Essex County Civilian Oversight Task Force

Annual Report 2021

In Memoriam

A note on Task Force member Eddie Cannon

The Task Force and the greater Essex County community lost a true public servant in Eddie Cannon, who formerly occupied the Task Force member seat dedicated to a demonstrated corrections expert. After retiring as the Acting Director of Custody at Northern State Prison with 25 years of experience with the NJ Department of Corrections, Eddie Cannon returned to public service as a valuable volunteer in the Task Force's early activities.

We honor the memory of a vital member of the Task Force and the Essex County community.

Essex County Civilian Task Force

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Essex County Civilian Task Force

Summary

In 2019, Essex County constituted a Civilian Oversight Task Force ("Task Force"), composed of community stakeholder representatives, to thoroughly and methodically review systemic issues and challenges at the Essex County Correctional Facility ("ECCF"). Pursuant to Essex County Ordinance No. 0-2019-00017, upon completion of its review, the Task Force is to provide Essex County with detailed recommendations for improving the quality of life and safety of individuals detained and incarcerated at ECCF.

Recognizing that this is a years-long project, the Task Force has compiled this Annual Report to inform the public of its progress in 2021, which included among many activities an assessment and analysis of ECCF health practices, visits to ECCF both organized and unannounced, dialogue and collaboration with community partners and experts, and a review of complaints that community members submitted throughout the year to the Task Force.

Pursuant to its mandate, the Task Force expects to release to the public in 2022 its first report with recommendations. This report will provide a comprehensive review of the medical and mental health practices at ECCF, with recommendations for systemic improvements. It represents the culmination of the work of the Task Force in collaboration and conjunction with experts on issues of correctional health, public health experts, physicians and other health providers, members of the public, and ECCF authorities.

In furtherance of its mandate, the Task Force has determined that ongoing oversight of ECCF is warranted. Accordingly, the Task Force will continue to review operations and practices, and to conduct both organized and unannounced visits. As the Task Force becomes aware of further systemic issues and events of public concern, it will assess whether to issue recommendations for improvement.

The Essex County Civilian Oversight Task Force

On December 11, 2019, the Essex County Board of County Commissioners approved Ordinance No. 0-2018-00017, authorizing the establishment of the Task Force for the dual purpose of assisting ECCF to meet its custodial responsibilities to individuals incarcerated or detained at its facility, and providing residents of Essex County an independent public channel to ECCF.

Just as the nascent Task Force was taking shape and contemplating how best to focus its efforts, the first wave of the COVID-19 pandemic hit the State of New Jersey. With Governor Phil Murphy's March 2020 declaration of a State of Emergency, and Public Health Emergency in New Jersey, the Task Force's efforts came to a near standstill. However, as the statewide (and nationwide) crisis wore on, the Task Force quickly agreed that it could best serve the community by focusing its efforts on the health of ECCF's detainees and inmates, a cohort widely recognized as among the most vulnerable to COVID-19 infection on account of constant and close confinement. Toward that end, Task Force members established and maintained an active channel of communication with ECCF medical staff about evolving practices and procedures (including testing, mask wearing, and ultimately vaccinating the population), held Town Meetings outdoors and on Zoom to hear and respond to the community's concerns, and visited ECCF to observe its operations.

The Task Force, in response to one of the greatest challenges of our time, has been able to adopt an organizational structure flexible enough to permit course shifts when circumstances demand, without losing sight of its dual purpose to serve the most vulnerable and provide the public with greater access and transparency than heretofore available.

The Essex County Civilian Oversight Task Force

The Essex County Civilian Oversight Task Force

Creating the Task Force

The Essex County Board of Commissioners and Essex County Executive Joseph DiVincenzo appointed Jose Linares, former Chief Judge of the U.S. District Court for the District of New Jersey, as the Task Force's Executive Director, and James McGreevey, former New Jersey Governor and current Chair of the New Jersey Reentry Corporation, as the Task Force's Chair. The Board also designated seven Task Force seats to represent a diverse range of criminal justice special interest groups, and an eighth seat to represent the public at large.

Under the leadership of Judge Linares and Governor McGreevey, these eight seats were filled by a representative from a recognized detainee advocacy group, a representative from a recognized inmate advocacy group, an individual formerly incarcerated, a corrections expert, a member of the New Jersey criminal defense bar, a social justice advocate, a medical expert, and a member of the public.

