THE DOWNSTREAM EFFECTS OF CRIMINAL JUSTICE INVOLVEMENT

By Lindsey Eldred, JD and Elizabeth Gifford, Ph.D

The United States incarcerates about 1.2 million parents each year, affecting 2.7 million children (The Pew Charitable Trusts, 2010). Research has shown that children who experience parental incarceration are at risk for physical and mental health declines (Wildeman, 2010; Ziv, Alva, & Zill, 2010), early substance use initiation (Roettger, Swisher, Kuhl, & Chavez, 2010), criminal activity (Geller, 2012; Hannon & DeFina, 2012; Murray, Loeber, & Pardini, 2012), being exposed to maltreatment or harsh parenting (Lee, 2013; Turney, 2014), and poor school outcomes (Hagan & Foster, 2012a, 2012b; Haskins, 2012). Despite this growing body of evidence pointing to the negative effects of incarceration on child development, criminal justice decisions are often made without consideration of these downstream effects. As can be expected, remaining in jail pretrial, potentially for years, has consequences not only for the individual, but for their entire family. The incarcerated individual, even at the pre-trial stage, can lose visitation with their children, and, in the extreme, their parental rights may be terminated. All of this occurs before a conviction or even a trial.

Federal law requires permanency planning hearings for children within 12 months following removal from the home, and parental rights termination proceedings to be initiated for children in foster care 15 of the preceding 22 months. For many incarcerated parents, the result is that the state can and does initiate proceedings to terminate parental rights after the time limits have passed even while the parent is in jail awaiting trial. In part, this is subject to judicial discretion. For instance, one parent had termination proceedings initiated during his pretrial incarceration. At judgment, the judge commented that the father had removed himself from his child’s life by recurring incarcerations. Since this all occurred pretrial, the judge calculated what the possible sentence could be if the father were convicted and used this to make a permanency determination. Appeals can be made to reverse termination judgments on several grounds including showing that the parent wasn’t given the resources necessary to allow for the return of their child. In terms of policy solutions, bail reform may have the most impact on maintaining parental relationships, keeping families together while awaiting trial, maintaining normalcy for the child, and allowing the parent to access services they need to make progress and keep custody of their child. Many states are moving to reform or remove pretrial release conditions for all but the most serious crimes, and this can help address some of the issues families experience when they are unable to meet bail requirements. As a first step to build the evidence base on the health effects of parental incarceration, our ongoing research examines the connection between pretrial incarceration and health of the children of incarcerated individuals.
Hiring physicians, dentists, psychologists, psychiatrists, nurse practitioners and physician assistants is a big component of staffing in correctional settings. There are several challenges in this endeavor. They include: low unemployment rate, perceived prejudice towards correctional employment, bias against privatization of correctional health services, upward pressure for salaries in the face of limited public-sector dollars, etc.

When the country suffered the economic downturn in 2008, the medical profession was spared. Employment rates remained high and salaries were strong. Now that the economy is better in many parts of the country, recruiting physicians for correctional work is increasingly difficult. Candidates are asking for more than money. Compensation packages now include CMEs, better health benefits, increased matching funds for the 401K, loan repayment assistance, license fees, relocation assistance, plus sign-in and retention bonuses. In rural areas, transportation and hotel reimbursement is often included. Telehealth can help alleviate these pressures but that would be a topic of a different discussion. Despite all these incentives, difficulties with staffing and marginal physician quality remains an issue.

When I first came to the correctional field in the nineties, the state of California was offering $65,000 annually to do colonoscopies at their Vacaville facility. When I was hired by the state of Indiana in 1995, a $100,000 a year salary was the highest paid position in the state government, so the governor of the state had to sign the authorization to pay my salary. A quarter century and a whole new millennium later, compensation for medical professionals in the correctional setting is a lot higher. Staff physicians can now make over $400,000 a year in some rural areas; psychiatrists can make over $600,000 in some institutions and nurse practitioners can also make over $250,000 in those same settings.

State budgets have not kept pace with this rapid salary growth. About half of the medical services in correctional facilities are contracted to private firms which in turn have to use limited state budgets and return a profit, even with these trends of increasing salaries for medical professionals. Correctional agencies have to compete with local hospitals that are also being squeezed for talent. About half of the medical services in correctional facilities are contracted to private firms which then have to use limited state budgets and return a profit, even with these trends of increasing salaries for medical professionals. Correctional agencies have to compete with local hospitals that are also being squeezed for talent.

The correctional setting can be an attractive proposition for some providers as it can offer a more relaxed lifestyle with regular work hours, little night and weekend work, and lower expected patient volumes than the community. This can be very attractive for family-oriented providers who want to have this kind of flexibility.

