University Correctional HealthCare

June 2010

CRITICAL INCIDENT RESPONSE PROGRAM

UCHC is in the final stages of implementing the Critical Incident Response Program. This initiative will provide a structured format for reaching out to those who have been exposed to a critical incident in the course of performing their job. Specifics are detained below.

Purpose

To offer structured support to UCHC staff who have been involved in or exposed to a Critical Incident within 24 hours.

Planning Committee

Merrill Berger, PhD, Clinician Supervisor, CSL Program
Carol Christophillis, PhD, Clinician Supervisor, MYCF
Marci Masker, PhD, Clinician Administrator, Southern Region
Mechele Morris, PhD, Director of Training
Kathleen Penrose, RN, Staff Nurse
Anthony Tamburello, MD, Assistant Director of Psychiatry

Definition of Critical Incident

- Death of staff, inmate, officer
- Assault on any of those named above
- Anything out of the ordinary that causes someone to be threatened and/or frightened, i.e. where it is reasonable to believe the incident will result in trauma.

Notification

- Notification of the Critical Incident will come from Jeff Dickert, Rich Cevasco, Arthur Brewer, Rusty Reeves, Magie Conrad or their designee
- Staff will be offered the support of a responder ***if they so chose.***

Responders

- Responders are regional
- Clinician Supervisors and Nurse Managers will act as the Regional Team Leaders (RTL)
- The RTL will be responsible to contact the responder, provide contact information and arrange for a secure room on site for the responder to meet with the staff
- Responders will be multidisciplinary and ***not*** work in the facility with the staff member exposed to the Critical Incident in order to maintain objectivity
- If asked to respond on a weekend (Saturday or Sunday) the responder will be compensated at a per diem rate
- The responder's Clinical Supervisor must approve releasing them to respond

Response Modeled on Psychological First Aid

Published in 2006 by the Red Cross, Psychological First Aid offers a non-intrusive look at coping skills and meeting immediate needs. Specifically, the following will be the recommended protocol for our responders:

- Making a connection
- Being kind, calm, and compassionate
  - Ensuring the staff member has a safe way home
  - Contacting family members if necessary
- Listening
- Giving realistic assurance
- Encouraging good coping
- Helping people connect with EAP if requested
- Ending the conversation
- Taking care of yourself

Critical Incident Responders

Central Region

Carmen Hodges, PsyD, ACWYCF
Cori Feiner-Escoto, PsyD, Clinician Supervisor, ACWYCF
Paul Molnar, LCSW, GSYCF
Alice O'Shea, MD, GSYCF

Northern Region

Deborah Skibbee, PhD, Clinician Supervisor, EMCFW
Martha Jimenez, LSW, ADTC

Southern Region

Shannon Chanofsky, PsyD, SSCF
Lisa Little, MA, LPC, Clinician Supervisor

Please contact Mechele Morris with any questions, concerns and/or recommendations at morrisme@umdnj.edu or 609-292-2252.

ANTI-PSYCHOTIC MEDICATION THAT AFFECT BODY HEAT

Anti-psychotic medications may impair the body's ability to regulate it's own temperature. During hot and humid weather individuals taking anti-psychotic medications are at risk of developing excessive body temperature or hyperthermia, which can be fatal. Heat exhaustion is the most common heat-related condition. Heat stroke is a more serious condition of dehydration and salt depletion which can be life threatening.

Trade Name	Generic Name
Abilify	aripiprazole
Clozaril	clozapine
Geodon	ziprasidone
Resperdal	risperidone
Seroquel	quetiapine
Zyprexa	olanzapine
Haldol	Haloperiodol
Loxitane	loxapine
Mellaril	thloridazine
Moban	molindone
Navane	thiothixene
Prolixin	fluphenazine
Serentil	mesoridazine
Stelazine	trifluoperazine
Thorazine	chlorpromazine
Trilafon	perphenazine

HEAT STROKE

This occurs mostly during heat waves. Persons with chronic illnesses are most vulnerable. Heat stroke, the most serious heat illness, **can lead to death if left untreated.**

SYMPTOMS OF HEAT STROKE:

