ARE TWINKIES © 
A CONSTITUTIONAL RIGHT?

By Dean Rieger, MD, MPH, CCHP

Diet management is a key healthcare component in the treatment of many conditions. Sometimes it is calorie content that is most important, sometimes sodium, sometimes protein, sometimes carbohydrate—and I could go on and list many other nutrients. Good clinical care requires that we have confidence in the quality of the food provided, certainly in therapeutic diets, but also in the regular diet served in chow halls. No matter how closely regular and therapeutic diets meet recommendations and standards, there is always the issue of canteen food.

Considerations of supply and demand govern which foods are carried in canteens. High sugar content? Bring it on. High salt content? Tastes great. High fat content? Definitely satisfying. All three? Can’t beat it; that food will sell. Foods that sit on shelves without selling will disappear from canteen lists. Unfortunately, canteen foods tend to undermine healthy and therapeutic diets, whether the issue is salt, sugar, something else, or simply the substitution of less healthy foods for specifically prepared meals.

Inmates in jails and prisons have access to many items as a presumed “right,” and canteen access is prominent among these. Canteen lists may vary from facility to facility, and within facilities depending upon security level or bed placement, but access to the canteen list associated with the housing unit is expected. This is managed by housing and security, and not by healthcare administration. Informed consent refers to the members of ACCP.

Ethical principle is the respect for patient autonomy. What happens when a patient undermines his or her own dietary goals? Medical ethical principles include the injunction “first do no harm.” Interfering with canteen access, which is in the interest of the patient’s health, meets this ethical imperative. However, there is a difference between taking actions which harm a patient and forcing a patient to submit to a healthy intervention. Another medical ethical principle is the respect for patient autonomy.

Correctional clinical personnel are familiar with informed consent and informed refusal. In truth, these concerns are more salient in corrections than in the outside community, simply because patient options for health care providers are so much more limited inside the walls. Informal consent refers to a patient being informed regarding the pros and cons of receiving certain care and deciding to receive it; informal consent is documented to a greater or lesser degree depending upon the risks associated with the planned care and the perceived benefits.

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PREPARING FOR LARGE-SCALE DRUG EXPOSURES

By Keith Ivens MD, FACCP

The entire prison system in Pennsylvania was put on lockdown after 13 employees were sickened by unknown substances at three separate facilities between August 5th and August 13th. Fifteen more employees at the Allegheny County jail were sickened. Early reports indicate that it was a K2-like substance. See this link: https://www.wtae.com/article/pennsylvania-state-prisons-make-changes-after-staff-mysteriously-sickened/22805584.

K2 and fentanyl are tearing up our facilities. Correctional physicians must respond. Facility administrators look to us for answers. How much Narcan should the facility keep in stock? How do we protect the staff? Do we buy hazmat suits? Are N-95 masks good enough to protect people from powder fentanyl? What about safety in the mailroom? Do we treat every white powder as a hazardous event? What about community correctional programs where there are little to no healthcare services? What are the right answers?

We correctional physicians are often unprepared, but we have resources. We have each other, continuing education and the ACCP. Let’s start conversations from the front lines. How do your K-2 patients present? Are they high for several hours or several days? What treatments have you tried? Let us know the drug combinations with which you are struggling. Is your K-2 laced with fentanyl? Which patients go the hospital? What kind of patient is safe to keep at the facility? Do your hospitals offer any more treatment than what you already have at the facility?

Getting educated is our biggest weapon. There are many online educational opportunities. But keep in mind that some only offer general information, and very few of them are directed toward corrections. The American College of Correctional Physicians, American Correctional Association, National Commission for Correctional Health Care, and many other organizations in our field hold national conferences. All of them offer educational opportunities in modern drug use and treatment.