In outlining the first by-laws and procedural goals of the Task Force, Essex County officials and Task Force leadership consulted public defenders, prosecutors, corrections officers, victims' advocates, civil rights leaders, elected officials, community activists, and clergy. County administrators, county commissioners, ACLU-NJ members, and stakeholders representing the interests of Immigration and Customs Enforcement ("ICE") detainees, all assisted in crafting the original enabling ordinance and continue to provide input regarding the evolution of the Task Force.

Following the Task Force's review of identified systemic issues, the Task Force will provide detailed recommendations for improvements to the quality of life and safety of individuals incarcerated at ECCF. Particularly in light of the Public Health Emergency, throughout the Calendar Year 2021, the Task Force focused on the critical issue of providing exhaustive, quality medical and behavioral health supports to those housed in ECCF. A detailed and evidence-based report of recommendations is forthcoming in Spring 2022, produced in collaboration with ECCF and experts in the correctional health field.

The Task Force has since initiated a dialogue and review of concerns presented by members of the public, individuals incarcerated at ECCF, legal advocates, Essex County officials, and ECCF authorities. The Task Force has continued to collect statements from those currently incarcerated, advocates, ECCF leadership and staff, families, and other stakeholders, with the intent of identifying systemic issues that may be further investigated and addressed.

A note regarding an amendment made to the Ordinance No. 0-2019-00017 –

In April 2021, Essex County Executive Joseph N. DiVincenzo announced Essex County would end the practice of housing federal immigration detainees at ECCF. On August 17, 2021, County Executive DiVincenzo confirmed no federal immigration detainees remained housed in ECCF. Instead, Essex County would utilize its capacity to house inmates from Union County.

On October 29, 2021, the Essex County Board of County Commissioners approved an amendment to the Task Force's enabling ordinance, including a response to the new absence of federal immigration detainees at ECCF; the Task Force seat formerly designated to a detainee advocacy group will now be filled by an additional representative of the public.

The Essex County Civilian Oversight Task Force

Initial Task Force Activities

The Task Force has focused its initial efforts on the following activities:

- Establishing Task Force protocol to conform with its mandate and by-laws;
- Studying current conditions and administrative protocols at ECCF;
- Gathering facts and information to identify systemic issues at ECCF;
- Assisting ECCF in responding to individual grievances sent to the Task Force;
- Developing an open line of communication with ECCF administrators; and with inmates via facility tablets;
- Consulting community advocates and stakeholders regarding civilian oversight practices;
- Encouraging those housed at ECCF, their families and advocates, as well as ECCF personnel and Essex County residents generally, to avail themselves of the newly created Task Force to bridge the access gap; and
- Providing recommendations to the Essex County Executive and the Board of Commissioners regarding medical and behavioral health operations at ECCF.

In light of the new challenges the COIVD-19 pandemic has wrought on the community, civilian oversight of ECCF is more critical now than ever to ensure the health and safety of the jail's exceedingly vulnerable population. To that end, the Task Force has been closely monitoring the following matters:

- The status of COVID transmission among ECCF staff, inmates, and others housed at the facility;
- Facility lockdowns;
- Incidents of violence and death within the jail population;
- Incidents of violence by corrections officers, as reported in the media and by ECCF administrators to the Essex County Executive and the Board of Commissioners;
- Complaints and litigation involving corrections officers;
- Issues affecting ICE detainees when they were housed at ECCF;
- The transition of Union County inmates to ECCF;
- The transition of Union County inmates to ECCF
- Visitation suspensions and limitations imposed on account of COVID;
- Individual complaints of abuse, poor conditions, deprivation, lack of medication, and special dietary needs ignored;
- ECCF intake procedures;
- Medical Department and Mental Health Department operations and procedures; and
- Social Services and Inmate Advocate operations and procedures.

The Essex County Civilian Oversight Task Force

The Task Force Moving Forward

The Task Force has only begun to review, study, and debate the myriad challenges individuals face while housed at ECCF and upon reentry into society, as well as the challenges ECCF faces to provide the highest standard of care and safety to every individual who passes through its doors. The Task Force is acutely aware of the immense amount of work ahead, and the need to obtain the public's full support and collaboration if it is to succeed in bringing about critical improvements in the quality of life at ECCF.