For about 30 years, the ACCP has been an advocate for higher quality medical services offered to the incarcerated population.

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WHAT YOU DIDN’T WANT TO MISS: THE ACCP 2018 SPRING EDUCATIONAL CONFERENCE: ESSENTIAL TOPICS FOR CORRECTIONAL PHYSICIANS – LEGAL AND MENTAL HEALTH

Michelle Staples-Horne MD, MPH, CCHP

A CCP members and participants gathered on March 24th for a robust educational conference in Minneapolis, Minnesota. The spring conference this year focused on legal and mental health issues, including the use of isolation. These “hot” topics were in contrast to the cooler weather we experienced in Minneapolis, but the topics covered significantly warmed up the room.

One of the most informative and interactive sessions was the mock deposition led by Deanna Johnson, JD as the Judge. She made quite the impression upon her entrance into the conference room “court” with her impromptu black tablecloth robe. Attorneys Larry Wulkan and Beth Boone acted as the prosecuting and defense attorneys. We had our own physician colleague, Dr. Grant Phillips, who bravely volunteered as the physician on trial and Dr. Todd Wilcox who acted as the expert witness. The case involved the death of an incarcerated patient who had been receiving daily omeprazole prior to confinement. The case synopsis included the patient’s complaint that, after exercise squats, he experienced groin pain and was sent to the ER for a presumed hernia. At the ER, and again back at the correctional facility, he received ketorolac. When he presented later complaining of abdominal pain, the nurse employed a company nursing hernia protocol and he was provided with ibuprofen 800 mg TID. Shortly afterward he was found dead in his cell, the trial following two years later. Without providing full details of the medical record, the attorneys presented opening arguments and demonstrated cross examination of the witnesses. We were able to experience the details of cross examination, such as a lengthy discussion of the definition of medication error and its relevance to the case. The importance of the deposition and its use during the trial was also dissected, with a demonstration of how every word used in a deposition can come back to bite you. The attorneys stopped frequently to explain their rationales in the proceedings and their terminology. Tips were given on eye contact, body positioning and even expressed personality. We also covered the use and qualifications of the expert witness. After a brief discussion regarding Federal law versus State law cases, malpractice and deliberate indifference, the attorneys made their closing arguments. We, the jury, were faced with the onerous task making a verdict.

Of course, we could not all agree and had more lively discussions. Fortunately for us, lunch was waiting and Judge Johnson was willing to release the jury rather than sequester us!

The next educational session, during lunch, was “Evidence-Based Approach to Safety and Harm Prevention of Patients in Isolation” presented by Drs. John Wilson and Joel Andrade. Definitions and the prevalence of the use of isolation were discussed, as well as the recommendations against the use of solitary confinement from several reputable national organizations. Conditions leading to the increased use of solitary confinement in the 1980s included the War on Drugs and the increase in prison and jail populations resulting from the closing of mental health facilities. As a result of the subsequent overcrowding, prison riots occurred and were used to justify prolonged isolation for large numbers of inmates. Significant court cases relating to the use of solitary confinement were also presented. A very profound film was shown to the audience to mimic the conditions and distortions brought about by the use of prolonged isolation. The psychological harm brought about through the use of solitary confinement was discussed, including the increased risk of suicide.

Our next session discussed “Bizarre/Agitated Behavior: Differentiating Mental Health from Medical Etiologies”, presented by Drs. John Wilson and John Lay. The critical differential diagnosis highlighting physiological agitation versus that caused by psychiatric or behavioral causes was demonstrated in this session. Drug use, particularly the synthetic cannabinoids (K2) and their lethality was discussed in detail. The differential diagnosis of delirium, dementia, depression, and schizophrenia was discussed based on the etiology of onset, orientation, attention and memory, diurnal fluctuation, psychotic symptoms/hallucinations, mood/affect, and course over time. Short video clips gave a powerful visual of how destructive these drugs can be to the mental state, including the true risk of harm to oneself either by falls or psychotic-like behavior, or due to the actions of staff to try to secure the patient for safety.

The educational conference closed in the afternoon with what has become our signature session, “ACCP Talks to its Patients”.

CorrDocs
Rosie Raez of “Aspire to Win”, a non-profit service for citizens returning from correctional institutions, brought five male survivors of administrative segregation to participate in our panel. The length of solitary confinement for these men ranged from 10 to 25 years.