We as physicians can do our part by showing leadership. You can meet with your wardens and tackle the difficult questions. You can challenge them with the need to stem the drug trade within the facility. Show your nursing staff videos of patients on K-2 and opioids so they know what symptoms to look for. Give criteria for vitals and transfers to the ER. Agitated patients often run fevers and will not eat and drink. Keep plenty of IV fluids available for use and use it. As for fentanyl, I recommend the average risk institutions keep at least four intra-nasal Narcan doses in stock, keep some at the disposal of the officers and train, train, train. At higher risk facilities, you might need a dozen or more doses of Narcan, N-95 masks, and hazmat suits. A few years ago, the Bureau of Prisons purchased fume hoods to protect staff in the mailrooms. Is it time to consider that? Meet with your local emergency preparedness agencies to gather more recommendations.

Be flexible. As the gangsters reformulate drugs to keep ahead of the laws, our patients are dying. Last year’s recommendations are out-of-date. Listen to good ideas, reject the things that no longer work, and share your experiences.

The ACCP’s Executive Director, Christine Westbrook, will collect any responses you send. Write her at christine@accpm.org. As your president, I will be happy to share the best recommendations and comments in future editions of CorrDocs.

BEHIND BARS IN BERMUDA

Rebecca Lubelczyk, MD, FACCP, CCHP-P

This summer I crossed another thing off my “bucket list” – I took the Boston cruise to Bermuda. I had never been to that small piece of paradise and with Boston only 30 minutes away by car, it was an easy choice to jump on a cruise. As luck would have it, I bumped into Prabhakar Kayam, the Medical Officer for the Bermuda Police, Prisons and Fire and Rescue Service. I asked what any of us die-hard correctional docs would ask of each other when we are on vacation: “Can I get a tour of your prison?” Kayam said of course and we planned the most unique shore excursion of any of the passengers aboard our cruise.

I must say, Bermuda is a gorgeous island. Conveniently enough, the prison is right at the wharf. We were docked for 3 days and Kayam hosted us every day, taking me and my husband to whatever sites we wanted to visit. We climbed a lighthouse, went to Horseshoe beach not once but twice (one of the most beautiful beaches in the world), and had tea at his house amongst other excursions.

The prison tour was a highlight of our cruise. Kayam arranged for us to spend the morning at the prison (but none of the security staff were aware, of course, just like in the U.S.). Once we finally got clearance, he handed us over to the Director of Security who took us all around.

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The day we were there, their census was 126 (Yes, one-hundred-and-twenty-six!) of which 6 were women and there were no juveniles that day. Granted it is a small island, but the DOS noted that they had implemented programs to significantly decrease the daily census.
After we finished our tour, Kayam took us out to lunch and the entire medical unit went with us. Since the lunch lasted longer than expected, the nurses told Kayam that he was not going to see patients that afternoon as it was getting late and they didn’t want to stay and take off orders. They told him to take the afternoon off and they’ll schedule them tomorrow. Now that is truly island-life.

Huge thanks to Kayam and his staff at the Bermuda Dept. of Corrections! If anyone is interested, I hear the medical director contract is coming up and Kayam may be looking for another venue – anyone interested in a little bit of paradise? You’ll have to go through me first!

One, sentences were reduced for minor crimes such as not paying child support. Another was to institute home monitoring for non-violent crimes. Since many of the crimes are drug-related, these programs affected many individuals.

I asked the DOS if they had many problems with drug contraband coming in. “Are you kidding?” was his response. “Our borders are so porous. Did you see how close we are to the ocean? They come up to the edge on jet skis and throw the drugs over the fence. Look over at that old fort/former prison above us. They allow tours to go through and we get stuff thrown down onto our basketball courts.” Wow. I told him that was so old school. We have K-2 coming in through the mail where they impregnate it in paper and reconstitute it on the other end. The DOS was amazed and realized that they didn’t have it so bad after all.

Finally, we got a tour of the medical facilities by Kayam and his Director of Nursing. What impressed me was they had 4 nurses for 126 inmates, a ratio unheard of in the States. Also, they were very excited that they had treated their first hepatitis C patient with the new medications. “It’s so expensive, we could only treat one so far. It cost us $15,000 just for him.” I was in shock. “$15,000 or $50,000?” I asked. “$15,000, of course”. Oh no, not of course. I explained to them that in the U.S. starting prices for a full treatment were upwards of $100,000. Now with more drugs on the market and some competitive contracts, some systems are paying as low as $25,000. “That’s ‘low’???” We could not believe the striking contrast, amongst many of the other differences we observed during our time in the Bermuda prison.

