

# THE RAPID PULSE

January 2007

## Faces & Places

### WELCOME

#### Elov, AZ:

Ms. Anna Johnson  
Ms. Brenda Tesfaye  
CDR David Ransom  
Ms. Kate Randall

#### Florence, AZ:

Ms. Dawn Kordas  
Ms. Jacqueline Feller  
Ms Silvia Nido

#### Houston, TX:

Ms. Latasha Winn  
Ms. Rebecca Stephens

#### Pinal, AZ:

Ms. Cynthia Espinosa  
Ms. Linda Illesanmi  
Ms. Sharon Fitzgerald

#### Port Isabel, TX:

LT Andre Damonze  
LT Jeffrey Sherman

#### Stewart, GA:

CDR Betty Shaw  
Ms. Lakeitha Hardy  
Ms. Thaddeus Piotrowski  
LCDR Vickie Scott-Lewis  
Ms. Yolanda Moseley

#### Washington, D.C.:

LT Gia Lawrence  
LT Nicole Cyriaque  
LT Tonya Walston

#### Willacy, TX:

Ms. Laura Eddy  
LCDR Sean Allain

### FAREWELL

#### Elizabeth, NJ:

LCDR Karen Kuo

#### Florence, AZ:

CDR David McIntyre

#### Tacoma, WA:

CDR Richard Storch

## THE DIRECTOR'S PERSPECTIVE

By Dr. Gene Migliaccio

This is my last Director's column before my retirement from the United States Public Health Service and I wanted to share a couple of thoughts.

First thank you for your service with our important mission to the nation; and second, I want to answer a few questions that many of you have asked.

### With the rapid growth in the Division, staffing is a major concern. Will we see relief soon?

Yes, with the Action Plan we are working from, I would predict that within the next six to nine months we should be at steady state. As we have discussed over several all-hands meetings, we continue to recruit and will be applying the most competitive salary and benefits to our contract staff. For federal staff, we are looking at the Senior and Junior COSTEP (Commissioned Officer Student Training and Extern Program) to help and we have launched a major recruitment drive via school visits, career fairs, journal articles, and coordinating with the Public Health Service to bring in Corps staff.

### What is the future of the Division?

The Division, as an operational clinical program serving expanding populations, will always embrace change. We will continue to grow along side ICE and respond to the national immigration issues of the day.

We will continue to grow through a performance-based health care system that revises its health care policies and integrates them into the ICE infrastructure. We will see a one systems approach since DIHS is the medical authority for ICE.

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## ***SUICIDE: THE SCOPE OF THE PROBLEM & WHAT CAN BE DONE***

By Brenda Gearhart

***Editor's Note:*** This is the second installment of a three-part series on suicide.

**Jail Suicides** (information in this section is from "Jail Suicide," *Preventing Suicide: The National Journal*, September 2003):

It is useful to look at the data and approaches used in jails to prevent suicide, since this population most closely resembles the population found in ICE facilities. However, these are not DIHS policies; refer to DIHS policies and procedures for care of suicidal detainees.

### 1. Facts about jail suicides

- 75% of jail suicide victims are detained on non-violent charges,
- 60% of victims are intoxicated at time of confinement,
- 51% of suicides occur within the first 24 hours of confinement (with 29% occurring within the first three hours),
- Two out of three victims are in isolation, and
- 94% of suicides are by hanging.

### 2. Recommendations for preventing jail suicides:

(NOTE: Not all of this information follows DIHS policies since the population and issues are not entirely the same. Do not utilize this information as policy; it is for informational purposes only)

- Maintain a multidisciplinary approach for enhanced communication to prevent suicides
- Avoid creating barriers that discourage inmates from accessing mental health services.
- Provide 8 hours of initial training followed by 2 hours of annual training on suicide prevention to all correc-

tional, medical and mental health staff. This training should include predisposing factors, high-risk suicide periods, warning signs and symptoms, and the facility's policy on suicide prevention.

