Mental Health Satisfaction Survey Results Are In!

Approximately one-third or 1,100 inmates receiving mental health (MH) treatment responded to the annual University Correctional HealthCare Mental Health Satisfaction Survey. In brief, the inmates report being satisfied with MH services and would like even more.

Overall, with a mean score of 3.75 where “3” reflects good care and “4” reflects very good care, our inmate/patients are reporting overall satisfaction with MH services. These results are comparable to past surveys where results hovered between 3.7 and 3.8.

These results clearly reflect our success in demonstrating “care” to the inmates we service. Responses in descending order at or above average are: respecting confidentiality (4.0), professionalism (4.0), courtesy (3.9), attention to privacy (3.9), availability (3.7), helpfulness (3.7), overall quality of care (3.7), and opportunity to participate in treatment planning (3.7).

The services falling slightly below the mean are: addressing MH needs (3.6), frequency of MH appointments (3.6), wait for first MH appointment (3.6), and helpfulness of medication & treatment received (3.6).

From a continuous quality improvement perspective (CQI), opportunities for improvement appear to relate to inmate/patient expectations regarding treatment frequency and effectiveness. Most inmates with MH needs are seen twice per month by a MH clinician and one to two times every other month by a psychiatrist. It might prove helpful to let our inmate/patients know that we’ve been able to seen them on average, twice as often as they could have been seen in the community where contacts average once a month. The same is true with psychiatry medication monitoring follow-up which happens in the community every 90 days give or take, but we have typically been able to offer this service twice as often.

It’s probably safe to say that some inmates may have unrealistic expectations about the impact of medication and therapy. By providing more information (“We Teach”), we can help them better appreciate the realities of their conditions and the importance of their own efforts in addressing their MH problems. To this end, let’s make sure to help them clearly articulate what they personally will do to work on their problems.

Again, results of the MH survey were positive as the inmates responded favorably that “We Care” in the treatment we provide. This, coupled with additional education (“We Teach”) can only help to improve their perceptions about the impact of our services on their overall MH.

Jeff Dickert, PhD Lisa DeBilio, PhD
Vice President Director of Quality Improvement
Dear Mechele,

Over the years I've seen some things that I wish I hadn't, but nothing so overwhelming that I would consider leaving corrections. I've recognized that it's possible to have empathy while also maintaining the boundaries mandated by the Dept of Corrections. I've worked at a few different facilities and talked to enough people to know that, despite statewide policies, each institution operates a little differently from the others. Attitudes regarding policies and procedures can change with each shift and vary depending on who you talk to.

One of your previous letters addressed our responsibility as care providers & cautioned us to not become cynical or lower our standards of care because we work with inmates. I happen to agree. I probably have more empathy than the average person who works in prison, & I think it's worked pretty well for me over the years. I feel I have a good rapport with the officers, & the inmates know I'm committed to offering them the best care I can within the limits of our work environment.

With all that said, I'll make my point... These days I'm seeing more & more of my co-workers doing things with inmates that I think have a potential for trouble down the line...nothing blatant like sex, drugs or cell phones, but things that are concerning; maybe some would even consider disturbing.

Case in point... I watched a co-worker open a soda & discard the aluminum pull tab in the trash. I casually said, "You know the inmates empty that trash don't you?" My comment was dismissed with a shrug so I continued... "Someone could use that tab to cut up or make a shank;...again, no response. I've seen staff share their lunch; give up candy, fruit, coffee & other "treats." I'm not without compassion, but officers & staff who've been around for awhile have told me that such behavior rarely goes unnoticed. They say inmates look to see if you're generous or have a soft heart. Then the inmates either share their impressions with other inmates or file it away for future reference.

I've seen bad things happen in the past, but they were usually more blatant violations. Right now I find myself torn, not knowing exactly what to do. I don't want anyone to lose their job over something as trivial as a piece of candy, but on the other hand, blatant disregard for the rules could endanger any one of us, including me. Is there anything I can or should do about this or am I just overreacting?