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SCRIEING IN PRISON

By Elizabeth Hance

In general, medical scribes are the people you see attached to a provider’s hip with a laptop, typing as fast as the speed of light. We work to increase the provider’s efficiency by typing their documentation in real-time while they see patients and by taking care of clerical duties like filing and tracking down paperwork, writing referrals, or answering phone calls. Because we help to increase the efficiency of the medical providers with whom we work, they are able to see patients more quickly and can see more people throughout their day.

It isn’t always easy being a medical scribe in a correctional facility. The patient population is very different compared to the outside. There are security limitations. There are also amazing experiences. As a project manager for ScribeAmerica, I have started scribe services at several prison facilities from scratch and worked in them, too.

Most of the medical scribes who work in correctional medicine have never even set foot into a correctional facility before. Only 25% of the correctional scribes with whom I worked had been in a facility prior to employment. Every scribe with whom I have spoken has mentioned that they were very nervous about their first day in the prison because they did not know what to expect. My parents were skeptical of me becoming a scribe in a prison because they were afraid of the possible dangers that I might face inside. Sarah Waterhouse, former scribe, mentions her family’s reaction.

“My family was shocked about me working in a prison and at times worried about my safety. However, my family was proud of the work I was doing, as they put an emphasis on the importance helping others no matter the circumstances.” Other scribes have mentioned to me that their families wanted to push them outside of their comfort zone and thus were convinced to enjoy this unique opportunity.

Aside from working in a whole new environment, we are also exposed to a different set of medical illnesses and practices. Outpatient medical scribes are trained on common chronic diseases, how to write notes, medical abbreviations and terminology, but this training did not specifically prepare me for correctional medicine and how medically complicated inmates can be. I asked five outpatient medical scribes what were the most popular chronic disease that they see in non-incarcerated clinics is, but they answered Type 2 Diabetes. The most common chronic disease we see in corrections is asthma, but we see hepatitis C often which is not as prevalent as outside of corrections. We also see a lot of patients with multiple comorbidities, which helps us to learn how providers deal with complications and treatments of these illnesses.

In correctional medicine, there is a lot of documentation and paperwork to complete within a work day. Most of the patients that we see require medical restrictions, special diets, renewal of medications, inside/outside facility referrals, and more. All of this has to also be completed on top of the typical SOAP note. This makes it hard for a provider to manage all of their paperwork during their shift. Having a medical scribe makes organizing and completing paperwork so much easier. Scribes always try to keep their providers on track and organized, so we make sure to document a complete plan during the patient’s visit. This makes it easy to remember to complete the applicable paperwork. Medical scribes also help the providers complete the forms that they need for their patient. We can do this together as a team, which makes everything a lot more efficient. This helps us to finish what the patient needs before the next patient even arrives.

Because we work in a prison, we have to follow the rules set by security. Can you imagine being a scribe without a laptop? Most facilities don’t let them in and, if they do, there are still a lot of restrictions. There are also a lot of times when I am unable to enter a patient’s room because of security, but I do my best to document as much and as accurately as I can, and afterwards follow up with the provider. Just like everyone else in corrections, we make do with what we have. Another difficulty we often face is understanding our surroundings and how to act in certain situations, but it is easy to adapt to the environment with help from security. They are always there to help us feel safe, offer advice, and deescalate situations that may arise with patients.

Although we do run into some road blocks, the exposure we have to correctional medicine outweighs it all. We are the provider’s right-hand, so we do see a lot of interesting medical situations such as suicide attempts, foreign body ingestion/insertion, multiple types of infections, and more. Sarah Waterhouse reflects, “There is never a dull day working in correctional medicine. Looking back on my experience as a scribe, I truly believe there was no other setting where I could have gained the vast knowledge I have now in medicine, mental health, and even substance abuse.” Personally, I have been told by a physician with whom I used to work that it is nice to have a scribe to be there as an emotional support. Sometimes we see patients who are not the happiest or level-headed people, and doctors enjoy knowing that they always have someone there with them, facing the same experience and having the same goal – to care and document that care.