They talked about their physical and mental conditions during solitary confinement, their interactions with medical staff, and grief and loss issues while incarcerated. These men also expressed their difficulties in adjusting to life upon release into the community. All had some interaction with the juvenile justice system prior to adult sentences. They felt if they had had mentors during that time, their lives might have taken different paths. Their stories were both heart wrenching and thought provoking. How could one endure such conditions of human deprivation and survive? How did we allow ourselves to get to the point of solitary confinement being socially acceptable? It is my hope that since we know better, we will do better and pursue the elimination of the use of long term isolation. We need to be advocates for our patients and stand with our correctional administrators and staff to end its use throughout corrections.

More Than Skin Deep from Page 2...

It was melanoma. The oncologist said if I had waited any longer, it would have spread and I’d be dead. So, you saved my life, Doc. I never forgot that. And I wanted to say thank you.”

Yes, it’s true. I make a point to examine skin while doing the heart and lung exam. I hardly listen through cloth, not because I can’t hear but because I believe it should be done directly to the body. There’s my physical exam plug – always go skin-deep. As for my patient, I was amazed that he was now cancer-free, and that I had made such an impact.

Until we tackled his knees. Right now, we’re in a little disagreement on how best to manage his osteoarthritis. He still is polite and respectful, but I can tell that “you’re the best Doc” glow has faded a bit. That’s okay. I still did my job and I continue to do so to take care of him. To take care of our patients, we all know it takes a little more caring and attention than just skin-deep.

The Downstream effects of criminal justice involvement from Page 1...


Addressing the Challenges in Hiring Quality Correctional Physicians from Page 2...

And we have made strides at attaining this goal. But how do we move forward with the challenges of higher salary demands and still-limited government budgets? Just this month, the ACCP was recognized as a specialty and service society by the AMA. The AMA wields a lot of power and advocates for providers in all fields across the nation. Our goal is to become a member of the AMA board of delegates so the ACCP will be able to advocate on a nationwide basis for the needs of the correctional providers.
The Trauma that Surrounds us in the Practice of Correctional Medicine

This year’s conference will focus on types and manifestations of trauma that we encounter as correctional practitioners.

Topics include:

• Head trauma
• Self-induced injury
• Trauma-informed care
• Managing patients with disabilities - ADA
• Emotional trauma to our correctional colleagues
• PTSD

Please see our website for the full agenda, at www.accpmed.org, visit our Facebook page for event updates, www.facebook.com/AmericanCollegeofCorrectionalPhysicians, or email Christine@accpmed.org.
THE AMERICANS WITH DISABILITIES ACT (ADA):
WHAT’S IN A “MEDICAL ORDER”?*

By Rebecca Hall, LICSW, CCHP

The Americans with Disabilities Act (ADA) was first implemented in 1990, with an amendment revision in 2008. This federal law aims to provide protections for people with disabilities in five key areas: 1) employment, 2) state and local government, 3) public accommodations, 4) telecommunication, and 5) transportation. Correctional facilities fall under state and local government, specifically Title II:

The ADA mandates that no qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

Boundaries are clear in the community; medical providers are asked to diagnosis, treat, and document an appropriate treatment plan. In corrections, medical providers may be asked to diagnosis, treat, verify, and modify treatment plans in the interest of meeting custody concerns including a request for an ADA accommodation. It becomes difficult to determine where medical involvement should end and custody obligations begin. Here are key principles that should guide correctional medical practices to comply with ADA requirements:

► Medical providers treat serious medical conditions with the objective of sustaining and improving quality of life.

► The ADA is meant to ensure equal access to programs and services within a government facility for those with physical and mental impairments.
  ○ Not every diagnosis is covered under ADA; a qualifying diagnosis must have three elements by definition
    1. A substantial limitation in major life activity
    2. A documented record of impairment
    3. A perceived limitation/inability to access the program and services avail

Some exclusions apply to the ADA and include (but are not limited to) simple physical characteristics (ex., eye color), normal deviations (ex., strength, height), personality traits (ex., irritability), environmental disadvantages (ex., limited education), sexual identity or sexually based disorders, and behaviorally based disorders.

The medical department does have a role in assisting custody staff in the verification of a need for an ADA accommodation. Medical staff may confirm or deny a relevant diagnosis, as well as consult on the perceived impairment the condition may create for a patient. If the impairment appears to be an unaddressed symptom of the medical treatment plan, then medical staff should assess and treat as appropriate – and not solely endorse an ADA accommodation. However, if the medical plan addresses the necessity of care, then custody should review what resources are available to further assist a person in gaining equitable access to programs and services.

An example may help to make this clearer. Consider an elderly patient diagnosed with COPD who has stopped attending church due to difficulty walking to and from the chapel. The man is treated under chronic disease guidelines and considered stable. He does not otherwise require a wheelchair. He has requested a wheelchair and companion to get him to/from the chapel on Sundays. This is the only prison activity he cannot accomplish.