- Agitation, confusion, seizures, lethargy or coma (all may be first symptoms)
- High body temperature (102 degrees Fahrenheit or above)
- High blood pressure initially (shock may follow, resulting in low blood pressure)
- Rapid pulse and heartbeat
- Rapid, shallow breathing if person is moving about; slow and deep breathing if the person is still
- Hot, dry, flushed skin

TREATMENT:

As soon as you recognize the signs of heat stroke, take immediate action:

- Call 911 immediately
- Loosen or remove outer layers of individual's clothing
- Move to a cool place
- Use CPR if needed
- Replace fluids and sodium only under medical orders

HEAT EXHAUSATION

This can occur in both active and sedentary individuals. It happens suddenly, and may be quite brief.

A doctor should be called. Recovery may be spontaneous or intravenous fluids may be needed to prevent unconsciousness.

SYMPTOMS OF HEAT EXHAUSTION:

- Irritability or change in behavior
- Low or normal temperature
- Slight low blood pressure
- Rapid, full pulse and heartbeat
- Rapid breathing
- Cold, pale skin (may be ashen-gray)
- Profuse perspiration
- Dizziness, headache, and weakness
- Nausea, vomiting
- Cramps in the abdominal area or in the extremities

TREATMENT:

If a person displays symptoms of heat exhaustion, he or she should be:

- Moved to a cooler place as soon as possible
- Given water or other liquids immediately (there is no need for salt)
- Encouraged to rest for a short time

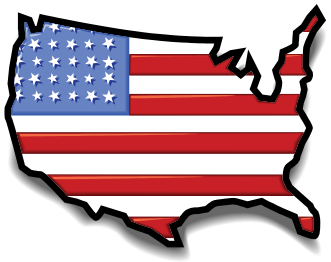
PREVENTION OF HEAT REALTED ILLNESS

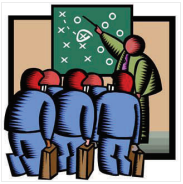
When in periods of high temperature and humidity, there are things everyone (and particularly, people at high risk) should do to lessen the chances of heat illness.

TRY TO KEEP COOL

Keep windows shut and draperies, shades, or blinds drawn during the heat of the day. Open windows in the evening or night hours when the air outside is cooler. Move to cooler rooms during the heat of the day.

- Avoid overexertion, particularly during warmer periods of the day
- Apply sunscreen lotion as needed
- Drink plenty of fluids (Avoid coffee, tea & alcohol)
- Dress in loose fitting, light-colored clothing
- Lose weight if you are overweight
- Eat regular meals to insure that you have adequate salt and fluids





Strategic Plan Update

As we come to the close of the UCHC fiscal year, it is time to take stock of our efforts toward achieving the goals set in last year's Strategic Plan; and to move forward in establishing new goals for the upcoming year. Overall, we have done well achieving the majority of our goals.