“Editor’s note: In the correctional setting having a second clinically-oriented person in the room likely makes the provider more aware of the patient and the record being generated. And, should review subsequently be necessary (such as after a bad outcome or a response to a lawsuit), the presence of a second memory is reassuring.”

Booth Volunteers needed for the 2018 ACCP Fall Conference
Paris Hotel—Las Vegas, Nevada

Volunteers are needed on Monday, October 22 between 9:30 a.m. and 1:00 p.m.
and Tuesday, October 23, between 9:00 a.m. and Noon

Please email christine@accpmmed.org with your availability
Many of us in correctional medicine supervisory positions have Utilization Management (UM) duties. One common duty is to review requests from primary care practitioners (PCPs) for patient care services like an MRI and decide whether to approve the requests or write an Alternative Treatment Plan (ATP). This process is loosely based on a similar practice that is done within HMOs in free world medicine, but there are important differences. In an HMO, the evaluator is deciding whether the HMO will pay for the procedure. If the requested procedure does not meet HMO criteria, the evaluator will deny the request. The procedure can still be done, but the patient and her physician will have to find an alternative method of paying for it. Also, the HMO evaluator does not offer opinions on whether the procedure is appropriate nor does she offer suggestions as to what could or should be done instead.

Correctional medicine UM is different. Those of us doing these evaluations are not being asked about payment; we are being asked for permission to do the procedure itself. We cannot simply deny the request like an HMO can. If we do not think the procedure should be done, then we must say what should be done instead: The Alternative Treatment Plan. At its essence, the ATP is a formal communication between two colleagues. When done poorly, the ATP can pit the site physician and the UM evaluator against each other in an adversarial relationship. When done well, the UM evaluator and the site physician are equal collaborators and the ATP process actually improves patient care. UM is an important process, yet we must say what should be done instead: The Alternative Treatment Plan.

Like any other bit of writing, it is important at the outset to define who your audience is. The ATP should be written with three potential readers in mind. The first is the site practitioner who made the initial request. A bad ATP will leave the PCP feeling underappreciated, threatened and disrespected: “I don’t trust you and you are stupid.” A good ATP will leave the PCP feeling like you are on the same team and that you have their back: “You’re doing great! Let me help you.”

The second potential reader of the ATP to keep in mind is The Adversary, like a plaintiff’s lawyer or an advocacy group. A bad ATP may suggest that you are denying the patient reasonable and necessary medical services. A good ATP will show that nothing was denied and will not imply that any medical service is off limits.

Like any other medical order, ATPs are also read by nurses, who may transcribe and record the ATP in the official record. A good ATP will make their life easier. One example is that the UM nurses will want us always to date our ATPs.

**Step 1: Restate what is being requested.**

The first sentence of the ATP should briefly summarize the case and re-state what is being requested.

- 56-year-old male s/p colonoscopy done for guaiac positive stool. Request is for a routine post-procedure follow-up with the gastroenterologist.

**Step 2: Support your ATP.**

The next section of the ATP contains the evidence that supports your ATP. This evidence can be pertinent positives, like x-rays, labs, previous visits. This evidence can also be pertinent negatives like incomplete exams or missing data. Finally, this paragraph can also include pertinent research that supports your ATP, such as a quote from a respected resource such as UpToDate, RubiconMD or InterQual:

- The colonoscopy was negative except for a single sigmoid polyp. The pathology report on the sigmoid polyp is not attached to the report.

**Step 3: The ATP should defer the request, not deny it.**

It is important to never (or rarely) use the word “denied.” Instead, you should restate what was requested and then say it is “deferred” pending whatever you want done instead, such as “Pending receipt of missing information,” “Pending complete evaluation of the patient at the site,” or “Pending case evaluation in a case review conference”

- Routine post-procedure follow-up with GI is deferred, pending complete evaluation of the patient and colonoscopy findings at the site.

**Step 4: Tell the Primary Care Practitioner what you want them to do instead.**

The next sentence contains instructions to the site physicians and says “The PCP should ______ whatever you want them to do.”