Snitch or Don't Snitch

Dear Snitch or Don't Snitch,

It's fortunate that you've found that place where you can provide the inmates with the help they deserve, but still recognize that by working in prison, "you're not in Kansas anymore." For some, that balance is more difficult to come by.

I remember entering my unit every day & going to the pantry for a cup of hot water & a teabag. One day, I didn't have time to stop & went straight to my office. There on my desk was a box of teabags. When I asked the inmate pantry worker about them he said, "I know how much you like having your tea in the morning, so this way you'll always have it." So, in this seemingly innocent situation a couple of things happened. The inmate took notice of my stopping every morning for a cup of tea (he knew my routine). He arranged to have the tea (state property) placed in my office (an area off limits to inmates). He considered this a favor to me personally (think quid pro quo). It only took me about a second to know what I needed to do. I immediately returned the teabags to the pantry, thanked him for his consideration & warned him that to accept the tea would cause trouble that neither of us needed.

The morale to this story is that the inmates watch what we do...what else do they have to do to pass the time? And catching us doing something wrong could provide them with an opportunity. I don't know for sure if that particular inmate would have taken advantage of me if I'd kept the teabags. But quite frankly, I have enough to worry about & wondering whether or not I might be someone's pawn down the road is not a risk I was willing to take. I love my work, I believe I provide a valuable service & I know that what I do makes a difference. But I've never lost track of the fact that, "I NEED MY JOB!"

Also, just let me say that I take umbrage with the term "snitch." Just this AM my favorite morning radio show discussed the evolution of the term "no snitching." The term was initially meant as a code among thieves. If you got caught & your friend didn't, you accepted the consequences & didn't give up your friend. The idea of disclosing something that's wrong, something that could cause others harm isn't snitching, its protection.

Now there's several ways to do this in the real world of corrections. I've cautioned colleagues & officers about questionable practices & asked that they do the same for me. Fortunately, in most circumstances they've listened. When brushed off I made it clear that anything threatening my personal safety was not acceptable & if anyone got hurt I would not hesitate to sing like a canary (I remember what happened to Lil Kim for lying). Using "Ask Mechele" was a good mechanism for putting this issue out there. You could also send an anonymous note to your supervisor or approach a custody member for advice on a "hypothetical" issue. In an environment where "good lookin out" is a catch phrase describing our way of life, please don't stop pointing out your concerns. Even if it means you have to remove that tab from the trash, your vigilance is appreciated.
Staff Survey Results

Each year we ask staff to complete a Satisfaction Survey. Our most recent one was completed in April 2009 and results were sent to UCHC staff through the managers and supervisors. Recently, one of our team pointed out that we had yet to summarize the findings for our newsletter.

Four hundred eighteen (418) of approximately 1000 staff completed the April 09 Survey. To assess overall staff morale we used morale scores from prior surveys at both University Behavioral HealthCare (UBHC) and UCHC. The items include:

- Interest in my work
- Proud to work at UCHC
- Lack of frustration with my work
- Joy in my work
- Time to respond to inmates’ needs
- Physical work environment being adequate
- Ability to handle workload
- Ability to handle demands
- Enthusiasm about job
- Work being satisfying
- Feeling able to manage amount of work expected
- Feeling good about UCHC
- Feeling supervisor has realistic expectations
- Not stressed by working with inmates

Overall, our staff morale score, even with the addition of medical and dental team members, has been fairly consistent with prior years’ scores. For each item staff selected one of the following: never (1); rarely (2); sometimes (3); quite often (4); most of the time (5). The average annual score has remained at 3.7 since 2005. In this most recent survey, sites with a mean score of 4.0 or higher include AC Wagner and Mountainview Youth Correctional Facility, Northern and Southwoods State Prisons.