- Based on a 10 month period, we anticipate our actual expenses to be $144 million or approximately $10 million below budget. About one-third of the savings came from pharmacy, one-third from favorable hospital pricing and one-third from savings in various subcontracts and reduced reliance upon medical specialists.
- We have consistently exceeded the 40% benchmark established by NJDOC in treating our patients with diabetes with hemoglobin A1C's less than or equal to 7. We average almost 10% higher.
- Dental has expanded a cleaning program for inmates with diabetes to now include ADTC, NSP, EMCFW, MSCF & SWSP.
- We have far exceeded the 40% hypertension threshold of achieving blood pressures at or below 140/90 by almost 50%.
- For inmates with hyperlipidemia, we have been able to reduce LDL levels to less than or equal to 130, 60% of the time.
- Grievances resolved through March 2010 of this fiscal year reflect an approximate reduction of 17% from the prievious fiscal year. The adjusted annualized number of complaints based upon data through March 2010 is as follows: Medical down from 3,900 to 3,239 (17% reduction); Dental down from 247 to 201 (18% reduction); Mental Health down from 423 to 362 (14% reduction).
- Through May 2010 of this fiscal year UCHC medical/ nursing teams have achieved the 97% threshold for the 35 Objective Performance Indicators 88% of the time. In four of the months they exceeded this threshold 90% of the time or better.
- During the second half of this fiscal year UCHC mental health teams achieved the 90% indicator on average, over 95% of the time. For January it was 95%, February, 93%, March, 97%; and April 95%.
- Hospitalizations resulting from the need to repeat AV grafts and shunts have been reduced by 2/3 this past year.
- Within NJDOC we exceeded the 30% threshold for special needs inmates participating in group treatment. Transition groups have been made available for inmates moving from specialty mental health units to the general prison population. Within the Juvenile Justice Commission (JJC) we exceeded the 40% threshold.
- Our Community Supervision for Life groups enhanced their standardized, cognitive/behavioral group treatment program.
- Nursing implemented the Multiple Chronic Disease Self Management Program. The program is designed to encourage inmates with chronic medical conditions to take increased control of the management of their medical conditions, thereby reducing the risk of medical complications. In an effort to expand, program facilitators have been trained at each of the adult prisons.
- The telemedicine program has yet to achieve its goal of reducing specialty physician visits to out-of-secure care. However, starting in September 2009, the use of telemedicine for emergency evaluations has resulted in a reduction in emergency room visits. There has been an approximate 20% decline per month in emergency room trips from an average of 66 per month for the first 10 months of the Agreement to an average of 52 per month for the last 9 months.
- Average Inmate Satisfaction Survey scores on mental health services was 3.74 where 3 indicates "good" and 4 indicates "very good." Overall, the small improvement in these scores corresponds with a reduction in inmate complaints about mental health services. UCHC scored above the 3.9 level in professionalism, respect for confidentiality, and courtesy shown by staff to the inmates.
- Drs. DeFilippo, Yuhasz, and Reeves trained mental health staff on the "Impact of Brain Injury" on November 11, 2009.
- Regional training was made available for medical/ nursing staff on HIV education, wound care, splints, managing difficult patients, dementia, emergency medical assessments, and SBAR (Situation-Background-Assessment-Recommendation) communication between primary care providers and nursing staff.

Strategic Plan Update (Cont'd)

- Staff satisfaction results for medical and mental health teams this last year was 3.77. This is comparable to past results from our mental health team and the results achieved by staff working at UBHC.
- The Forensic Psychiatric Fellowship Program has two residents/fellows starting in June. NJDOC supports three psychology interns and JJC supports one.
- Three additional masters' level mental health interns are working within JJC secure care.
- Drs. Reeves, Lieberman, and Vyas published an article, "Creation of a Metabolic Monitoring Program for Second Generation (Atypical) Antipsychotics," in the October issue of the Journal of Correctional Health Care.
- JJC mental health staff began receiving funding to conduct resident risk assessments for the New Jersey State Parole Board at the time of their Judicial Restriction date.
- Mental health intakes for NJDOC now include the Brief Mental Health Screen and JJC intakes include the MAYSI II which are standardized mental health assessment tools.
- The decision was made for UMDNJ/UCHC to assume responsibility for JJC medical services effective January 2011.
- UCHC is providing tele-psychiatry to JJC remote residential community homes.
- UCHC had 39 projects in last year's PI Fair.

Milestones not achieved that will require further attention in our next fiscal year are:

- More consistently achieving undetectable viral loads for inmates on three to six months of HAART treatment.
- Achieving the 97% Objective Performance Indicator threshold at least 90% of the time.
- Reduced reliance on off-site specialty consults through increased reliance on telemedicine.

Other areas of attention include:

- The Implementation of an evidenced-based group treatment curriculum for inmates with special mental health needs and problems related to substance abuse.
- Development of medical benchmarks for the treatment of asthma and seizure disorders.
- Assuring that >95% of all staff members requiring CPR certification remain current throughout the year.
- Assessment of the mental health and medical programs within the JJC, designing plans to improve their programming and assuming the responsibility for their medical services.
- Assessing the NJDOC health care system to determine compliance with HIPAA and addressing any identified problems.
- Designing HIPAA related training for UCHC staff that is relevant to a prison health care setting which provides care to inmates and training all staff in this curriculum.
- Training staff on assessment and intervention with inmates who have been sexually assaulted.
- Establishing chronic disease self management groups at all 13 NJDOC prisons.
- Further reduction of medical complaints by 10%.
- Development of a system to assure key recommendations from the morbidity and mortality reviews are implemented.
- Successful completion of all NCCHC site surveys.