- Conduct intake screening for suicide risk immediately upon confinement and prior to housing assignment
- Avoid removal of clothing (excluding belts and shoelaces), as well as physical restraints, when possible; utilize only as a last resort for periods when the inmate is engaging in self-destructive behavior.
- Two levels of supervision are recommended for suicidal inmates in jails:
  - i. Close Observation – reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of suicidal behavior, requires supervision at staggered intervals not to exceed every fifteen minutes.
  - ii. Constant Observation – reserved for the inmate who is actively suicidal (threatening or engaging in the act) requires constant supervision on a

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*Suicide- From Page 2*

continuous, uninterrupted basis. CCTV or inmate companions/watchers can supplement, but not be used as a substitute for these observation levels.

- Interventions
  - i. All staff should be trained in standard first aid and CPR.
  - ii. Any staff member who discovers an inmate attempting suicide should immediately respond, alert other staff to call medical personnel, and begin life-saving measures.
  - iii. Staff should never presume the inmate is dead, but begin appropriate life-saving measures.

3. Lawsuits in Correctional Settings – most lawsuits target three major areas:

- Identification of potentially suicidal behavior – did the inmate verbalize or exhibit non-verbal behavior that demonstrated potential suicidal behavior?
- Management of the suicidal inmate – once identified, was the inmate properly and safely monitored?
- Response to the suicide attempt – how quickly did staff respond to the suicide attempt.
- Other possible liability issues: failure to communicate, provide a safe environment, train, and provide appropriate treatment/assessment.

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*Happy New Year to all DIHS staff!*

## ***LCDR DeBarros is Young Federal Healthcare Executive of the Year***

By LCDR Elizabeth Osborne

At the American Academy of Medical Administrators' (AAMA) 49<sup>th</sup> Annual Conference in Atlanta, GA, LCDR Jean Pierre DeBarros was the recipient of the YC Parris Young Federal Healthcare Executive of the Year Award.



*LCDR Osborne, LCDR DeBarros, YC Parris (for whom the award is named), and the recipient of the award the very first year it was given*

This award recognizes outstanding contributions and achievements in federal healthcare management. As the Special Assistant to the Director and subsequently the Chief Financial Officer for the Division of Immigration Health Services, LCDR DeBarros' accomplishments were noteworthy for many reasons.

With oversight for a \$71.3M budget, he was instrumental in the implementation of a pharmacy benefit manager program that realized \$1.5M in cost savings.

He serves as the budget intermediary between the Department of Homeland Security's (DHS) Immigration and Customs Enforcement (ICE) and the Department of Health and Human Services (HHS)/Health Resource and Service Administration (HRSA).

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Additionally, as one of three U.S. Public Health Service officers selected to serve as liaison between the Office of Secretary Leavitt (HHS) and the City of Houston during Hurricane Katrina relief efforts, LCDR DeBarros personally federalized 28 civilian volunteer doctors, nurses, physician assistants, and administrative assistants who were critical in the provision of medical care to the evacuees.

LCDR DeBarros has been a member of AAMA since 2000 and has achieved the esteemed status as a Credentialed Member of the American Academy of Medical Administrators (CAAMA). As his familiar email tag line reads during this period of capacious growth in the division, he now spends his days building a healthcare system.



*YC Parris and LCDR DeBarros*

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### *Epidemiology Corner*

Thank you to the Infection Control Officers, HSAs and medical staff who have diligently sent in their infectious diseases surveillance forms.

Below is a table that represents all cases reported in the last few months. If these numbers do not accurately represent your facility, please let us know.

### **DIHS Infectious Diseases, Reported Oct 1 – Dec 15, 2006**

Facility	CT	Chronic Hep C	HIV/AIDS	MRSA	GC	Varicella	Total
AGUA			1				1
EL CENTRO	2						2
EL PASO						1	1
ELIZABETH			2				2
HOUSTON		1	5	1		1	8
PEARSALL			2		1	6	9
PORT ISABEL						2	1
SAN DIEGO			1				1
SAN PEDRO							1
TACOMA		1	1				2
WILLACY						4	3
Total	2	2	12	1	1	15	33

### **TB Continuity of Care White Paper**

The TB Continuity of Care White Paper is now available to all facilities and staff to read and to better understand the program. A copy can be found in: G:\Specialty Folders\Epidemiology\TB Continuity of Care\ICE TB Binational Issues White Paper FINAL 061128.doc. The white paper will be submitted to the U.S./Mexico Border Health Commission Priority Committee in January 2007 to further address this issue.