Staff were also asked to answer another thirty nine (39) “Yes” or “No” questions. For many of the items we have limited ability to make an impact such as those related to the physical environment. However, many of the areas identified will receive the attention of our leadership group. These areas include:

- Increasing central administration leadership staff site visits
- Providing opportunities for staff input into clinical and administrative practices
- Improving top down communication with staff
- Clarifying the UCHC organizational structure for staff
- Holding training in more convenient locations

In an effort to address these areas of concern we are:

- Enhancing our newsletter and committing to six (6) editions per year
- Instituting teleconference community meetings with plans for six (6) this year
- Having each central office administrator attend one CQI meeting every other month & one administrative meeting on opposite months
- Soliciting articles by staff for the newsletter
- Providing on site Performance Improvement trainings

Though only identified by a small subset of our staff in response to a few unfortunate incidences, we have organized a response program for those staff members identified as having possibly been traumatized at work. Undoubtedly prisons are not easy places to work; so the fact that you are able to do your jobs in such a restrictive environment with pride and professionalism is something that is highly appreciated by me and has clearly been recognized by the leadership of the New Jersey Department of Corrections.

Here are the results of the additional items on the April 2009 Staff Satisfaction Survey. While site specific results were sent out several months ago through the managers and supervisors, they are also available through our Central Office.

| 1. I am treated with respect by my supervisor | 82
| 2. Space for treatment is adequate in size and the degree of privacy | 54
| 3. UCHC adequately funds staff attendance at continuing education conferences | 60
| 4. The condition of furniture, floors and walls on my unit is poor | 58
| 5. Training and in-services are held in convenient locations | 48
| 6. Rapport between staff and supervisors is satisfactory | 71
| 7. I feel valued as a person at UCHC | 50
| 8. My unit receives up to date information about available training | 65
| 9. Staff vacancies take too long to fill | 69
| 10. I need more information about Performance Improvement activities and results | 41
| 11. Human resources policies (re; compensatory time, attendance, etc) are easily accessible | 78
| 12. Caseload sizes are fairly distributed among clinicians | 63
| 13. I am afraid that I might loose my job | 29
| 14. I do not receive regular and accurate health information (i.e.; information about flu shots) | 25
| 15. I received timely information about UCHC statewide initiatives | 60
| 16. Bathrooms at our work site are clean | 63
| 17. Administrators/Managers/Directors should visit our site more often | 56
| 18. My contributions to my unit and UCHC are recognized and appreciated | 57
| 19. I am pleased to be part of the University setting | 76
| 20. Staff vacancies adversely impact my work | 58
| 21. My supervisor meets with me on a regular basis | 67
| 22. I am very familiar with the organizational structure at UCHC | 57
| 23. I am treated with respect by my coworkers | 87
| 24. The chart review process is appropriate and useful | 67
| 25. The annual evaluation process is too subjective | 38
| 26. The electronic record has made my job easier | 67
| 27. Courtesy and interaction among UCHC is adequate | 69
| 28. I feel that the UMDNJ & UCHC new hire orientation process is helpful | 67
| 29. Courtesy and interaction among UCHC staff (custody & DOC administration) is adequate | 79
| 30. I have concerns about my personal safety at work | 25
| 31. Top to bottom communication between management and line staff is adequate | 51
| 32. I have the resources/tools to do my job well | 59
| 33. I have to attend too many meetings | 13
| 34. The temperature at work is comfortable | 50
| 35. Staff input regarding clinical and administrative practices is taken seriously by management | 54
| 36. Clinical and administrative communication is adequate | 59
| 37. Supervisory feedback about shortcomings in my performance is communicated | 76
| 38. I feel free to express my ideas about how to improve processes at my site | 67
| 39. There is adequate access to review charts and document treatment contacts in the EMR | 50

Staff respondents were approximately equal between medical and mental health staff.

I appreciate and thank you for the feedback from this survey.

Jeff Dickert, PhD
Vice President
dickerje@umdnj.edu
UCHC re-scored the 2009 PI Projects using criteria consistent with the PI Training Materials and Guidelines presented over the past five years. Magie Conrad, Marci Masker, and Rich Cevasco were selected to judge the projects since they have familiarity with, and are involved in, PI Training. The top three physical health care and mental health projects selected are highlighted below:

**Top 3: Mental Health PI Projects**

#1: **MYCF: How Inmates Cope in Detention**  
Team Members: Donna Crabtree, James Yuhasz, Lashawn Brooks, Jay DeMartino, Carol Christofilis, Henry Kogler, CO Bellis, CO Willever, CO Barber, Decon Dumschat and Valerie Smith

