The ACHSA 2014 Multidisciplinary Educational Conference

CORRECTIONAL HEALTHCARE: AND ALL THAT JAZZ

Interested in attending a great educational conference on correctional healthcare? Make plans to meet us in New Orleans to share all the latest trends in medical care from behind the walls. A comprehensive program is planned to meet the needs of the diversity in the membership of our national organization. Mark your calendars now!

But the conference is not all work. Take some time while you are in New Orleans to enjoy all the sights and sounds that the historic French Quarter has to offer. Or perhaps relax with some coffee and beignets at Cafe du Monde for those of you with a sweet tooth. The art and jazz on Jackson Square can provide an unforgettable evening of entertainment. The creole cookin' just doesn't get any better than in the heart of the quarter!
A MESSAGE FROM THE PRESIDENT

Mary Raines, RN, BSN, CCHP

I am not sure how it came to be fall already. Summer has vanished in a blur and if your schedule has been like mine it does not seem possible. In addition to many things such as fall sports and holidays, fall also brings another favorite occasion. Fall is the time that the State Chapters of ACHSA hold the majority of their local conferences.

There is a variety to choose from and anyone is welcome to attend regardless if you are a member of the State Chapter. The Southeast Region Chapter will be meeting at Jekyll Island in Georgia September 27-29. The same weekend if you are on the opposite side of the continent, the Oregon Chapter will be meeting at Spirit Mountain Resort outside of Salem, Oregon. Knowing these are occurring soon and may be hard to plan for on short notice, California/Nevada will be hosting a meeting in Sacramento, California, November 7-8.

The State Chapter Leaders spend many hours planning these conferences. Each of the conferences includes a jam-packed schedule of learning and fun. It is always a great time to meet old friends and to make new friends. It is a great way to learn about correctional health and gain information to help with the day-to-day challenges. It is a great way to put a face with that voice you speak to on the phone and makes that next phone call more enjoyable. The State Chapters of ACHSA are what makes ACHSA. It is the grass roots, reaching out to everyone.

As we look past the fall, the National Board has scheduled the 2014 Annual Conference for March 6 – 8, 2014 in fun filled New Orleans, Louisiana. Pre-conference sessions will be on March 6th, with the main conference commencing on March 7th. There is ample time and opportunities to become involved. Please contact Stephen Mitchell, Executive Director or any of the members of the Board. It takes the members of the Association to make our organization successful.
The Affordable Care Act (ACA) signed into law by President Obama in March 2010 affects most Americans, including those who are incarcerated. In addition to attempt control over raging healthcare costs, the ACA is designed to put uninsured folks into the healthcare system via a “medical home.” This concept means patients will have a place identified for them to seek care. This will hopefully eliminate use of the local emergency department for healthcare needs that are not urgent or emergent. In addition, the ACA will pay for preventive screening with no cost to the patient in most cases, including things like mammography and pap smears for women and screening colonoscopies for both men and women.

Providers and some insurance companies will participate in either a state-managed plan or a federal-managed plan. Grant monies are available for a variety of care-based programs and development of new ones. Enrollment for clients into contracting entities in states starts October, 2013 for patients to begin receiving care in January, 2014. Correctional facilities may have inmates who will be seeking care after parole or who need care while incarcerated via the ACA.

Many inmates who are Medicare (federally funded) or Medicaid (state funded) may be eligible for enrollment in these programs, even if they are now not participants. Individuals that are 65 years or older or permanently disabled may already be on Medicare. Medicaid is being expanded in most states to cover more uninsured patients than ever before. This means that inmates may already be or may become eligible under the ACA for care, a medical home and coverage enrollment.

There are currently about 1200 health clinics throughout the country that already serve uninsured populations. They are called federally qualified health clinics (FQHC). These clinics are already supported by and receive federal monies from the Health Resources and Services Administration (HRSA). These clinics form the foundation of the care management structure for the ACA. HRSA states that one out of every 15 people living in the US relies on one of these clinics. In many parts of the country, over 50% of the clinic population already being treated has previously been incarcerated. Therefore, these clinics are where most folks on parole are getting care, unless they are eligible for other types of insurance coverage.

What drives the care process in the FQHC clinics is strong clinical and community-based case management. Many of the clinics use mid-level providers, particularly nurse practitioners. Clinical case management by RNs and community case management by licensed clinical social workers (LCSW) is what keep costs down, chronic diseases under control and patients on needed medications. FQHCs also provide mental health and chemical dependency care, and other patient education programs like domestic violence, safe sex and needle exchanges.