### **TB Case and Suspect Report and International Referral Form**

On January 1, 2007 a new TB Case and Suspect Report and International Referral Form was released. This form will replace the existing DIHS TB Surveillance Form, and it will also be accepted by several state and local health departments such as Washington, California, Florida, and Arizona. We are still in the process of confirming approvals from Texas, Georgia, and selected local health departments. The new form has also been approved by the two TB referral programs that DIHS currently

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works with: CureTB and TBNet. The new reporting form may appear lengthy, but it meets all documentation requirements from the respective state health departments, CDC RVCT, our TB referral programs, and the DIHS TB Continuity of Care program. It should also eliminate duplicate reporting at the facility level. If you have any questions or concerns, please feel free to contact the Epidemiology Unit.

**Links and Articles**

**The following practice articles on varicella are available to everyone in G:\Site Folders\Washington DC\Medical Services Branch\Varicella Articles. Please check these folders in the future for updates.**

**Varicella - American College of Physicians PIER: Physicians' Information and Education Resource**  
<http://pier.acponline.org/physicians/diseases/d275/d275.html>

MacMahon, E. et al. Identification of potential candidates for varicella vaccination by history: questionnaire and seroprevalence study. *BMJ* 2004; 329; 551-52.

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*Farewell– From Front Page***Question 3: What is the future of additional civil servants within DIHS?**

As the Division evolves there could be opportunities for a larger civil service presence. This is dependent on several factors: first, the organization where the Division will sit – ICE or HRSA; and, second, will the FTEs be available to hire.

Finally, I want to share with you my thank you remarks from my last duty day that I sent via email on 19 January 2007.

For the past 12 years, I have been privileged to work with the most dedicated group of officers, civil service and contract staff at the Division of Immigra-

tion Health Services (DIHS). I want to thank each and every one of you for your dedication to duty and sacrifices as we built a first-class health care system.

TEAM DIHS was always focused on vision, mission, values, and spirit. The TEAM always placed service over self and was always part of something bigger than ourselves. Together we achieved much as we grew from an organization of small clinics to health centers and ultimately a 24/7 integrated delivery system.

Together we achieved success with our national accreditation programs, as the first system in the country to earn the triple crown from the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the National Commission on Correctional Health Care (NCCHC), and the American Correctional Association (ACA).

Together we were able to rapidly identify and treat tuberculosis (TB) through our world-class TB surveillance program using teleradiology. Together we were able to expand our program quickly to care for increases in the population.

Over the years, I have been privileged to work for the Health Resources and Services Administration that provided us the opportunity to grow, the encouragement to innovate and be creative, and the management infrastructure.

I have also been privileged to work with our federal partner, the U.S. Immigration and Customs Enforcement, that believed in taking care of their population and also believed in our ability to make change and build a quality driven, cost-effective, and accessible system.

I will never forget the honor, responsibility, and trust the United States Public Health Service bestowed upon me. I will never forget all the wonderful people that I had the distinct

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honor of "Serving" with that made this dream come true. It takes a TEAM to make the magic of our wonderful career and you were a magnificent TEAM!

If we go through life with a couple of good friends, we are truly blessed. I have been richly blessed with hundreds of friends.

Thank You.

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*Director's Retirement Ceremony- In Pictures*

A retirement ceremony was held for DIHS Director CAPT Eugene A. Migliaccio at the Army Navy Club in Washington, DC on January 12.



**Former DIHS  
Deputy  
Director  
Dr. GERALYN  
JOHNSON served  
as  
Mistress of  
Ceremonies**



**Former U.S.  
Surgeon  
General  
Dr.  
RICHARD  
CARMONA  
hosted the  
retirement  
ceremony**



**Current U.S. Acting Surgeon General RADM KENNETH MORITSUGU on stage with CAPT  
MIGLIACCIO**