photocopier after making copies.

Unauthorized disclosure of a patient's medical information is not only embarrassing and harmful to the patient-provider relationship, it is also illegal. Consider the following scenario: During a medical examination a nurse learns that the patient she is assisting is HIV-positive. She knows that her son is a friend of the patient's and that her son has been using IV drugs. She inquires of the doctor whether she may tell her son of his friend's HIV-positive status. He tells her that the law prohibits disclosure without the patient's permission, but because the nurse is so distraught over the situation, the doctor grants her permission to let her son know, as long as she doesn't use the patient's name. This scenario is based on a case in which a ruling was made that a physician could be sued for authorizing disclosure of a patient's status without permission from that patient, even though he did not disclose the information and told the nurse not to release the name.

At certain times, it may be appropriate to share medical information as long as it is done in the proper setting, in an appropriate manner, and as long as it is required for official purposes. The medical staff shall notify the DOC staff of any physical limitations and/or requests the inmate may have. For example: changes in activity level, housing unit requirements, advising the correctional and central transportation staff in the use of any necessary precautions when handling/transporting an inmate, suicide watches and releases, and changes in status and special needs.

Please remember to keep all conversations regarding PHI private, discuss only in environments which are secure and all present have a "need-to-know." Every individual, regardless of his/her status has a right to privacy where medical information is concerned. Violating that right can have serious consequences. Keeping PHI safeguarded is everyone's responsibility. Your contribution to protecting patient rights is appreciated and will continue to maintain the integrity of this office and the services we provide.



Elizabeth Topol
Statewide Ombudsperson

Are you familiar with the Office of Transitional Services?

The Office of Transitional Services (OTS) is a New Jersey Department of Corrections (NJDOC) department, run by Director Darcella Sessomes. UCHC staff should know about her office as it offers many services as well as providing information to state inmates throughout their incarceration. Note its official description:

The Office of Transitional Services provides oversight of all of the department's social services and transitional programs and is the core unit within the Department of Corrections to coordinate the inmate reentry process. The goal of the Office of Transitional Services is to match inmates to institutional programs and community based services according to their identified risk to recidivate and needs for rehabilitation (based on the LSI-R). These programs and services are coordinated in four key interrelated areas: employment and economic stability, mental, physical and spiritual health, housing and family stability.

OTS has standardized programming throughout all DOC institutions in order to ensure that offenders receive access to the same level of programming regardless of where they are assigned. Programs are offered in cycles with approximately 15-20 offenders in each group. Referrals to these programs are made in advance and generally come from the inmates themselves as all programs are voluntary. Programs include:

Every Person Influences Children (EPIC) – 10 weeks, 1x/week, 90 minutes

Thinking for a Change (T4C) – 11 weeks, 2x/week, 120 minutes

Cage Your Rage (CYR) – 10 weeks, 1x/week, 90 minutes

Successful Transition and Reentry Series (STARS) - 13 weeks, 2x/week, 120 minutes

Helping Offenders Parent Effectively (HOPE) – 10 weeks, 2x/week, 90 minutes

Successful Employment and Lawful Living Through Conflict Management – 6 weeks, 1x/week, 120 minutes

In addition, the Correctional Reentry and Transitional Environment Program (CREATE) is available to qualified inmates. This is a unit based program designed to assist offenders with transitional services that are not eligible for traditional Residential Community Release Programs (RCRPs).

Other OTS services include:

- PREPARE (Providing Re-Entry Pre-qualification and Referrals for Ex-Offenders) helps offenders who are in the release process pre-qualify for benefits such as: General Assistance, food stamps, Temporary Assistance for Needy Families (TANF), social security disability or veterans benefits, by assisting them with completing applications and setting up meetings with external agencies prior to release
- Fact Guide – Brochure on obtaining identification and post release benefits after prison
- Resource Guide for Family Members – Booklet for family members covering topics such as Inmate Telephone Calls and Correspondence, Visiting Inmates, Commissary, and Inmate Services (medical, legal, religious, etc.)

Finally, Living on the Outside, A Pre-Release Handbook (Charming, Bete Co., Inc., 2005 Edition), is utilized by the social services staff to counsel inmates on key aspects to successful re-entry such as: finding job leads, filling out applications, getting along with co-workers, finding transportation, managing your money and taking care of your health, to name but a few. To view this handbook, you may go to www.channing-bete.com for item #PS97187.

As you can see, the Office of Transitional Services provides many services to inmates that you may or may not have known. Hopefully, this brief overview has been helpful and the NJDOC Social Service Supervisor at your site should be able to provide you with additional information as needed.

