

# THE RAPID PULSE

October 2006

## Faces & Places

### WELCOME

**El Paso, TX:**  
LCDR Aurelia Thomas

**Port Isabel, TX:**  
LT Andre Damonze

**San Diego, CA:**  
ENS Kevin Fitzgerald

**Taylor, TX:**  
LT Kara Lampasone

**Washington, D.C.:**  
LT Christa Hrynyshe

### FAREWELL

**El Paso, TX:**  
Gloria Sandoval

## THE DIRECTOR'S PERSPECTIVE

By Dr. Gene Migliaccio

Welcome to another installment of *The Rapid Pulse*!

I want to begin by welcoming aboard our brand new facility in Stewart, Georgia, which opened on October 1 under the leadership of CDR Lynn Harris. The Stewart facility has 1,000 beds, 6 observation beds, and 3 isolation rooms. Congratulations to the staff at Stewart for a successful opening!

Next, as we welcome a new fiscal year (FY), I want to take a look back at our accomplishments from FY06. To give you a snapshot of the magnitude of work and scope of our accomplishments from FY06, there were:

- over 450,000 patient visits,
- 48,000 TAR adjudications,
- 109,000 chest radiographs,
- 132,000 prescription medications filled,
- 1200 SSU admissions,
- 660 inpatient hospitalizations, and
- 288 international medical escorts.

Also, during the month of August, a DIHS Inspection Team performed on-site assessments of all sites for the purpose of conducting a comprehensive review to determine compliance with national policy. The team, led by CAPT Philip Jarres, consisted of CAPT Yvonne Anthony, CDR Mary Bowling and CAPT (Ret) Nina Dozoretz. The team toured each facility, observed clinic process, reviewed documentation and conducted interviews.

Their findings concluded that there was overall compliance with national policy mainly in the form of the clinics following local operating procedures. Information obtained from the visit supports the need to update, streamline and standardize the current policy and procedure manual. A Policy and Procedure Work Group has been developed for the purpose of having a final product by February of 2007. I would like to take this opportunity to thank all field staff for their input provided to the Team members.

I want to thank everyone for their ongoing dedication to our mission, and for their continued support of the Division during this period of rapid growth.

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## *Recruitment Update*

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By LCDR Kelly Brown

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The Human Capital team has been working ardently and "flexibility" has become our watchword. As many of you know, hiring a qualified staff to stand up a facility is no easy task and as many of you accepted TDY assignments to fill-in, we have also been traveling to meet this heightened staffing demand.

Under the tutelage of LCDR Kelly Brown and Mr. Corey Vines, a recruiting team has been traveling extensively throughout Texas and Arizona with a stop in Columbus, GA for our Stewart facility.

The success of the recruiting can be attributed to the hard work and dedication of LTJG Eugene Hayes, Ms. Kim White and Ms. Joyce Fitzgerald. They have the primary responsibility for the advertisements, candidate screening, interviewing, and obtaining recommendation for hire into DIHS.

This is no easy task if you consider that both Joyce and Kim are working with circa sixty candidates each and each candidate has unique needs! There is no cookie-cutter approach to recruiting and being a corporate recruiter takes a special person with a lot of patience (pun not intended).

The months of October and November will be very busy with several recruiting teams heading back out to attend nine additional recruitment venues, which focus on our critical staffing categories and specialties. The push is to build relationships with various local academic institutions and develop a candidate pool for the Commissioned Corps.

Finally, it is important to credit our Director and the team at STG Corporate HQ for providing guidance and fully supporting our efforts. Their encouragement, solidarity, and cooperation has enabled the team here in Human Capital to succeed and reach out beyond our objectives.

Just so you know...

## *Quality Improvement, Performance Improvement & Accreditation*

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CDR Mary Bowling

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Many times the terms Quality Improvement (QI), Performance Improvement (PI), and Accreditation are used interchangeably. Let's clear that up.

**Quality Improvement** is the implementation of actions to increase the effectiveness of activities and processes within an organization. QI is based on standards (either our own or those of accrediting or regulating organizations) and focuses primarily on processes and systems. DIHS is continuously implementing Quality Improvement (QI) initiatives intended to facilitate performance improvement (PI) at all levels of the organization.

**Performance Improvement** (based on JCAHO) is the ongoing study and implementation of functions and processes that are intended to better meet the needs of the individuals using the services. PI measures the functioning of those processes and services with a focus on individual performance within that system. QI measures assist in identifying performance issues.

The DIHS Policies and Procedures Manual is a quality improvement tool. The policies and procedures set the standards by which our organization is to operate.

The Performance Improvement activities that we employ (PI monitoring, etc.) help us to measure our effectiveness in meeting those standards (QI). When the measurements are

*see PI- Page 3*

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not in an acceptable range, that is an indication of the need to implement quality improvement studies to determine what needs to be done to improve our performance.

**Accreditation**, on the other hand, is a confirmation of our efforts to effectively implement quality improvement and improve the organization’s performance. Though the various accreditations that we achieve confirm that we have met or exceeded the standards of quality for a specific accrediting organization, it reflects only a small component of our overall QI effort and certainly not all of our performance improvement effort.