Who should provide the wheelchair? Should it be...

a. Medical due to difficulty walking a prolonged distance
b. Custody due to difficulty accessing a program within the facility
c. Nobody, the inmate can read his bible on the housing unit

Under the ADA, the answer is “b.”

Due to the patient being under routine medical care with a treatment plan resulting in a stable condition, and the specific request to attend a program (church), the accommodation should be met by custody staff.

The ADA process is complicated and the best case scenario is to develop a cooperative partnership with custody staff to address the overall needs of the patient. That said, it is vital that medical providers do not extend a patient’s treatment plan past what is required for good medical care, solely to address custodial obligations. Supervision and counsel should be sought when conflicts arise; the underlying question is always, “Is this medically necessary to treat the presenting serious medical condition?” If the answer is yes, then it is a medical obligation, if the answer is no, then it is usually a custody obligation.

For additional resources, please reference www.ada.gov

WHERE IN THE WORLD IS ACCP?

Can you guess where one of our ACCP members visited? First to respond with the correct answer will win a beverage with the CorrDocs editor at an upcoming conference. Send your responses to Rebecca@lubelczyk.com. Good Luck! Hint: Look down under.
Australia is known as a country settled by convicts. One might wonder how this critical historical fact has impacted treatment of Australia’s own inmates today and yesteryear. Have Australians shown more compassion to their inmates because of a “shared consciousness?” Or, given the incredible hardships suffered by the early non-convict settlers, were they inclined toward harsher prison conditions?

With this question in mind my family and I toured several former Australian prisons including what remains of the Boggo Road Gaol (Jail, in British-speak) on a sweltering March day in Brisbane, Queensland, Australia. The façade boasts a lintel which reads H.M. Prison for Men, with reference to Her Majesty Queen Victoria when the facility was opened in 1883. The facility operated for 119 years until July of 1992. Boggo Road is reported to have been Australia’s most notorious prison with forty-two inmates executed by hanging. The 1980s were tough times for the facility, with dramatic escapes, riots, hunger strikes, and roof top protests which eventually forced prison closure. I was able to experience the specially designed cell with triple-bolted doors for the prison’s infamous inmate “Slim Halliday”, who was known throughout Australia as “The Houdini of Boggo Road” because of two successful escapes from this high security facility.

The cells are not significantly different from the cells in my correctional facility with an important exception. Even up until its closure in the early 1990s inmates used “slop buckets” in lieu of “loos” found in Australian prisons today. While there was neither heating nor air-conditioning, the cells seemed cool and almost comfortable in spite of the searing heat outdoors. The inmates of Boggo Road were kept busy from sunup to sundown with various jobs, including making uniforms, mattresses, furniture and various other manual and skilled jobs. Solitary confinement was used short-term and for major disciplinary issues.

The Organization for Economic Co-Operation and Development (OECD) average was about A$69,000. True, we incarcerate at about seven times the rate of our Aussie friends down under, so this spending disparity may be less than it seems, given fixed vs. marginal costs. However, these numbers are dramatic. My impression from recent news articles and discussions with the Boggo Road Museum Director is that other differences between US prisons and Australian prisons today include our high rates of solitary confinement, limited access to inmate jobs, and voting opportunities. Most Australian prisons then and today allow, and even require, that inmates perform at some productive work during their sentences. In Australia today, most inmates are allowed to vote in both federal and state elections.

How modern Australia’s origins as a convict colony impacted prisoner conditions in the nineteenth century and to the present day is a complex question for historians. For the rest of us it is fascinating and rewarding to visit correctional facilities both past and present. How will history remember today’s prisons two hundred years from now?
A DAY IN THE LIFE: PHYSICIAN CARES FOR HIV-POSITIVE PATIENTS IN JAIL – JAMA NETWORK

Jack Kearse/Emory University

Spaulding spent 5½ years in the Rhode Island corrections department post, overseeing the care of an average daily census of 3500 incarcerated people. After a 2-year stint with the Centers for Disease Control and Prevention, she served from 2003 to 2005 as the associate statewide medical director of Georgia Correctional Health Care, a collaboration between the Medical College of Georgia and the Georgia Department of Corrections. She helped supervise approximately 50 physicians who cared for the 45,000 people in the state’s 70 prisons and provided HIV and hepatitis C care to women in the Georgia prisons.

In 2005, Spaulding joined the epidemiology faculty at Emory University’s Rollins School of Public Health. She is also an associate professor of medicine at the Emory School of Medicine. From 2005 to 2012, she consulted for Georgia Correctional Health Care as an HIV and hepatitis C expert, and since January 2017, she has been working every Tuesday as a staff physician and infectious disease consultant at the Fulton County Jail in Atlanta.