#2: **NJSP: Bye Bye Birdie**  
Team Members: Kerri Edelman, Virginia Gogarty, Steven Reed, Andrea Frazier, Susanne Pitak-Davis and Randy Wilson

#3: **SWSP: Seeing Through a Broken System**  
Team Members: Marci Acquilino, Maryse Ciccio, Penny Farside, Joyce Rapp and Joy Kwap

**Top 3: Physical Health PI Projects**

#1: **ADTC: Distributing KOPs in a Timely Manner**  
Team Members: Kathleen Gill, Leslie Ortiz, Adeline Varrielle, Brittany Allen and Pamela Reddick

#2: **SSCF: Medication Administration and Documentation**  
Team Members: Narissa Pierce, Claire Schmidt, Deborah Vasile, Sharon Repko and Laura Gabrylewicz

#3: **MYCF: Patients who are Obese with BMI Greater than 35**  
Team Members: Dr. B. Patel, Barbara Barath and Jamie Tibolt
The Case of the Missing Backslash.

In the last Technology Corner I provided a game matching special characters to their name. Due to an unfortunate editing oversight, the backslash was dropped. To correct this grave oversight, behold the ever popular backslash \ in all its glory. As an aid to remembering the difference between the slash and backslash: backslash \ is upper left to lower right and the slash, aka forward slash, / is lower left to upper right. Personal thanks go out to Dr. Komal Saraf for bringing this issue to my attention.

Microsoft® Word Document (.doc), Word Template (.dot) and Word 2007 (.docx or .docm)

Believe it or not there are differences in these documents depending on what version of Microsoft Office is being used. For background, the Department of Corrections (DOC) and UMDNJ standardized using Microsoft Office 2003. Office is a suite of software programs providing word processing (Word), spreadsheet (Excel), presentation (PowerPoint), and data base (Access). For Word 2003 a document is given the file extension .doc. When saving your work, (reports, letters, memos, etc) Word will append this extension to the file name to signify that this is a Word document.

If there’s a need to produce the same type of document over and over, for example a business letter, then a document template can be used and the necessary elements will give you the user, a starting point to make it easier to create your document. While templates are available on you local computer online, downloading them from the Microsoft website could be blocked by DOC. However, they can also be created and customized to meet your individual needs. Since standard UCHC/UMDNJ templates may already be available, I suggest you ask your peers if templates are available to make your job easier. The extension used for document templates is .dot.

To further confuse matters, Microsoft changed the file extensions in Word 2007 to .docx or .docm. Some use this program when working on their home PC. But Word 2003 will not recognize a document created in Word 2007 unless a converter program is installed on the PC with Word 2003 or the document is saved as a Word 97-2003 type document in Word 2007. Note that the converter program isn’t on all DOC PCs.

To make your files readable by those without the converter, save your files by changing the file type using the “save as” option and then the drop down for file type. If you’re using any of the Office 2007 applications make sure to save your files in the correct format for reading by Office 2003. In the “save as” type list, click the 97-2003 file format. For example, click Word 97-2003 Document (FILE_NAME.doc) for Word files, Excel 97-2003 Workbook (FILE_NAME.xls) for spreadsheets, or PowerPoint 97-2003 Presentation (FILE_NAME.ppt) for presentations. More information on this can be found at: http://office.microsoft.com/en-us/word/HA102464561033.aspx#1.

If there’s a topic you’d like to have addressed in this column or questions regarding technology, feel free to email me at: agrillle@umdnj.edu
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December 18, 2009

Dear Mr. Kosseff:

Every state is challenged by the need to provide health care to prison inmates. The goal is quality care at reasonable cost. As in many other states, New Jersey has tried a variety of approaches, including privatization, to achieve this goal. Over the past six years we have embarked on a unique collaboration with our State’s health sciences university that has proven to be most successful.

I commend both the University of Medicine and Dentistry and the New Jersey Department of Corrections for crafting a structure that has improved the quality of prison medical care while significantly reducing costs.

Here are just a few highlights:

- In the past year, services met the quality standards set by the Department of Corrections and finished the year approximately $7 million under budget.