Structured case management also needs to drive the provision of care within correctional facilities. Correctional healthcare centers are well positioned to cope with the ACA in some cases. How can you tell if your facility is prepared?
Correctional ACA Checklist:

- Your facility has an structured and aggressive clinical case management program overseen by RNs that manages chronic disease populations.
- Your facility has aggressive utilization management of the care given to inmates outside of correctional facilities, e.g. hospitals, medical specialists to ensure appropriate and cost effective use of resources.
- Your facility uses LCSWs to provide community case management for vocational training, housing, jobs for parolees. These are face to face meetings with inmates prior to parole or at the first parole meeting.
- Your facility uses nurse practitioners in the existing correctional health treatment center, or other mid-level providers.
- Your facility utilises an electronic health record (EHR)
- Your facility uses RNs, LVN/LPNs and MAs to provide care within your correctional treatment center within their licensed scope of practice, and that legal scope is supported by all policies and procedures.
- If your contract out healthcare services for your correctional facility, your contract includes components of contracting for ACA, scope of practice, state and federal regulations requirements and operations practices.
- Your correctional healthcare contract for services includes language and strategies about ACA implementation in your community.
- Your correctional healthcare staff has met and discussed ACA with corrections staff.

If your facility has these components, you are well situated to deal with the ACA. If not, use the list as a roadmap to gear up. The ACA is coming....ready or not!

Resources/Works Cited

http://www.hhs.gov/healthcare/facts/bystate/id.html
www.hhs.gov

Not a member of ACHSA yet? Do it today!
Log onto ACHSA.org and click on the “membership” tab from the toolbar. We have made it easy to become a part of our organization.

The Member Organization for Correctional Healthcare Professionals!
Southeast Chapter News Update

At this writing we are all looking forward to our Fall Conference at beautiful Jekyll Island, Georgia. We have an outstanding program prepared with CEUs and CMEs offered for our participants. We will all enjoy networking with colleagues and meeting new members who have joined our chapter since the last conference.

At our last conference, the members decided to open up membership in our chapter to our fellow correctional health care workers not only from all over Georgia, but also South Carolina, North Carolina, Florida, Alabama and Tennessee. We know they will find our conference enjoyable and will find the educational sessions interesting.

Georgia has joined with many other states in passing legislation requiring Registered Nurses and Licensed Practical Nurses to provide proof of Continuing Education Units with license renewal. This will begin for nurses in Georgia with the renewal of licenses in January 2016, so beginning in January, 2014, nurses will begin to keep track of CEUs earned over a two year period. RNs will be required to have 30 CEUs and LPNs will be required to have 20 CEUs per two year period. We encourage RNs and LPNs across our state to consider membership in our Southeast Chapter. Each year we work very hard to provide educational sessions that offer CEUs and CMEs for our membership and the cost is included in the conference registration fee. What a marvelous opportunity to have a great time among colleagues and friends and also earn the CEUs necessary for licensure.
Letter from the Editor

Perplexing Pain

Not even one week after seeing another of many inmates with chronic pain I was fascinated to read the new Perspective piece in the New England Journal of Medicine (NEJM) by Philip Pizzo, M.D. describing his personal tribulations coping with chronic low back pain. (NEJM 369;12 September 19, 2013). Dr. Pizzo had lived a pain free life, running one to three marathons each year until twisting his back loading a suitcase on to an airport conveyer belt. After this injury he suffered chronic back pain localized in the mid-buttock with radiating discomfort and loss of left hamstring strength. Dr. Pizzo reports that he was subjected to cursory exams and poorly reasoned conclusions. He suffered life-threatening episodes of respiratory depression from narcotics. He became depressed. Finally, a year into suffering from his pain and treatments, electromyography and nerve conduction studies suggested that his symptoms were caused by entrapment of his sciatic nerve. Following a surgical procedure Dr. Pizzo believes he is improved.

Prior to suffering pain himself, Dr. Pizzo had chaired an Institute of Medicine committee on “Relieving Pain in America” and coauthored in 2012 a NEJM article about alleviating pain in the US. He was a physician without pain writing authoritative articles about pain suddenly stricken by pain which none of his physician colleagues could relieve. It is hard to not see some irony in the circumstance of a pain specialist afflicted with pain. But Dr. Pizzo’s brave telling of his story imparts at least four lesson to all of us working in correctional medicine of great importance.

First, I am reminded of the saying: Don’t judge a man until you have walked a mile in his shoes. The treatment of pain is difficult under any circumstance, but the tendency to see chronic pain patients as simply chronic complainers does not make it any easier to provide adequate care. Any provider who has suffered severe pain and especially severe chronic pain understands well the need to approach the patient complaining of pain with great sensitivity.