Staff members are invited to forward their suggestions in our efforts to continue to improve our services through Strategic Planning to Jeff Dickert (dickerje@umdnj.edu).

Jeff Dickert, PhD
Unit Vice President

Ask Mechele

Dear Mechele,

Never in a million years did I ever think that I'd be in this kind of situation. I've been working in the prison for years with no problem. I love my job and the inmates like me because they say they can tell I don't judge them. As a matter of fact, I've had more conflict with the officers than the inmates. Anyway, I have a good family life and look forward to coming to work every day. Well, here's my problem. There's this one inmate that I've had regular contact with for around 6-10 months now. He's pretty shy but very polite and it took him awhile to even say anything other than hello. Over time we've had brief conversations but it's now to the point that he seeks me out to talk about his life and problems he's had in the past, and he's had to deal with a lot. I've noticed that many of the things he talks about I can relate to my own life too.

We share a love of cooking and I think that's probably where I first got into trouble. We began sharing our favorite recipes so when I told him I was planning to make one of my specialties over the weekend; he said that he would love to have "just a little taste." We both laughed about that statement, but when I began packing away the leftovers after Sunday dinner, I found myself putting a little aside. I managed to get it inside the facility on Monday and admit I got kind of a rush when I realized I'd pulled it off. I couldn't wait to have him sample my special dish. He was so excited and grateful calling my gift, "a little slice of heaven in hell."

When weeks went by without him asking me for anything I was sure that he was simply a good guy who had taken the wrong path because of his life circumstances. We continued our talks and it was several months later that he asked me to mail a letter for him since he missed the mail pickup. Knowing how much he looked forward to hearing from his mother and since the food issue never came back to haunt me, I figured it wouldn't do any harm. I was so wrong!!!!! I know you probably think the problem is him but it isn't…it's me.

I've reached the point where I can't stop thinking about him and I know the feeling is mutual. I've bought him things here & there, food, jewelry, a couple of dollars…nothing illegal like drugs or cell phones. I truly believe he cares for me. Last week for the first time he kissed me and I felt like I was a teenager again. I know this is sooo wrong, but I feel almost powerless when I'm around him. I schedule my entire day around being where we can sneak a few minutes to ourselves. The stress of this situation is driving me crazy…I have trouble sleeping, I'm losing weight, I could care less about my husband…it's like I have an addiction. I know it's only a matter of time before somebody catches on to what's happening but I seriously don't think I have the willpower to stop it. I'm considering quitting my job and then just seeing him out in the open. What do you think, have I completely lost it?

Caught Up

Ask Mechele

Dear Caught Up,

While I'm typically blunt by nature, I do attempt to temper my forth rightfulness so as not to appear completely harsh or intolerant. However, your letter is cause enough for me to set all that aside. **YES, YOU HAVE COMPLETELY LOST IT!!!!!!!** Based on what you've said here, I'll be amazed if you're still employed by the time this newsletter finds its way into your hands. For the sake of clarity I'm going to address your letter point by point. My hope is that you may still have some grain of objectivity that might help you understand the impact of what you've done. What you describe is almost a text-book version of what not to do when you work in prison.

First, you talk about the inmates liking you and that they treat you better than the officers. As service providers in prison, being liked shouldn't be a focal point. Having a good rapport…ok, but I don't have to be liked to do my job well. As for the officers and the inmates, it's probably not a good idea to do comparisons as the two are apples and oranges. The inmates have demonstrated their inability to adequately function and adapt in society. The officers are sworn public servants charged with maintaining safety and security. Some seem well suited to their profession and others don't, but that could be said of any profession.