- Inpatient hospitalization days and costly emergency room visits have each fallen by about 5% each.

- Monthly pharmacy bills have been reduced from an average of $2.15 million in 2008 to an average of $1.73 million in 2009.

UMDNJ and the New Jersey Department of Corrections have created an efficient and effective system for health care delivery in New Jersey’s prisons.

Sincerely,

[Signature]

Jon S. Corzine
Governor
Transfer Summaries-Improving Communication of Pertinent Mental Health Information to Receiving Providers: New Jersey State Prison (Inpatient Mental Health Program)
September 2008-August 2009

Team Members: Team Leader: Kerri Edelman, PsyD, Inpatient Clinician Supervisor, Team Facilitator: Virginia Gogarty, LCSW-Mental Health Clinician III, Team Members: Steven Reed, PhD, Forensic Mental Health Clinician; Andrea Frazier, CSW, Mental Health Clinician III; Susanne Pitak-Davis, AT, Art Therapist and Randy Wilson, RT, Recreation Therapist

Title of Project: Bye Bye Birdie

Purpose:
Transfer Summaries are composed by staff from a variety of mental health (MH) disciplines as a means of communicating important MH information when inmate/patients move from one level of care to another. On the Inpatient Units at New Jersey State Prison (NJSP), Transfer Summaries were reviewed for inmate/patients moving from the Residential Treatment Unit (RTU) to the general population (GP), Transitional Care Unit (TCU) to GP and/or TCU to RTU & RTU to TCU. These Transfer Summaries focus on incorporating a comprehensive overview of the inmate/patients’ treatment (Note: Transfer Summaries written for inmate/patients being transferred to the Stabilization Unit (SU) were not evaluated due to the brief timeframe as many are frequently readmitted). As a result of the Transfer Summaries varying content, the MH staff chose this as an area in need of improvement. Therefore, the purpose of this PI Project was to:

• Improve the communication of pertinent MH information to the receiving provider/institution.

• Assure that the Transfer Summaries contained the specific information identified by the MH staff as essential to improving the continuity of inmate/patient care.

Design & Method:

• The Performance Improvement (PI) Team consisted of multi-disciplinary MH staff from both the RTU and TCU at NJSP. Through the utilization of a Fishbone Diagram, we were able to identify reasons why the content of the Transfer Summaries were inconsistent; primarily because of the lack of a structured format to be used by all MH disciplines as well as a lack of training on the matter.

• The PI Team began meeting in September 2008 to Brainstorm for the purpose of creating a Peer Review Form to assess the MH staff’s thoughts regarding the specific content to be included in the Transfer Summaries.

• Method: A staff meeting was held in order to assess MH staff’s thoughts regarding the importance of qualitative content to be included within Transfer Summaries. Upon receiving the feedback, a Transfer Summary Peer Review Form was developed in order for pre-test data (n=56 which is 100% of all Transfer Summaries completed over the 2008 year) to be collected and analyzed to assess the content of Transfer Summaries. Following the collection of the pre-test data, a Didactic Training was implemented to educate staff about how to use the Transfer Summary Peer Review Form. Following the Didactic Training post-test data (n=22 which is 100% of all Transfer Summaries completed between February 2009 through August 2009) was collected and analyzed.

Results:

• Results of Pre & Post-test Data from Transfer Summary Peer Review Forms

Results from the pre and post test data (after implementing the Didactic Training) indicated a significant improvement in MH staff endorsing the specific content that was perceived as being essential in Transfer Summaries:

Transfer Summary Section – Does the Transfer Summary include the following:

a. Identifying information (i.e., age, gender, race, max-out date, etc.)

Pre-test=80% Post-test=95%

b. Presenting problem and location of transfer from (i.e., what brought the IM into the unit)

Pre-test=86% Post-test=91%

c. Psychiatric History (i.e., psych hospitalizations, suicide attempts, family history, assaultiveness, etc.)