- The site practitioner should obtain the pathology report on the sigmoid polyp and call me to discuss the case. The timing of follow up colonoscopy will depend on the biopsy results.

**Step 5: State that whatever was requested can be reconsidered later.**

I always add this last sentence as well, to reaffirm that I am not denying any medical care. “The request from the first paragraph” can be considered thereafter, if clinically appropriate or anytime if medically necessary.

- Off-site GI visit can be considered thereafter, as clinically indicated—or at any time if appropriate.

**Step 6: Contact the PCP to let her know that her request was ATP’d.**

I don’t think that PCPs should find out from a UM nurse that their request was ATP’d. They will feel much better about the process if you contact them. This also opens a method of communicating about the case if they have more questions. This can be accomplished with a simple email:

- Hi Dr. X! Before we send this patient off-site to see the gastroenterologist, we need the biopsy report. If the adenoma is low risk, you can deliver the good news to the patient and tell him when his next colonoscopy will be scheduled. You’ll be seeing him in chronic care clinic in the meantime.

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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.
INFORMATION PLEASE
By Fritz Vohr, MD

Operator.” said the voice on the phone. The voice belonged to Miss Mamie Tracy, my next-door neighbor and local telephone operator.

“Hi Mamie, do you know where my Dad is?”
“I think so” was the answer. “I’ll find him.”

My Father was a General Practitioner practicing out of our house in Lee, Massachusetts. The year was 1946. That phone call was a simple and immediate information retrieval system.

Fast forward to 2018 and your county jail with several incarcerated but hospitalized inmates. Your hard-working UM folks are tasked with following each inmate’s hospital course, progress, medical tests, and discharge planning.

The hospital team managing your patient usually consists of one or several hospitalists, a charge nurse or floor nurse, physical therapist, several consultants, and the utilization management team. Each has carefully noted their parts in your inmate’s care on their laptops, and most, but not all, of that information is stored in the large PC on the nurses’ ubiquitous trolley.

Cool! But how does that get back to the jail medicine staff? Most of the information is compartmentalized, and although the whole story may be on the computer, getting the facts, plan of care, and discharge plan can be daunting.

Flash back to 10 or 20 years ago. There was an attending physician, charge nurse, floor staff, and consultants all writing paper notes, some in lovely cursive, some totally illegible, some long, some short, some useful, some not. There were morning bedside rounds and reports with verbal exchanges of information resulting in the staff, charge nurse, and an attending physician who actually knew what was going on. A phone call to UM, the charge nurse, or attending was rewarded with current and accurate information.

Flash forward to 2018. The hospitalist is new on scene starting his 5-day rotation. He is not quite sure what is happening, and his assessment is different from that of his predecessor. He, in fact, has been hard to reach and delayed in returning your calls. He, is likely clueless about your jail’s medical capability, but thinks that the patient may be released tomorrow to the jail infirmary.

But wait a minute. You don’t have an actual infirmary.

“Can you do IV antibiotics? “ he asks, “and daily PT, manage his wounds and tracheostomy?”

And then you remember that the previous hospitalist attending just told you that the patient needed at least another week in an acute care setting in the hospital. Ouch!! Now everyone is getting frustrated. So what is the solution? In a perfect world the jail would have access to the hospital’s computerized records. When I was the Medical Program Director for the RIDOC, I was also on the hospital staff and had access to such. More importantly, I knew the hospital staff.

Solution #1: Make sure your Medical Director, UM, HSA, and DON establish contact with the hospital providers early on. Start with a call to the ER when an inmate is sent out and write down hospital contacts. You will soon learn which contact is most helpful. The best contact is peer-to-peer. Keep conversations, e-mail, and phone calls short and focused.

Solution #2: Set up a meeting between your Medical Director, UM, HSA, DON with the ER/UM/DON/ Hospitalist and explain your facility’s medical capabilities. Remember that hospitals get out their brooms on Friday and sudden discharges are not uncommon. Mention that we need time to get prepared for our patient’s release as we may need to get equipment or adjust staffing.

Solution #3: Ask your warden to invite hospital staff to visit your jail. The first ten minutes of controlled access, banging doors, sparse furnishings, and a look at a cell will be an experience not easily forgotten and will convey a sense of the venue to which hospital patients are released.