Second, I am also impressed in reading about Dr. Pizzo’s experience that even the very best medical care he received did not lead to a quick diagnosis or
resolution of his symptoms. We may need to remind our patients and ourselves that many conditions that are difficult to diagnose and treat in the free world are no easier to manage behind the wire.

Third, Dr. Pizzo learned first—hand how an MRI does not hold all the answers. Dr. Pizzo’s MRI was unremarkable. We need to appreciate that MRI tests are not by themselves the best means of diagnosis. The MRI is no substitute for careful history and expert clinical evaluation.

Fourth, this case reiterates the hazards of opiates. If a patient as carefully watched over as Dr. Pizzo can suffer respiratory suppression so severe as to require nalaxone reversal and ICU care, then our inmates are surely at great risk as well when prescribed substantial amounts of narcotics.

Dr. Pizzo’s case should not lead us to do EMG and NCV testing on all patient with low back pain. Not all sciatica merits aggressive medical therapies. The relief he reports in the short term following piriformis entrapment release does not ensure good long term results. Nor does Dr. Pizzo tell us that surgery was the only way to treat his condition. Dr. Pizzo believes that his sciatic nerve compression syndrome became worse than it might have because of overzealous treatment early on. A more cautious approach in the beginning of his symptoms might have alleviated his symptoms without bringing him to surgery.

Dr. Pizzo reminds me how important compassion is in the course of our care. But the compassion we feel need not and should not lead us to unnecessary or excessive drugs or surgical treatments. When faced with a chronic condition caused by uncertain etiologies with no discernable alteration in daily living, watchful waiting may still be the best treatment.
News Update for California/Nevada Chapter
CA/NV chapter of ACHSA holds its annual multi-disciplinary conference at the Red Lion Hotel and Conference Center in Sacramento, California on Thursday Nov 7 and Friday Nov 8, 2013. The CCHP Exam is also offered the evening before this program starts through pre-registration with NCCHC.

The Sacramento program has been approved for up to 12 continuing educational credits by the authorizing agencies for physicians, dentists, psychologists, nurses and LCSW. This is one of the very few medical conferences offering approved continuing education in all of the disciplines for correctional care. For more information, please check the CA/NV website: Statepen.org

November 6, 2013 (Wednesday)

1800-2000 CCHP Exam (MUST pre-register at www.ncchc.org)

November 7, 2013 (Thursday)

0700 - 0800 Registration/continental breakfast
0800 – 0900 Jail to Prison and Back to Jail Again: the Realignment Effect – Panel discussion: Taylor Fithian, MD, Pratap Narayan, MD, and Michael Kim, MD. Sheriff Laurie Smith, Moderator
0900 – 1000 Medical Homes for the High Risk Inmate: The Stockton Project 2013 – Larry Fong, PhD, Oliver Lau, MD
1000 – 1100 Spiritual Resources to Heal Physical Pain: Expanding the Role of Clergy in Medical Care – Panel discussion: Prison clergy and healthcare providers from California Medical Facility. Michele DiTomas, MD, MS Chief Physician and Surgeon
1100 – 1115 Business and Lunch meeting, CA/NV Chapter
11:15 – 1215 Luncheon Speaker: Prison Tattoos: the Health Significance and Meaning of Prison Tattoos – Bruce P. Barnett, MD, and Brian Parry, Criminal Intelligence Analysis Unit
1230 – 1330 Feet Don’t Fail Me Now: Podiatry Care for Inmates – Andrew S. Sawicki, DPM
1330– 1430 Prison Drugstore: How Inmates Combine Your Prescriptions into Potent Intoxicants – Moshen Sadaat, DO
1430 – 1530 Intoxication and Withdrawal: Identification and Treatment – Alexander Chyorny, MD
1530 – 1630 Hepatitis C Treatment Update: Modern options for Inmates – Robert Rudas, MD

November 8, 2013 (Friday)

0700 – 0800 Registration/continental breakfast.
0800 – 0900 Nurses’, Doctors’, and Dentists’ Legal Liabilities: 10 Ways You End Up in Court – Kathy Wild, RN, MPA and Royanne Schissel, RN
0900 – 1000 Violence and Mental Health: Practical tips for Assessment and Management – Pratap Narayan, MD
1000 – 1100 Inmates’ Oral Pathology: Diseases and Other Strange Things – Ron McCuan, DMD, JD
1100 – 1200 Changing Paradigms in Correctional Health: Process Improvement Behind Bars – Dania Schaffer BPA and Chia Lee, FNP-C

Make plans to join us Sacramento in November!