Pre-test=63% Post-test=86%

Date of Admission to Current Level of Care Section (with specification of institution IM transferred from)

Pre-test=93% Post-test=95%

Date of Recommended Transfer to Different Level of Care Section

Pre-test=95% Post-test=100%

Reason for Transfer Section (i.e., including met/not met tx goals, any recommendations for housing, etc.)

Pre-test=88% Post-test=100%

Treatment at Current Level of Care Section

a. Identifying IM’s symptom presentation when admitted to unit (i.e., symptoms, behaviors, level of participation, medication compliance, etc.)

Pre-test=83% Post-test=91%

b. Continuity between treatment and problem areas addressed in treatment plan (i.e., identifying what was specifically used with the IM to target symptoms [individual therapy and coping skills, specific groups, etc.-be specific regarding IM’s treatment], admissions to SU

while on unit and why, and why goals were met/not met, etc.)

Pre-test=77% Post-test=95%

c. Discharge Planning (as it relates to transfer to a lower level of care and/or maxing out or paroling [where IM will reside, with whom, outpatient programming he will attend, etc.])

Pre-test=63% Post-test=88%

Medication Compliance Section (i.e., including history of non-compliance, identification if on Forced Medication Protocol or history of being on it and IM’s insight into need for medication)

Pre-test=91% Post-test=91%

Does the problem list have a rule out, question of or provisional diagnosis

Pre-test=23% Post-test=5%

Interventions:

• Preliminary discussion of pertinent information to be included within Transfer Summaries in order to identify relevant and important information to be communicated to receiving units/institutions.

• Based on feedback from the staff obtained via monthly staff meetings, a Transfer Summary Peer Review Form was developed to improve the communication of pertinent MH information to the receiving provider, which in turn impacts the continuity of care.

• Pre-test data (n=56) was collected to assess Transfer Summaries written prior to the development of the Transfer Summary Peer Review Form.

• Didactic Training was conducted on the specific content to be included in the Transfer Summaries.

• Post-test data (n=22) was collected in order to determine if the content of the Transfer Summaries improved.

Future Directions:

• Follow-up data will be collected within six (6)-months of collection of the post-test data with participation of the inpatient clinician supervisor and feedback being provided to the staff.

• Peer Review Transfer Summary Form Orientation - new staff/new hires will be trained on how to compose Transfer Summaries via the essential content included within the Peer Review Transfer Summary Form.

• Propose standardization statewide regarding documentation of Transfer Summaries with the implementation of Didactic Seminars to train inpatient and outpatient staff at other institutions.
Employment Information:

Tiesha Brown, HR Generalist
Phone: 732-235-9412
Email: browntj@umdnj.edu

Handles all non-nursing titles (includes Physician Specialists, Physician Assistants, Dentists, Optometrists, UCHC Secretary, Mental Health Clinicians, Occupational/Recreational Therapists)

Christine Tsirikos, HR Generalist
Phone: 732-235-9402
Email: tsirikch@umdnj.edu

Handles all nursing related titles (includes RN’s, LPN’s, UCHC Technician I, II, Medication Aides, Nurse Assts., APN’s and Nurse Managers)

Benefits Information:

For employees hired BEFORE October 2008, direct calls to the New Brunswick Benefits Team:

Nancy Kiernan, Benefits Associate
732-235-9416
Charles Collard, Benefits Associate
732-235-9415
Lola Vickers, Benefits Representative
732-235-9417

For employees hired AFTER October 2008, Benefits processing is split between campuses:

Facility: EMCF, MYCF, NSP, EJSP, ADTC
Contact representatives on the Newark campus:

Takesha Ellerbie, Benefits Associate
973-972-1868
Robin Hynes, Benefits Associate
973-972-6071

Facility: CRAF, NJSP, GSYCF, MSCF, ACW
Contact representatives on the New Brunswick campus:

Nancy Kiernan, Benefits Associate
732-235-9416
Charles Collard, Benefits Associate
732-235-9415
Lola Vickers, Benefits Representative
732-235-9417

Facility: SWSP, BSP, SSCF
Contact representatives on the Stratford campus:

Celeste Rebardo, Benefits Associate
856-566-6162
Tamika Major, Benefits Representative
856-566-6168

For Employment Verifications, Name Changes, Time Accrual Questions:

Dorothy Copeland, HR Information Systems Specialist
732-235-9418
Mary Martin, HR Information Systems Specialist
732-235-9419

**All payroll questions should first be directed to the person who handles time-keeping at your site.

Visit the HR website for updated news, forms, policies and employment opportunities:
http://www.umdnj.edu/hrweb/

Christine Tsirikos, PHR
Human Generalist
UMDNJ - Human Resource
Just What is an Ombudsperson Anyway?