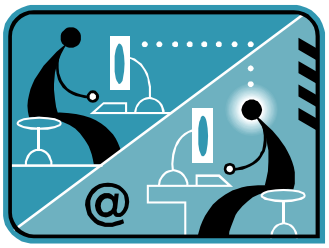
Next, you're engaging in personal conversations with this inmate. Having never revealed your position, I'm not sure whether or not these conversations are within the course of your job, but even if they are…you're taking this inmate's story and personalizing it with your own. Empathy has its place, but for you it appears that you're skating on thin ice and treating your conversations as some sort of bonding experience. I wholeheartedly agree that you took things to a new level when you brought contraband to the inmate. **That's a criminal offense**, and the fact that you got a thrill out of it means that you've begun to abandon all rational thought. And please, don't try to justify that what you've done is not serious because of the type of contraband. You're guilty of bring illegal items into the secure perimeter of a state prison facility. By doing this you've placed everyone at risk.

You have also deluded yourself into believing that this inmate is being completely truthful. Have you ever considered the possibility that you might not be the only person bringing him goodies? A clever manipulator studies their prey over time to learn their interests, woes and level of compassion. Inmates often look to better their position and you are now a ripe candidate for extortion as this inmate now has items in his possession that could easily be traced back to you. The fact that you've written me this letter is the only glimmer of hope I see in this dangerous scenario. I take your asking for advice as a sign that you know you're in some serious trouble. And, if you don't take immediate action, you're about to lose more than sleep, weight and/or your family…you're jeopardizing your freedom.

My advice to you is simple. Arrange a meeting with your supervisor and/or a member of the DOC Special Investigations Division (SID) and sing like a canary. Confess to what is and has happened up to this point now, before you do something that could be a matter of life and death. Maybe you can be transferred to another facility. But you'll definitely be judged more favorably by coming forward on your own than if your duplicity is discovered or the inmate gives you up. The most you may lose right now is your job. Continue on with this craziness and you risk becoming a resident at Edna Mahan Correctional Facility for Women. You can find another job, but do you seriously want to be wearing khaki and a state number? And what if someone gets hurt, how would you be able to live with yourself?

Confession is good for the soul, do the right thing.

**Since no letter was submitted to Ask Mechele this month, I took some poetic license with the scenario above which was taken from an actual case.*



Technology Corner

with Leo Agrillo

Forms, Forms and More Forms

In today's work environment, the ability to perform assigned tasks often depends on filling out and submitting the correct form. Unfortunately for us, at this particular place in time most of these forms can't be done electronically, so for the time being we have to go the "print them, sign them, submit them" route.

New Jersey Department of Corrections (NJDOC)

Internet Access

Internet access to the DOC Network requires that you complete the correct form, have it signed by your supervisor and submit the original (faxed copies are not acceptable). For existing employees, those returning from leave, or those who have lost their privileges due to inactivity, an Attachment 3.0 Form must be completed and submitted. This form is available from the DOC Intranet or from your department's support staff. To verify whether or not you have internet access go to www.google.com. If you successfully reach this page, congratulations…you have access; if you receive a Forbidden Error 403 you don't have internet access; but you can get it by submitting the 3.0 Form as described above.

For new employees hired after April 1, 2010, the Attachment 2M Form provides internet access (Form 3.0 is not needed if a 2M was done). To verify internet access follow the same steps mentioned above. If you don't have internet access contact the DOC help desk by phone at (609) 984-8288 or email (helpdesk@doc.state.nj.us) and inform them that your 2M Form was submitted and you require internet access.

Local Drive / Network Drives

A Local Drive is a disk or tape drive directly attached to the user's computer. The term is used to differentiate the drive from one on a server in the network which would be called a "network drive" or "remote drive."

Shared Network Drive

The G: drive is our shared "network drive" on the DOC Network. All users can assess parts of this drive. Access to the G: drive is achieved by clicking on My Computer and then on the drive name. The full name of the G drive is "Groups on 'Dochubgrps\Grps' (G:)." When you click on this drive you'll see one or more folders depending on your access, which is based upon your business need. Medical is the first folder that can be accessed. Clicking on Medical will show you additional folders to access. Some of the sub-folders under Medical are AllMed, RecRegs OPI, inmate complains, Dental and Billings. All Med can be accessed by all UCHC staff and there are more sub-folders below. Access to the other folders for the Medical records data base (Objective Performance Indicators {OPI}, inmate complaints, Dental and Hospitalization) can be granted if you have a business need by sending an email to Lisa Debilio debilila@umdnj.edu.