Solution #4: Stay in contact after discharge. Tell the hospital staff how the patient is doing and how much you appreciated their help and cooperation.

Make hospitalization a joint venture.

Are Twinkies © a Constitutional Right? from Page 1...

Informed refusal is quite similar; it differs only inasmuch as the patient refuses care and the documentation required is more thorough because it serves to protect the provider from subsequent allegations that care was not offered (when the refusal has resulted in harm).

Informed and competent patients can refuse care. Informed and competent patients can refuse therapeutic diets. This recognition leads to a straightforward approach to the patient who is undermining his or her medical treatment by using the canteen foods to excess.

While clinicians prefer to believe that an informed patient will adhere to clinical recommendations, this hope is not borne out in actual practice. This is especially true in populations which demonstrate less of an ability to defer gratification and more of a wish for “what I want when I want it, which is now.”

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Nearly 90 former inmates are buried here on the grounds of the North Central Correctional Institution at Gardner. Before inmates, the state buried patients housed at what once was the Gardner State Colony for the “mentally disturbed.”

Meredith Nierman / WGBH

A Massachusetts state prison is expanding the graveyard where it buries inmates who die in custody, one consequence of the state’s huge increase in aging prisoners. And as more inmates age and die behind bars, the cost of their care is skyrocketing, fueling new efforts to release prisoners who are too old or sick to pose a threat.

With 17 percent of its inmates now older than 55, Massachusetts has one of the highest rates of aging prisoners in the nation. And nationally the number of inmates older than 55 years old in state prisons has quadrupled since the ‘90s, due largely to longer prison sentences for violent crimes and an uptick in people older than 55 being sent to prison, according to the latest Justice Department report.

When some of these inmates die in prison and their bodies go unclaimed by family, they’re buried in a prison cemetery, under crosses made out of white plastic plumbing pipe.

At a prison an hour north of Worcester, Mass., some 90 men are buried in graves bearing no names, only numbers.

“It’s very humble. It’s nothing much,” said Kerry Keefe, the director of treatment at this state prison who’s also in charge of burying prisoners whose bodies go unclaimed by family — about three or four a year.

“This isn’t a bad place to spend eternity, but I think you’d want someone to cry for you,” he added.

A local funeral home charges the prison about $1,000 per burial, but a new law creating a system for medical parole in Massachusetts could spare the state that small cost and millions of dollars more spent caring for the oldest and sickest of inmates.

All but four states in the U.S. have such a provision, also known as compassionate release, but it’s rarely used. In Massachusetts, the new parole is an option only for prisoners who can prove they are physically or cognitively incapacitated.

But even Keefe, who expressed some sympathy for the inmates he’s helped bury, is skeptical of releasing such prisoners.

“I get it kind of saves money,” Keefe said. “It’s fairly obvious the person can’t do any kind of serious destructive behavior, but you got to pay attention and temper it with the demands of justice.”

Also pushing back is Charlie Baker, the state’s Republican governor. Baker’s staff pressed state lawmakers last spring to exclude first-degree murderers and some sex-offenders from eligibility for medical parole.

In a medium-security state prison in Shirley, Mass., 38 beds in a locked unit are set aside for inmates needing assistance with basic daily tasks.

“We have individuals who are full care patients that may be post-stroke or in complete quadriplegia that just require our full care — with everything — dressing, changing, and diapering. And then we have patients who suffered from dementia and they are just confused,” said social worker Elizabeth Louder who oversees what looks like a nursing home behind bars.

Massachusetts doesn’t track the cost of caring for these inmates, but its prison hospital spends more than $283,000 a year to care for a single, sick inmate, four times the cost of housing an inmate in its maximum security prison.

Studies by Pew Charitable Trusts found that older prisoners with chronic illnesses cost at least two times more than other inmates. When prisoners need specialty care in off-site hospitals, officers go along to guard them, sending costs even higher.
Joseph Labriola, a 71-year-old inmate in the Shirley prison, said he was guarded around the clock when pneumonia landed him in a hospital off prison grounds.