Pronounced Om-buds-person, the first ombuds position was created in Sweden in 1809 as a people’s representative to hear their complaints about the government.

Here at UCHC the Ombudsperson’s role is:

- **Independent** - Responsible to the vice president
- **Impartial** - Working to achieve resolution of problems. The Ombudsperson is not an advocate for any particular individual or group, but considers the rights and interests of all parties and advocates for a fair resolution of concerns
- **Informal** - An additional option to the formal grievance process, services rendered by the Office of the Ombudsperson do not replace the NJDOC grievance process
- **Confidential** - Acting only with the complainant's permission the fear of retaliation is diminished. Issues presented to the Ombudsperson remain confidential unless a release of information is obtained

The Ombudsperson **does not**:

- Conduct formal investigations
- Change rules, policies or procedures
- Participate in any formal hearing or grievance process
- Provide legal advice
- Supersede the authority of the organization’s executives and officials

The Ombudsperson’s role is also to analyze trends in inmate complaints and provide feedback toward identifying areas of their concerns. It is believed that improvement in these identified areas will likely increase inmate/patient satisfaction and decrease liability because:

\[
\text{Client Satisfaction} = \text{Good Client Relations} = \text{Improved Outcome}
\]

Each NJDOC site has an Ombudsperson so, if you haven’t met yours yet, you really should. They are:

Peggy Powell (ACWYCF)  Adeline Varriale (ADTC)
Marie Gonzalez (BSP)  Lolita Brown (CRAF)
Colleen Courter (EJSP)  Lerone Smartt (EMCFW)
Teresa Marshall (GSYCF)  Susan Sweet (MSCF)
Tracy Fisher (MYCF)  Joanne Howell (NJSP)
Gaynor White (NSP)  Deborah Vasile (SSCF)
Anthony Thomas (SWSP)  Elizabeth Topol (Central)

Feel free introduce yourself. They’re there to help.

Marci L. Masker, PhD, LCSW
Clinician Administrator
Southern Region
NOTES FROM AFGHANISTAN

Monday, December 14, 2009 1:20 pm, Bagram, Afghanistan

This is what I see every morning on my 2 minute walk to work. It's surreal to think this place is a war zone.

I had to quickly master transporting patients from point of injury to the nearest medical treatment facility for stabilization then to a long term center. I memorized locations of Medical Treatment Facilities, Task Forces, Battle Task Forces & the 14 providences in the East Region of Afghanistan. I brief the Joint Operation Center (JOC) daily & expected to use the correct pronunciation for the regions. Those who know me understand this hasn’t been an easy task!!!

Tuesday December 15, 2009 8:30 pm

Accommodations are better than on Survivor! I share a long, narrow room made out of tin with a young AF Captain. We go outside, down stairs & walk in the bitter cold to use the bathroom. Lucky shower #3 seems to have hot water most of the time & thank goodness the smell doesn’t cross the internet…it’s horrific... I miss my home.

Friday, December 25, 2009, 1:15 am

I went on an 8 mile walk/hike with 3 Marines, 1 Army guy and a British Captain on Christmas Eve. They wore rucksacks & flax vest weighing about 30 pounds. I wore my PT (physical training sweat suit) w/ sneakers, no vest or additional weight except for weapons.... maybe 2 extra lbs. I kept up with them the whole time.... they were impressed. Not because I’m a girl but because I’m an AF Officer...we Air Force folks get no respect when hanging with the Army or Marines. After the walk we went to the coffee house for some Christmas cheer; Vanilla Chai for me & the Brit, fruit smoothies for the Marines. The food is healthy or unhealthy but after awhile it all tastes like Styrofoam. I’m working today 8am -8pm it should make the day go fast. Miss everyone.