Personal Network Drive

Every user is given a personal network drive named (H). Its function is to store files for a particular user. This drive is labeled with your login name, for example: ""Cmsagri on 'Usrs_server\Usrs\Users\Medical'(H)." Sub-folders are predefined on this drive and it may only be accessed by the assigned user.

Store Files on the Network

All files should be stored on network drives as these are backed up nightly and allow access from any DOC computer. If you store files on a local computer and it crashes, all your files will be lost and there is no way to recover those files. A word to the wise: *Store your files on a network drive*.

Tip of the Month!

Have you set up your secret questions and answers?

Both UMDNJ and NJDOC use secret questions to reset a forgotten password without having to call the help desk. If you haven't already done so, please make sure that you have entered and answered secret questions for both networks.

The New Jersey's Inaugural Behavioral Health Care Quality Improvement

On June 2, 2010, University Behavioral HealthCare (UBHC) sponsored its first PI Fair where all New Jersey mental health organizations had the opportunity to display their PI initiatives. The winner would walk away with the coveted Richard Codey Behavioral HealthCare Trophy. Now, in case you're wondering why the trophy was named after Senator Codey, it's because of his significant contributions to New Jersey mental health services which really came to the forefront during his stint as governor. This inaugural event brought out over three hundred attendees and showcased the PI projects of 21 agencies. There were 57 PI projects in total and 17 were from our own UCHC (see below).

First place went to the PI team from Ancora Psychiatric Hospital for their project entitled, "Tools to Replace Two and Four Point Restraints." The Ancora team successfully demonstrated how they reduced their use of restraints by more than 50% on one of their hospital units. Ancora will keep the Richard Codey Behavioral HealthCare Trophy until they pass it on to next year's first place winner.

There was a tie for 2nd place between The Division of Schizophrenia Research at UBHC and Atlantic Care Behavioral Health in Egg Harbor. UBHC was recognized for their project, "Implementation of Universal PTSD Screening in SMI Clients." Atlantic Care won for their presentation, "Enhancing Access to Outpatient Services and Client Engagement." South Jersey Healthcare in Bridgeton took 3rd place for their project, "Expanding the Least Restrictive Continuum, an Effort to Help Reduce the Use of Restraints and Violence." Finally, two honorable mentions were awarded. Meridian Behavioral Health in Wall Township was acknowledged for their project, "Working Your Way to Recovery" as was the Christian Health Care Center in Wyckoff for, "Prevent a Fall, Save a Life."

Overall, the program was a huge success and this was confirmed by some of the comments overheard as the crowd began to disperse. The one that most reflected the mood of the day was..."just wait until next year..."

<u>UCHC Projects:</u>

1. ACW, Team Leader: Coriann Feiner-Escoto, Project Title: Groupies-Improving the Quality of Care through Groups
2. BSP, Team Leader: Wayne Blodgett, Project Title: Diagnostic Factors Associated with Suicide Watch Status
3. EJSP, Team Leader: David Kalal, Project Title: To Refer or Not to Refer
4. JJC, Team Leader: Julie DeLuccy, Project Title: Fire & Desire
5. JJC, Team Leader: Mike Brady, Project Title: Increasing Participation of Families/Children Who Commit Sex Offenses
6. JJC, Team Leader: Tara Lally, Project Title: Early Identification of Residents with Problematic Behavior
7. JJC, Team Leader: Jason Fleming, Project Title: Revision of Anger Management Curriculum Utilizing the STAXI-2
8. MYCF, Team Leader: Carol Christofilis, Project Title: Effectiveness of Group Therapy
9. MYCF, Team Leader: Carol Christofilis, Project Title: How Inmates Cope in Detention
10. NJSP, Team Leader: Kerri Edelman, Project Title: Bye Bye Birdie
11. NJSP, Team Leader: Kerri Edelman, Project Title: Charting Growth
12. NSP, Team Leader: Carlos Martinez, Project Title: Compliance with Administering Metabolic Monitoring Protocol
13. NSP, Team Leaders: Gregory Benson & David Maxey, Project Title: Lets Meducate! Addressing Refusals on the IP Unit
14. NSP, Team Leader: Carlos Martinez, Project Title: Compliance with Administering Psychotropic Injections
15. Statewide, Team Leaders: Deborah Skibbee & Lisa Little, Project Title: Tracking Reentry of TCU/RTU Inmates to GP
16. Statewide, Team Leader: Anthony Tamburello, Project Title: Safely Removing Seroquel from the UCHC Formulary
17. SWSP, Team Leader: Karen Nevins-Goldman, Project Title: Get Out of Your Cell-Motivating Inmates to Improve Group Compliance