“Two guards. You have one sitting at the door with a gun and the other one sits right next to your bed, and your leg is chained to the bed,” he said.

Labriola has been in prison 45 years, serving life without parole for murdering an alleged drug dealer – a crime he says he didn’t do. His health problems include chronic lung disease that he blames on exposure to Agent Orange when he was a soldier in Vietnam. He now gets around in a wheelchair, pushed by a younger inmate.

More than anything, he doesn’t want to die behind bars.

George McGrath, age 70, was convicted in 1969 of first degree murder for his role in the death of two men in a drug store robbery. He is incarcerated at the “Assisted Daily Living” unit at MCI-Norfolk. He is seeking medical parole, claiming he is old, sick, and not a safety risk. McGrath said prison is a “young man’s game...obviously I’m not a young man anymore.”

Meredith Nierman / WGBH

“Dying in prison has a special aura to it. You’re not surrounded by people who love you, there’s nobody’s going to hold your hand on the way out the door,” he said.

Peter Koutoujian, a county sheriff in Massachusetts, is adamant that medical parole is the best a solution for the worst-off inmates.

“If you’re terminally ill or you’re medically incapacitated, you shouldn’t have to be in a jail, number one, and you don’t need to be in a jail, number two,” he said.

One big question surrounding the new policy in Massachusetts is where paroled inmates would go and who’d pay for their care. Backers of the new policy say federally-funded Medicaid or Medicare would cover costs.

Patricia Jehlen, the state senator who helped write the medical parole law, said some local hospice organizations are willing to take in prisoners.

“It’s going to allow people to die in a little more humane circumstances,” she said. “The growing number of elderly and incapacitated prisoners who are extremely expensive and hard to care for could be cared for in a much less expensive environment.”

But Massachusetts is an unforgiving landscape for convicts looking for parole, partly due to the Willie Horton effect. Horton was a convicted murderer who raped a woman in the 1980s while furloughed from prison. Political ads featuring Horton in the 1988 presidential campaign helped sink former Massachusetts Gov. Michael Dukakis’ bid for the White House.

Since 2000, 769 inmates have requested commutations — or a reduction of their sentences — from the state Parole Board, but only one request has been approved by a sitting governor, state records show.

Nationally, compassionate release programs have produced scant results. Few states are mandated to track the number of prisoners released under such programs and only a handful of inmates have won release in the states that keep any data, according to a report released in June by Families Against Mandatory Minimums, a nonprofit in Washington, D.C. A 2013 Justice Department report called the compassionate release program for federal prisoners “poorly managed and implemented inconsistently” and likely caused some eligible inmates to be overlooked and left others to die before their requests were determined.

And back in Massachusetts, the state just rejected the first petition for medical parole from an inmate with pancreatic cancer, saying his release would still pose a public safety risk.

This story was reported in partnership with the New England Center for Investigative Reporting, a nonprofit news center based out of Boston University and WGBH News. Chris Burrell can be reached at burrellc@bu.edu and Jenifer McKim at jenifer.mckim@necir.org.

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It is reasonable to manage use or avoidance of the canteen as a clinical recommendation, one which can be accepted and to which a patient may adhere, or which can be rejected, whether verbally or in practice. A patient’s decision regarding canteen foods which undermine clinical treatment should be documented clearly in the health record, and a written treatment refusal is very appropriate when a patient wants to continue canteen use.

Most facilities permit clinical personnel to obtain canteen records, at least on an occasional basis. It is reasonable to check on canteen purchases just as adherence to any other clinical recommendation can be checked. In correctional populations it is unfortunately common for patients to state adherence that is not confirmed when canteen records are checked.

Consider the diabetic patient. Diabetes management, especially for type 1 diabetes, requires close and consistent balancing of diet (especially carbohydrate intake and timing of food), exercise and activity, and medication. Failure of any of these three interventions to be managed results in hyper or hypoglycemia. Close management of all results in normalization or near normalization of glycosylated hemoglobin levels, which is the goal for optimal diabetes treatment. Use of more than occasional canteen food can undermine glucose management even for patients who are otherwise adherent to medical advice. (It is nonadherence to medical advice that underlies almost all so-called brittle diabetics.)