“It has turned out to be a really good fit for somebody who is interested in health disparities, infectious diseases, social justice issues, HIV, and hepatitis C,” Spaulding said of corrections medicine. “It has been a very good career path.”

She recently spoke with JAMA about her typical work day at the Fulton County Jail.

Starting the Day

Spaulding tries to rise at 5 am so she can go to the gym and then on to Bible study at her church before heading to the jail. “That’s very important for me to have a good focus on what I do,” Spaulding says of Bible study. Before she leaves home, she packs her peanut butter and honey sandwich—“that’s my treat on jail day”—and her fruit and vegetables in a clear plastic bag so the officer at the gate of the jail can see the contents.

Arrive and Huddle With Colleagues

Before Spaulding can be cleared by security at the jail, she must take off her white coat and stethoscope so they can be x-rayed separately from her. “I don’t bring a purse. I generally keep my car keys in my white coat. I can bring in a cell phone.”

Each Tuesday at 8 am, she huddles for about an hour with her colleagues—the medical director, 3 additional physicians, and a number of physician assistants (PAs) and nurse practitioners—to get caught up on what’s happened with patients during the previous week.

Spaulding never knows if she’ll see the same patient more than once. On average, people remain incarcerated in the jail for a couple of weeks, but within 5 days of entering, half have been released pending trial, she notes.

Her primary responsibility is caring for the more than 800 people with HIV who enter the jail each year. “Before I started working here, a physician assistant had been seeing all of them and knows the patients well,” Spaulding says. “The PA and I work together.”

Even after she got her first job in correctional medicine, Anne Spaulding, MD, never thought she’d spend her entire career in the field.

She grew up in Northern Virginia, earned her medical degree at the Virginia Commonwealth University School of Medicine, and completed her internal medicine residency in Rhode Island, followed by a fellowship in infectious diseases at the University of Massachusetts, Worcester. For family reasons, she wanted to stay in Rhode Island when she launched her career, but jobs in her field were scarce.

“There were very few positions available at the time for an infectious disease doctor in Rhode Island,” she said. One of her mentors suggested that she apply for the job of medical director of the Rhode Island Department of Corrections. Spaulding’s initial reaction: “Why would I want to go off and work in a prison?”

But a friend whose brother was incarcerated encouraged her to consider the corrections department position. “They really need to have improved medical care, and what’s the harm in looking?” the friend told her.

The night before her job interview, Spaulding read most of the medical literature on correctional medicine. “There was not a lot written about the field at that time,” she explained. She got the job, “and now, 20 years later, I’m still in corrections.”

Working Around the Jail

She aims to see a dozen patients a day, typically between 9 am and 4 pm. “Part of the challenge is that they are on different floors. We are guests of the jail, and although we have a legal mandate to be here, we need to coordinate the delivery of health care with its operations.” For example, “the correctional officers lock the doors at every shift change and have a head count to make sure everyone is still there. We need to work around the count at 3 pm.”

The correctional officers escort patients from their cells to the examining rooms on each floor, which are equipped with a table, an ophthalmoscope, and an otoscope. “Patients behave like patients wherever they are. You’ve got people who may seem very tough on the outside who are very vulnerable about their health. They will let their guard down,” Spaulding says. “I’ve been in corrections for 20 years. I’ve never been assaulted or felt in danger.” That’s not everyone’s experience in corrections, she adds.

Patients with medical conditions that require closer monitoring, such as HIV that’s not well controlled, severe mental health issues, and frailty due to old age, are placed in cells on the medical housing floor, where Spaulding spends about a third of her day. “Sometimes we don’t see somebody when they’re on our schedule because they’re at court. Going to court so they can get out of jail is a higher priority than a routine doctor’s appointment.”

If somebody is medically unstable, they can be taken to the local hospital emergency department, but that occurs only occasionally, Spaulding says. “One of the more common reasons I send someone out is for a lumbar puncture. We’ve had patients with fungal meningitis, which you’d see in late-stage HIV, or suspected neurosyphilis.”

When Epidemics Collide

About 4% to 5% of people in the Fulton County Jail are HIV positive, roughly the same percentage as seen in New York City jails, Spaulding says. “We have basically 2 epidemics coming together: the epidemic of incarceration and the epidemic of HIV.”

In the United States, about 750 of 100,000 persons are incarcerated at any given point in time, but the proportion in the South is 25% higher than the national average, Spaulding says. “In the Southeast, we have the highest incarceration rate in the world. The average entrant goes into jail 1.4 to 1.5 times a year. Sometimes there is a new allegation of criminal activity. Sometimes people are on probation or parole and haven’t met the requirements. One of my patients had 40 separate stays in Atlanta-area jails since age 18.”