Thanks to all who for participated in this event!

Lisa DeBilio, PhD
Quality Improvement Director

THE FISH POND

This month the "Fish Pond" spotlight is on the new Special Treatment Unit at the Avenel Annex

On 5/12/10, all of the civilly committed residents of the Special Treatment Unit (STU) in Kearny were moved to the building that had previously housed the East Jersey State Prison (EJSP) Administrative Segregation (AdSeg) inmates. Moving day started at 5:00am and the last of the residents and their property were moved out by 3:00pm.

The Medical Unit had packed up earlier and most of the items were already moved to the new location and the Special Treatment Annex on the Monday prior to the big move. In the midst of all this madness, the medical staff continued to provide care and treatment to the residents while working with limited space and supplies. In spite of not being given space in the new building, the STU staff were expected to be up and running in time to administer insulin at 4:00pm; so they set about coordinating medical treatment from the **very small** STU Annex Medical Unit.

While to some this might have been viewed as an insurmountable problem; that wasn't the case for this staff. They assessed what needed to be done and proceeded to take control of this difficult situation. In addition to unpacking, organizing and providing care, they worked closely with the DOC to organize insulin and medication lines. In between, they administered care to several residents and officers who had been injured when a fight broke out in the dining room.

The nurses assigned to the area for moving day, Edith Feldman, Beth Ward and Lorena Zapata did an outstanding job and their commitment to their patients, co-workers and jobs was evident. They went way above and beyond in maintaining the continuity of care for the residents by pulling together to make things work. Ms. Ward was even observed unloading a truck in search of the medication cart. We commend them all for true team spirit and a JOB WELL DONE.

Submitted by:
Dolores Guida, RN
Regional Manager, ADTC/EJSP

Special thanks to Department Manager Kathy Gill, RN and Regional Manager Dolores Guida, RN for their leadership in this endeavor.

Magie Conrad, DNP
Administrator of Nursing

Revised Central Office Staff Directory

Updated 6/10

	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	609-943-4373	hoovenem
	609-484-4000 pager	
	609-828-5706 cell	
Dolcie Sawyer	609-292-2352	sawyerdo
	609-484-4001 pager	
	201-407-3119 cell	

Training Team		
Mechele Morris:	609-292-2252	morrisme
Stephanie Turner-Jones	609-292-2226	turnerst
Denise Gould	609-292-1340	goulddj

Medical Records		
Cindy Romano	609-292-1393	romanoci

Infectious Disease		
Elliot Famutimi	609-292-3365	famutiel

Statewide Ombudsperson		
Elizabeth Topol	609-292-9095	topolcl

Telemedicine		
Leo Agrillo	609-984-1725	agrillle
	609-413-6944 cell	

Quality Improvement		
Lisa DeBilio:	609-292-5707	debilila
Debra Crapella	609-984-5843	crapelda
Debbie Pavlovsky	609-292-6478	pavolsde

Scheduler		
Patti Ford	609-984-1012	fordpa
Jose Torres	609-292-6953	torresj9
Patti Reed	609-777-1510	reedp1

CTI		
Megan Price	609-292-1385	pricemb

Rebecca Cozzens	856-459-8034	cozzenra
Samantha Pezzella	856-459-8453	pezzelss

UMDNJ Human Resources

Employment Information:

Tiesha Brown, Human Resource 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, Human Resource 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
Krystyna Plonski, Benefits Associate
973-972-6085
Seiichi Mano, Benefits Representative
973-972-5314

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 Resources Generalist
UMDNJ - Department of Human Resources

ANNOUNCEMENTS

UCHC Excellence Award

All Staff,

We recently received a suggestion at a community meeting to establish an employee recognition program for outstanding achievement, performance and/or significant contributions to the overall enhancement of UCHC. Toward that end, starting in August we will be presenting Service Excellence Awards to outstanding staff who perform their jobs exceptionally well; and we will be asking you to make the nominations. The criteria for nominations should include the following:

- Adhering to the values in the UCHC mission
- Exceptional customer service
- Volunteering to do things above and beyond their job duties
- Making positive contributions to the overall success of the UCHC team

Six front line staff and one individual in a supervisory position or higher will be selected annually. One award will be presented at the community meeting during the months of: February, April, June, August, and October; two awards will be presented in December. The Nomination Form is in this newsletter for your convenience. After completing the form, please fax it to Lisa DeBilio @ 609-341-9380 no later than Friday, July 16th.

Congratulations to our own Jennifer Storicks from the Central Office staff who recently graduated from Burlington County College (BCC) with an Associate of Science degree in Criminal Justice. And as if that isn't enough, Jen's sister Jessica is also a new BCC grad with an Associate of Applied Science degree in Nursing. Other than their proud family, it looks like someone else may be a big winner as Jen's sister Jess is applying to come on board at UCHC.

The following UCHC staff promotions will fill two vacant Clinician Supervisor positions.

Dr. Ken Vaughn will be Clinician Supervisor at Garden State Correctional Facility (GSCF). Ken has many years of correctional experience and has been serving as Dr. Laura Tahir's right hand person at GSCF.

Dr. Dave Wasser will be serving as Clinician Supervisor for the Southwoods State Prison (SWSP) Outpatient Program. Dave has been with UCHC since 2005 and spent many years prior with CFG and CMS. Dave helped out in the past by being the "lone clinician" to close Riverfront State Prison.

Please congratulate them on their new positions.

Please join us in celebrating another accomplishment with one of our own. Don Eugene Gibbons, PhD, Forensic Mental Health Clinician at New Jersey State Prison is senior author of the induction chapter in the second edition of the *Handbook of Clinical Hypnosis,* published in 2010 by the American Psychological Association. Dr. Gibbons, having already published five books, was the first to identify the process of *hyperempiria,* based on suggestions of alertness, mind expansion, and increased alertness and sensitivity, in contrast to traditional hypnosis, which is based on suggestions of relaxation, drowsiness, and sleep. The complete reference is:

Gibbons, D. E. & Lynn, S. J. (2010). Hypnotic inductions: A primer. In S. J. Lynn, J. W. Ruhe, & I. Kirsch (Eds.) *Handbook of Clinical Hypnosis, 2nd ed.* Washington, DC: American Psychological Association. Feel free to offer your congratulations to Don and don't hesitate to ask him some questions about this fascinating area.

Submit your articles by June 30th for the August newsletter

UCHC Excellence Award

Nomination Form

Guidelines:

1. A University Correctional HealthCare (UCHC) employee may nominate any other employee. (Administrative Staff are not eligible for this award). Individual nominees must have at least met their probationary requirements.
2. Nominations should reflect the values stated in the UCHC mission, demonstrate exceptional customer service (to clients, staff and vendors), volunteer to do things above and beyond job duties, and/or make positive contributions to the overall success of the UCHC team.
3. Six staff will be selected annually for this award (3 every 6 months) and one staff from a supervisory position or higher will be selected annually.

Name of employee being nominated:_____

Title: _____ Facility/Unit:_____

(Required)

☐ Excellence in Direct Care ☐ Excellence in Support Service

Explain in detail why you are making this nomination:

_____

_____

_____

Note: If additional space is needed, please use the back of this form or send an attachment via e-mail.

Signature of Nominator: _____ Date: ____/____/____

Print Your Name: _____

Please send this completed form to Quality Improvement, Attn: Lisa DeBilio