THIRD ANNUAL UCHC CONFERENCE

HEAD CASE: The Impact of Brain Injury

Where: Harris Auditorium

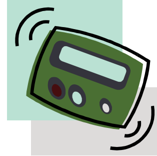
When: Wednesday, November 11, 2009

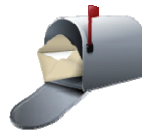
Time: 8:00-12:00 repeated 12:30-4:30

Additional information TBA

General Information

Test your pager on a routine basis - any problems should be reported to Melody Massa at 609-292-1247





ADDRESS

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609-341-3093
609-341-9380 - fax

Congratulations to James Yuhasz on the successful defense of his dissertation. With this accomplishment he has completed all of the requirements for his PsyD. As we strongly believe in showcasing the many talents of our staff, Dr. Yuhasz has been tapped to be one of the presenters at the Third Annual University Correctional HealthCare Conference to be held on Wednesday, November 11. This year's topic will be a study of brain injury within the cor-

Submit your articles by November 28th for the December newsletter

Articles submitted for publication in the UCHC newsletter may be held for subsequent newsletters at the discretion of the Editorial Board

Thoughts of a Clinician Supervisor Approaching Retirement

If a career was a long distance race, I am nearing the end of that race. As I look upon my work in correctional behavioral health as both a great first and last job, I feel the responsibility to pass along some thoughts to my younger colleagues. After all, I am in Erikson's Stage of generativity. The thoughts that follow come from a career that has involved fulltime teaching at Lafayette College, a short stay at an adolescent crisis center and a long stay at Camden County Health Service Center (affectionately called Lakeland), mixed in with some private practice along the way.

We in correctional behavioral health are able to provide psychotherapeutic services that were once the province of private psychiatric hospitals. Due to the confluence of forces, many private hospitals have gone the way of the dinosaur; with the comet being managed care and deinstitutionalization. We amazingly have a Mental Health Roster and "struggle" to remove patients from it. We have a captive audience that is in many cases, not only available for supportive work, but reconstructive work as well. What can go wrong with this optimistic picture? We can allow ourselves to become contaminated by our immediate surroundings. What are the signs that we might have been infected? Unlike infection from the H1N1 virus in which physical symptoms abound, "Correctional Infection" can be more insidious and difficult to diagnose. One suspects its existence when phrases such as, "Don't Hug a Thug" or "We only do supportive work," are heard. Or, we become overly involved in detecting malingering and catching the patient in pulling this or that scam. Further evidence of infection may be the desire to write charges, or evincing limited patience while conducting Detention Rounds (I've experienced this last symptom several times!). Or thinking and uttering the thought, "It's only Axis II pathology!"

The task of therapy is to enter into a relationship with a patient, knowing that in this particular culture it will be a difficult task for many reasons. Our prospective patients have often had an absence of quality human connections, trauma associated with prior connections, or the marked dependency on past connections and the resultant unreasonable expectations. Any of the above, among others, can and will render the establishment of a therapeutic alliance dead on arrival, or mortally wounded. Our task is do our best to establish this alliance where therapeutic enactments can occur and to provide the foundation and possibility for change. We have the opportunity to make a difference if we maintain a healthy respect, and at the same time, a psychological distance, from custody. This is the tight rope we walk daily.

Philip Slonim, Ph.D.
OP Clinician Supervisor
SWSP

OPEN ENROLLMENT

This year's State Health Benefits Program (SHBP) Open Enrollment covering health/dental plans for eligible employees is from October 1 through October 30, 2009. This is also the time to consider enrolling or re-enrolling in the NJ State Employees' Tax Savings Program (Tax$ave 2010). The Open Enrollment period for the medical and dependent care tax savings accounts is October 1 through October 31, 2009.

Fringe Benefits Management Company (FBMC) is the administrator for the Tax$ave Program's Flexible Spending Accounts (FSA). Please be reminded that participation in Tax$ave 2009 does not automatically carry-over into 2010. You must file a new Enrollment Form with FBMC during this Open Enrollment period to participate in 2010.

Please refer to the Human Resources web site at: http://www.umdnj.edu/hrweb/benefits/openenrollment.htm for detailed information.

Please contact your campus Human Resources Benefits Office at one of the following telephone numbers, if you have any questions.

Newark	(973) 972-5314
Piscataway/New Brunswick	(732) 235-9417
Stratford and Camden	(856) 566-6168

$ Reimbursement for Continuing Education

UMDNJ's Tuition Assistance Program (TAP) reimburses employees for courses, seminars and workshops. UCHC employees are eligible if 1) they qualify for benefits, 2) have worked continuously for one year, and 3) have satisfactory work performance. UMDNJ will reimburse all full time staff members for 100% of the courses up to a maximum of three thousand dollars ($3,000) annually for satisfactory completion of the courses (C grade or better) and seminars. UMDNJ will reimburse all part time staff for 50% up to a maximum of fifteen hundred dollars ($1,500) annually. For nurses attending UMDNJ's School of Nursing, UMDNJ increased those limits to $7,000 for full time nurses and $3,500 for part time employees with the year of service, benefits and satisfactory work performance.

To qualify you need to complete a TAP Form which is available on the UMDNJ Web Site: http://www.umdnj.edu/hrweb/forms/tap application.pdf

Applications and specified documents for reimbursements for college credit courses, special non-college credit courses and seminars must be received in Human Resources Office no later than 15 business days prior to the start of the course(s) seminar(s). It is your personal responsibility to see that the application arrives at HR. In order to receive reimbursement, the remainder of all required documents including the original grade report, certificate or verifiable copy must be received in the Campus Human Resources Office within 90 days of completing course(s) / seminars(s). You should keep copies of all submitted documents.

Magie Conrad, DNP,MSN, MPA, RN, BC, CTN
Nursing Administrator