A disproportionate number of people incarcerated in the United States, as well as in Georgia, are racial minorities, Spaulding says. “For the most part, I’m seeing newly arrived men. The majority (of her patients) are black men who have sex with men.”

A project that ended in December 2017 offered rapid HIV testing to anyone at the jail who did not opt out of it. Between March 2013 and February 2014, 89 new cases of HIV were identified as a result of the project, Spaulding reported in 2015.

Nurses continue to do some testing in the jail, Spaulding says, but most of the HIV-positive men she sees come in knowing their HIV status. “Over the years, I have seen maybe 1 or 2 guys a month who have just learned that they’re HIV-infected. We fill out the CDC form saying this is a new diagnosis of HIV.” But sometimes, it turns out that the men who say they didn’t know they were infected are already in the health department’s HIV registry, Spaulding says. “Often, getting an HIV diagnosis is an iterative process. Sometimes people need to hear it several times in order to have the reality set in.”

Continuity of HIV Care

Some patients she sees in the jail are homeless and always keep their HIV medication with them. If they’re not homeless, they might have had an opportunity to retrieve their medication before entering the jail.

Generally, though, the jail doesn’t allow people to take medication brought from outside because they might have replaced the anti-HIV drugs in their capsules with heroin or OxyContin. But, Spaulding adds, “if someone comes in with their hep C medications, which currently cost several hundred dollars a dose, we are glad to have the meds from home.”

“We try to provide medications from our pharmacy,” she says. For those who don’t bring in their anti-HIV medication, “we have wall charts so they can point to the pill that looks like the one they take.”

The goal is to avoid a break in treatment because of incarceration, no matter how brief. On days she’s not working in the jail, “I tell my colleagues that if somebody can tell you their credible medical regimen, continue that regimen. With HIV medications, you want to have seamless continuity of care.” That doesn’t necessarily happen in jails in less-populated Georgia counties, many of which don’t provide HIV medications because they haven’t budgeted for it, Spaulding says.

Wrapping Up

Spaulding tries to see a couple of patients after the 3 pm head count. Officially, her day at the jail ends at 4 pm, “but I might be finishing paperwork up to 6,” she says. “I’ve never been the fastest physician seeing patients. I tend to have notes that are too detailed. That’s who I am.” Given that they often have complicated medical histories, “writing about our patients is sometimes challenging.”

Winding Down and Looking Ahead

When Spaulding leaves the jail, she texts her husband, a physician who works for the Centers for Medicare & Medicaid Services in Atlanta, to let him know she’s on her way home and will be making dinner. “The thing that gives me a lot of joy, in addition to seeing my husband at the end of the day, is cooking. If you start with a good mix of vegetables and chicken, something good is going to come out of it. Something gets produced that is tangible.”

After dinner, she might try to wind down by reading or watching “NCIS” or “Designated Survivor.” But then there’s always a day’s worth of emails waiting for her to read and answer.

“Writing and publishing and being involved in scholarship is a really important part of what I feel like I’m called to do,” says Spaulding, who recently coauthored an article about how jails represent an “unappreciated” medical home that could link incarcerated HIV-infected individuals with care in the community after their release.

She recognizes that individual physicians seeing patients in jails or prisons can’t solve all of the problems of health care delivery in corrections. More research into best practices in corrections health is needed, but interest—and funding—is lacking, Spaulding says.

“Some of my work has been trying to address the lack of scholarship in correctional health. If I had funding, I would like to do a project that would look at barriers for young investigators to go into correctional health as a scholarly pursuit. I believe there are ways we could train our physicians in the ethics of criminal justice research that would make it inviting.”
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A SUCCESSFUL HEALTH COACHING AND LIFESTYLE MANAGEMENT PROGRAM FOR DIABETICS IN PRISON, ONE STATEWIDE SYSTEM SHOWS AN AVERAGE DECREASE OF 3.5 POINTS IN HGA1C

By Rebecca Luethy, MSN, RN, CNS, LNC - Centurion LLC, June 2018

It is estimated that nine percent of U.S. prison inmates have diabetes. Managing diabetes behind bars is challenging because offenders have little control over what food is served to them with little control over the amount and type of exercise available to them, and commissary items available for purchase do not typically include fresh, healthy fruits and vegetables.

The traditional method of managing diabetic patients in prison is to assign status in a “Chronic Care Clinic,” where patients routinely see a provider to review biometrics and medications and to discuss diet and exercise. Most diabetic education is provided during Chronic Care visits as well.

The American Diabetic Association (ADA) recommends diabetics maintain a glycosylated hemoglobin (HgA1c) level of 7% or lower. HgA1c levels over 7% lead to diabetic complications, costly ED visits, and hospitalizations.