Goals for adherent diabetic patients should be similar to those in the outside community. Goals for nonadherent patients should be less aggressive, not only because close control is impossible, but also because attempts at close control may place patients at risk for hypoglycemia (if canteen foods are skipped and everything else is held constant, carbohydrate intake is abruptly decreased).

*Continued on Page 10...*
Patient autonomy may be respected if a diabetic patient who elects to utilize canteen foods is informed regarding the long-term risks associated with higher glycosylated hemoglobin levels and asked to sign a document demonstrating informed refusal. The same approach can be useful with the patient who claims to be adhering to clinical recommendations but whose canteen record demonstrates otherwise. With higher glycosylated hemoglobin treatment goals (less than optimal), the patient can be managed with fewer dangerous low sugar episodes and, hopefully, with a more open and honest relationship between clinician and patient. This may even create an opportunity for continuing patient education which could result in adherence in the future.

Clinical personnel do not control canteen usage, other than in infirmary settings (where all foods are typically provided by food services). Diet restrictions made for therapeutic considerations are treatment interventions and, like other treatment interventions, should be subject to informed consent or refusal. The above example for diabetes can, with appropriate modification based upon patient’s needs, be generalized to other clinical conditions. This simple approach respects the ethical principles to do no harm and to respect patient autonomy while avoiding unnecessary conflict with custody and security administrative processes.

Best Practices: Writing an Alternative Treatment Plan (ATP) from Page 5...

Putting it all together, here is the full ATP:

56-year-old male s/p colonoscopy done for guaiac positive stool. Request is for a routine post-procedure follow-up with the gastroenterologist.

The colonoscopy was negative except for a single sigmoid polyp. The pathology report on the sigmoid polyp is not attached to the report.

8/27/2018 ATP: Routine post-procedure follow-up with GI is deferred, pending complete evaluation of the patient and colonoscopy findings at the site.

The site practitioner should obtain the pathology report on the sigmoid polyp and call me to discuss the case. The timing of follow-up colonoscopy will depend on the biopsy results.

Off-site GI visit can be considered thereafter, as clinically indicated—or at any time if appropriate.

Email to PCP: Hi Dr. X! Before we send this patient off-site to see the gastroenterologist, we need the biopsy report. If the adenoma is low risk, you can deliver the good news to the patient and tell him when his next colonoscopy will be scheduled. You’ll be seeing him in chronic care clinic in the meantime.

Here is another example:

53-year-old s/p treatment for tongue cancer in remission. Request is for routine follow-up with ENT at six months from last visit.

The patient has finished all of his radiation sessions. ENT note from 7/17 states that the patient is in remission and that the six-month follow-up visit is “prn.” The consult request notes no new symptoms.

2/14/18 ATP: ENT consultation deferred. Per last visit with ENT, further visits are to be “prn.” The site PCP should evaluate the patient at six months from the last visit and again at one year from the last visit. Off-site visit with ENT can be considered thereafter, as needed—or anytime if clinically necessary.

Hi Dr. X!

The ENT note says that this visit may be “prn.” You indicated that the patient is doing well and without new symptoms or problems. Will you please evaluate the patient and call me to discuss?

Final example (minus collegial email):

62-year-old who had a liver ultrasound as part of staging prior to receiving treatment for Hepatitis C. The ultrasound showed a hypoechogenic polyp or cyst at the neck of the gall bladder. The radiologist says “A CT may be of value.”

There is no report that the patient is symptomatic. I submitted the case to a Rubicon radiologist, who thinks this is an incidental finding and repeat ultrasound in six months is a better methodology to follow-up this incidental finding.

2/12/18 ATP: Abdominal CT is deferred. Per Rubicon radiologist’s recommendation, the site PCP should order a follow up ultrasound at ~six months. CT may be considered thereafter as clinically appropriate (or anytime if necessary).

In summary, when ATPs are well done, they can foster collegial communication regarding the patient’s care, decrease legal risk, and provide education to clinicians and nursing. When done poorly, the cost is more than monetary.
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