Friday, January 1, 2010 00:02

HAPPY NEW YEAR!!!!!!! (We’re 9.5 hrs ahead of NY) Have a drink on me! E-mails, letters & packages from the states are the highlights of the day for the troops on ground. Problems from home cause upset & frustration, but at the end of the day there’s only so much that can be accomplished from this end. The time difference causes issues when trying to resolve problems by phone. Voice systems are inconvenient when trying to reach the correct person at the other end. There should be a teleprompt saying, ‘If you’re calling from a warzone press 7 for immediate assistance.’ Maybe that would hurry up the process on a 30 minute usage limit.

Sunday, January 24, 2010, 11:30 pm

Thanksgiving, Christmas & New Year’s came and went; to us it was just another day. Some decorations, more packages, but the ambiance of the holidays just wasn’t there. The weather’s warmer than normal for this time of year, hence the continued attacks and rise in number of causalities & deaths. Yesterday we lost at least 1 life in the 5 battle force locations in the eastern region. No nationality was spared with US, French, Afghanistan military & local nationals killed throughout the day during several Improvised Explosive Devices (IED) attacks. Not a good day.

As the days add up it’s said that we “hit a wall.” That’s when you’ve reached the limit of exhaustion, frustration and resolution. A time when the reasons we’re here become blurred & you start to wonder ‘WHY?” You see soldiers going home in boxes & Purple Hearts given out & you ask yourself ‘WHY the hell are we here,” and, is the cost at the end of the day worth it? Are we making a difference? Do these people even want us here? I hit that wall the other day and it took all I had not to scream & curse the day we entered this war! Then I remembered 9-11, all the people we’ve already lost and the few that do want us here. We’re making a difference in the world and as Americans, this is what we do. Thanks to all who have sent packages & e-mails. Please continue as those things are the lifeline to home. It provides us with hope that things will return to normal once we return home as we complete our time here.

About the author: Elizabeth Topol, MHA, is the UCHC Statewide Ombudsman who is serving a tour of duty in Afghanistan from October, 2009 to July, 2010. You may email her at etopol61@msn.com. Marci Masker helped contribute to this article.
General Information

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

W-2 Hotline
For questions regarding your W-2 form the contact number to call is: 732-235-9217

Effective January 1, 2010 the mileage rate is $.50 a mile

Join us in celebrating another accomplishment with one of our own. Don Eugene Gibbons, PhD, Forensic Mental Health Clinician at New Jersey State Prison has penned a chapter in the second edition of the APA Handbook of Clinical Hypnosis with a publication date of February 15, 2010. The complete reference is:


Feel free to offer your congratulations to Don and don’t hesitate to ask him some questions about this fascinating area.

February is “American Heart Month”

Use the clues to determine the jumbled Heart Diseases & Conditions.

AIMHTYHRRRA
Disorders of the regular rhythmic beating of the heart; may lead to heart disease, stroke or sudden death.

OSTLECHLERO
Soft, fat-like, waxy substance found in the bloodstream and in all your body's cells; there are two types: LDL=Bad, HDL=Good. As these levels rise in the blood, so does the risk for cardiovascular disease.

DESTEBIA
Causes blood sugar to rise to dangerous levels. Increases cardiovascular disease risk two to four times.

RAETH CATAKT
May come on strong and sudden, or slow with mild pain and discomfort. Symptoms include chest, shoulder, arm, neck or jaw pain, shortness of breath, dizziness, cold sweat, nausea and/or vomiting. Can cause permanent damage to the heart muscle — or death.

THARE UAFELRI
This term makes it sound like the heart is no longer working at all. However, this condition means that the heart isn't pumping as well as it should be.

“*You can lower your risk of heart problems by making changes to improve your health. Building a healthier future is a partnership between you and the doctors, nurses, pharmacists and other healthcare professionals who can help you change your health habits. You can play an active role in making these changes.*”

Information obtained directly from the American Heart Association. Visit www.americanheart.org to learn more.

Submit your articles by March 31st for the April newsletter