A popular program to assist patients in managing their diabetes in the free world Medicaid population consists of telephonic disease management and lifestyle coaching, which connect diabetics with various diabetic subject matter experts (SMEs), such as exercise physiologists, dieticians, and diabetes nurse educators. These experts routinely meet with patients via telephone to discuss disease management through goal-setting and lifestyle modification.

Centurion is a leading provider of healthcare services to correctional populations and a subsidiary of Centene Corporation, the nation’s largest managed Medicaid provider. Centurion adapted into its correctional healthcare programs Centene’s successful free world diabetic disease management program, which we call Focus on Wellness, and which is designed to encourage and empower individuals to reach specific health goals, supplement their overall care, maintain good health habits, and make lasting health behavior changes. We modified the telephonic program to meet the security and health care delivery requirements associated with care delivery in prisons, and we now offer telephonic disease management and lifestyle coaching services to diabetic inmates in five states. All five state programs have shown immediate and sustained success in lowering our patients’ HgA1cs.

Of exceptional note is our success within the Tennessee Department of Correction. We began the Focus on Wellness program there in 2014, and in four years, have had over 300 participants and over 100 graduates from the six to nine-month program. Today we have 79 active participants in the program, and our 10 graduates to date in 2018 have shown an average decrease in HgA1c of 3.5 points.

The Focus on Wellness program follows an orderly path:

1. Centurion attains approval from the DOC to commence the program.
2. Diabetic patients with HgA1c levels of 8 or higher are identified as potential program candidates.
3. Lists of potential candidates are sent to Centurion administrative staff on site for further modification based upon the patient’s release date, security status, etc.
4. Program introductory letters addressed to final program candidates are sent to Centurion administrative staff on site for distribution.
5. Interested program candidates receive detailed program information and expectations, and sign a consent form to participate.
6. A 30-45 minute introductory telephonic disease management call for the new participant is conducted with an SME Health Coach (coach). A member of the Health Care Unit at the prison also participates in the call to act as gatekeeper and data gatherer. This satisfies security requirements. During the introductory call, baseline data is gathered and the coach and participant create a Health Plan based upon patient needs and desires. After the baseline call, a narrative note is sent to the Health Care Unit for inclusion in the patient medical record.
7. Routine 15-20 minute calls follow for each participant, approximately once per month. Each call also includes a member of the Health Care Unit team. Together the participant and the coach measure steps to success and the coach offers ideas, problem-solving, encouragement, and support to the participant. Each call is memorialized in narrative written form and submitted by the coach to the Health Care Unit for inclusion in the medical record.
8. After six to nine months of health coaching, most participants have achieved their goals and are ready for graduation. Two graduation certificates are sent to the Health Care Unit, one for inclusion in the medical record and one for the participant to keep. Graduation certificates are signed by Centurion’s state medical director.
9. Graduates are entered into a post-graduation program that follows their continued success and intervenes, when necessary, to redirect patients if biometrics trend in an undesired direction.

We attribute our success in Tennessee - and in other states where the average decrease in HgA1c is 2.1 points - to two things. First, the candidate list we use to identify participants is examined closely, and only those patients who the onsite administrative team feels would be active, successful participants are invited to join the program. The program is time-consuming for patients and busy health care staff and has limits on the number of participants that can be supported at one time, so we endeavor to enroll only those patients who caregivers believe would have the best chances at success. Second, the unintended benefit of having an outside caregiver show routine and sustained concern for our patient’s success was more meaningful to the participants than we had first imagined. The participants thrive under the care of diabetes coaches and the anticipation of sharing small steps towards success seems to drive the participants’ sustained engagement in the program.

This summer, we will increase the scope of the Focus on Wellness program in Tennessee to include those patients with Coronary Artery Disease (CAD). One requirement for eligibility will be that patients must have previously suffered a myocardial infarction. Our goal is for CAD patients to attain and maintain healthy lifestyles to reduce future sudden cardiac events.

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What would you do if someone told you that you had to write the prescription for the drugs used in an execution? What would you say?

That happened to me in 1989 in Nevada when I had only been a prison doctor for two years. I did not have a medical director to turn to for advice, nor did I have another physician in the system who had worked there longer than me. The last execution had been carried out in 1985 and I was shocked when I was asked to violate my Hippocratic Oath.

I didn’t hesitate when I said, “I’m not going to do it.” The person in administration was not pleased and told me that other prison doctors had done it in the past, that ‘it was my job.’ Visions of people giving shocks to other people in experiments and soldiers leading children into gas chambers in Nazi concentration camps surged through my mind, situations in which individuals unthinkingly did what they were told to do.