As an organization, we fare well with accreditations and inspections. This serves as validation of the effectiveness of our **Quality Improvement** initiatives. Ongoing effective **Performance Improvement** monitoring and measures should assure continuous **“Accreditation and Inspection”** readiness, so that there is never a need to “get ready” for an accreditation.

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Literature Review

*Varicella Vaccine and Post-Exposure Prophylaxis*

Dr. Timothy Shack

DIHS Policy 8.25, and Standard Operating Procedure 8.25, for the management of varicella and shingles, were recently updated to include the recommendation for use of the varicella vaccine in post-exposure prophylaxis.

The rationale for this change comes from evidence that the vaccine, given early after exposure to an active patient, can mitigate the disease process for the non-immune exposed person as well as reduce the duration of varicella outbreaks in a population.

I posted two documents on the G drive, under Site Folders, Washington DC, Medical Services Branch, Varicella Articles, which support this use of the vaccine.

The document from the American College of Physicians, on page 5 under “Rationale,” states that the vaccine can provide protective or partially protective immune response if given within the first few days of exposure.

On the same page, under “Evidence,” two small clinical trials are referenced. These trials show that postexposure immunization can prevent varicella.

The *Pediatrics* article describes postexposure vaccination performed at a women and children’s shelter, which was reported to be very successful.

However, susceptibility to varicella was determined through history and not corroborated by serology. Also, a vaccine effectiveness model was used, and was based on an assumed seronegativity rate among the children.

Applying this same vaccine effectiveness model to adults, and particularly to the DIHS population, would be an interesting project. As a baseline, I would like to know what the varicella immunity levels are among our population, and if this differs from the general population of the United States.

The option of using the varicella vaccine for our detainees in an attempt to reduce the duration of an outbreak at a facility is likely to be beneficial.

The drawback is how to quickly identify non-immune detainees who would benefit from the vaccine. I would be interested in mining data from our recent varicella outbreaks to try to answer some of these questions.

*DIHS Civil Servants Recognized For Length of Service!*

**Congratulations...**

*To the following DIHS civil servants, who were recognized by the Bureau of Primary Health Care for length of Service within the federal government:*

Dr. Erik Johnson (Pearsall)- 15 years

Ms. Isabel Junco (Krome)- 20 years

Ms. Eileen Givens (Special Operations)- 20 years

Ms. Miriam Pabon (Krome)- 15 years

*Congratulations, and thank you for your service!*

## *Epidemiology Corner*

October 1 marks the beginning of FY2007, so please remember to submit all of your FY2006 TB and Infectious Diseases surveillance forms to the Epidemiology Unit no later than November 01, 2006.

To facilitate, below is a reproduction of the American Thoracic Society TB classification system. Please keep it handy and use it as a reference guide. Remember that all TB patients should receive a final TB classification as determined by the treating physician. This information should be conveyed to the local public health department and the Epidemiology Unit in the form of a follow up surveillance report regardless of whether the patient remains in ICE custody.

### ATS Classification System for TB

Class	Type	Description
0	No TB exposure, Not infected	No history of exposure, Negative reaction to TST
1	TB exposure, No evidence of infection	History of exposure, Negative reaction to TST
2	TB infection, No disease	Positive reaction to TST, Negative bacteriologic studies (if done), No clinical or radiological evidence of TB
3	Current TB disease	<i>M. tuberculosis</i> cultured (if done) <b>or</b> Positive reaction to TST <b>and</b> Clinical or radiographic evidence of current disease
4	Previous TB disease	History of episode(s) of TB <b>or</b> Abnormal but stable radiographic findings, Positive reaction to TST, Negative bacteriological studies (if done) <b>and</b> No clinical or radiographic evidence of current disease
5	TB suspected	Diagnosis pending TB disease should be ruled in or out within 3 months

### *In the news*

The following articles were selected from the Morbidity and Mortality Weekly Report regarding current public health issues. We have provided a brief summary of each article, which reflects the article content and not a change in DIHS policy or procedures. The links follow:

#### **Prevention and Control of Influenza – July 28, 2006**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5510a1.htm>

- Updates to the 2005 ACIP recommendations regarding the use of influenza vaccine and antiviral agents are addressed in this article. See the summary section in the link for an abridged version of changes made.

#### **Multistate Outbreak of Mumps – May 18, 2006**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5520a4.htm>

- 11 states reported 2,597 cases of mumps in the U.S. between Jan 1 – May 11, 2006
- Three of those states (Colorado, Minnesota, and Mississippi) reported mumps cases associated with travel from one of the 8 outbreak states.
- Vaccine coverage surveys suggest that colleges with a lower proportion of students who have received doses of MMR vaccine (77% vs. 97%) have a higher attack rate.

#### **Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings – September 22, 2006**

[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s\\_cid=rr5514a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s_cid=rr5514a1_e)

- HIV/AIDS remains the leading causes of illness and death in the U.S.
- The revised recommendations are intended to increase HIV screening in patients in health care settings (including pregnant women).

For patients in all health care settings:

- High risk patients should receive HIV screening annually.
- Prevention counseling should not be required for HIV diagnostic testing.
- General consent for medical care is considered sufficient for HIV testing; no separate consent should be required. *See link for details.*