I did not write those prescriptions nor did I ever take part in the ten executions that took place during my career. I was curious, though, about the impact that it had on staff who were involved in the execution. I found out that the custody officers who were responsible for caring out the execution volunteered to be part of it, and one officer I talked to said it was an ‘honor’ to make sure the process occurred without a problem.

I talked with the Chaplin about his role in the execution process and he told me that the first execution he witnessed was in 1979, and a gas chamber was used. He said that an officer had to go in the chamber after the inmate died and pierce the inmate’s chest to let the gas out. The experience so affected the officer that he never again was able to work as a custody officer. The Chaplin said that that event and the concern that the old gas chamber was leaking into the viewing area led the system to change to lethal injection.

I also learned a history lesson about Nevada State Prison (1862-2012), where the executions occurred. In 1924 it was the first prison in the United States to use lethal gas. The historian for Nevada told me that the first time they the used gas (on Gee Jon) it didn’t kill him, and they had to repeat it the next day.

The whole process surrounding capital punishment did not make sense to me. Studies showed it didn’t deter crime. It was extremely costly for the system to prosecute and get the death penalty, keep inmates on death row, and respond to the subsequent legal appeals. I was told that the families of victims wanted revenge, and I was once chastised for not keeping a terminally ill cancer patient alive long enough so that he could be executed.

I don’t know how other systems and correctional physicians now deal with executions, but I’m glad that I chose not to be part of executions. When I left the Nevada Department of Corrections in 2016 I remembered one of my death row patients whom I first cared for in 1987. He had HIV, and over the years developed diabetes, neuropathy, kidney failure, and cancer. He was still alive on death row having been on dialysis for about ten years. If you had taken care of this patient for 30 years and he still wanted to live, would you turn around and write the medications for their execution?

Editor’s note:

The American Medical Association, the American College of Correctional Physicians, and the National Commission on Correctional Healthcare have long had policy statements designed to guide clinical professionals faced with this type of dilemma. Readers are encouraged to review these statements and seek assistance from one or more of the associations if they find themselves under pressure in a difficult situation.

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In another of our participating states, we introduced an incentive program for participants who meet their stated goals. The Minnesota Department of Corrections is actively participating in the incentive program by providing a number of small tokens from which successful participants and program graduates can choose to mark ongoing success in the program. Other initiatives include exploring provision of the program via telemedicine and provision of group coaching in all our participating states. These program expansions will likely roll out over the next year.

In 2017, the Focus on Wellness program won the DecisionHealth® Platinum Award for Outstanding Achievement in Disease Management/Population Health and for Outstanding Achievement in Patient Engagement/Education. Platinum Awards are private industry awards that highlight professionals’ and organizations’ work to ensure a safe, quality and sustainable healthcare system.
The Provost’s Office and the Office for Faculty Development and Diversity are pleased to announce a new fellowship program for staff and faculty aimed at building and embracing our diverse community.

The Inclusive Climate Leadership Fellowship (ICL Fellowship) is designed to:

- Further the development of sustainable educational, programmatic, and research interventions that foster an inclusive environment at the University
- Promote the careers of faculty and staff who are passionate about diversity, inclusion and cultural literacy
- Foster a more inclusive and embracing educational, service, and work environment at the University

The ICL Fellowship is a competitive two-year program open to staff and faculty at the University of Rochester who are passionate about incorporating diversity and inclusion into their UR careers. Generally, a cohort of 6 ICL fellows will be selected every 2 years. ICL fellows will spend 10% of their work time on the program, which includes a 3-hour monthly seminar series and completion of a capstone/action project. ICL Fellows will receive a stipend including salary relief for the sponsoring unit and funding for project expenses and relevant travel. Part-time employees will be considered on a case-by-case basis. The capstone/action projects are meant to create sustainable change that facilitates a more inclusive climate in the university. Examples of projects include programs, curricular changes, community outreach and organizational processes. Topics can include a broad range of diversity and inclusion projects, including (but not limited to) a focus on: race, cultural diversity, ethnicity, disability, gender, LGBT, veterans, socio-economic status, and global engagement.

In this program, ICL fellows work closely with their cohort and experts in diversity and inclusion to:

- Design and implement novel organizational or educational programs or interventions that promote diversity and inclusion
- Develop skills in leadership, professional development and mentoring
- Develop research skills and complete high-quality research designed to result in institutional change
- Learn theoretical foundations of organizational change and social justice, teaching methods and curriculum development
- Meet leaders from around the university to learn about organizational structure

**How to Apply**

When we are accepting applications, we ask applicants to complete the application form online and send any questions to Maggie Cousin at Maggie.cousin@rochester.edu

https://www.rochester.edu/
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