Special Housing Units (SHU) – The Task Force will next focus its efforts on the SHU to determine if ECCF is in full compliance with State law and policy. New Jersey recently enacted the Isolated Confinement Restriction Act ("ICRA"), which significantly limits the use of isolated confinement and establishes the conditions of confinement. Apart from facility-wide lockdowns, medical isolation, and protective custody, ECCF may only confine individuals in the SHU for disciplinary reasons when they present a substantial risk of harm to others. The Task Force will review ECCF policies and procedures, and make unannounced visits to observe the practices in the SHU. The Task Force already held its first public meeting on matters regarding the SHU in January 2022.

Expanded Stakeholder Input – The Task Force will continue to strengthen civilian oversight of ECCF by engaging the participation of the entire Essex County community, primarily through public meetings, which will permit residents to voice their concerns as well as ideas for reform, and provide the Task Force with the opportunity to update the public in as transparent a manner as possible.

The Task Force plans to survey individuals housed at ECCF regarding their experiences, while also ensuring current policies and actions remain in effect consistently. The Task Force hopes to increase dialogue with tier representatives and randomly selected inmates, as well as facilitate regular meetings between the Union County Office of the Public Defender, the Essex County Office of the Public Defender, and the Essex County and ECCF administration.

The Task Force continues to evolve outreach and contact methods. Task Force administration hopes to install and promote a mailing list to which interested individuals may subscribe and directly receive Task Force updates and notifications. Additionally, the Task Force hopes to engage clergy and faith leaders offering critical social services and reentry support to incarcerated individuals.

The Task Force is grateful for ACLU-NJ's consistent guidance and civilian oversight resources, including exhaustive recommendations in fulfilling the Task Force's mandate. Such recommendations have included advice on growing public awareness, communicating with currently incarcerated individuals, engaging criminal justice reform actors and the scholarly ruminations on the evolution of civilian oversight, and publicizing relevant Task Force activities and issues. The Task Force looks forward to further engaging families, incarcerated individuals, advocates, community providers, and all those who may augment the trajectory of this Task Force.

The duration of this report will describe the activities of the Task Force throughout Calendar Year 2021.

The Essex County Civilian Task Force – 2021

Task Force Designation	Member	Term
Executive Director	Hon. Jose Linares	2020 - 2023
Chair	James McGreevey	2020 - 2023
Expert in the medical field - Member	Dr. Chris Pernell	2020 - 2023
Member of the Public - Member	Rosa Santana	2020 - 2022; 2023 (*term renewed)*
Member of the Public - Member	Alessandra DeBlasio, Esq.	2020 - 2022; 2024 (*term renewed)*
Recognized inmate advocacy group - Member	Marshall Justice Rountree	2020 - 2022; 2024 (*term renewed)*
In good standing of the New Jersey Criminal Defense Bar – Member	Rubin Sinins, Esq.	2020 - 2022; 2024 (*term renewed)*
Formerly incarcerated individual – Member	Imran Rabbani	2020 - 2022; 2023 (*term renewed)*
Social justice advocate - Member	Pr. Pablo Pizarro	2020 - 2022; 2023 (*term renewed)*
Demonstrated Correctional Expert	Emmanuel Nso	2021 - 2023

The Essex County Correctional Facility

In Essex County & Surrounding Areas

Essex County Correctional Facility (ECCF) is a correctional facility in Essex County, New Jersey, located at 354 Doremus Avenue, Newark, NJ 07105.

ECCF is a county correctional facility, which means ECCF houses inmates awaiting trial or sentencing or serving a relatively short sentence following trial. These individuals stay an average of 29 days and may be residents of Essex County, or many of the surrounding areas.[1]

[1] This excludes the origins of detainees transported to Essex County or New Jersey by U.S. Immigration and Customs Enforcement.

Inmates are held on a temporary basis while awaiting trial or disposition of their charges, awaiting transport after being convicted and sentenced to one year or more in state prison, or awaiting transport to another county or jurisdiction while on a temporary hold for that jurisdiction. Inmates are held on a permanent basis while serving a sentence from a municipal court, of up to 180 days, or while serving the sentence of a superior court, of up to 364 days. State Re-entry inmates generally have 18 months or less to serve of their sentence.

Excluding the Federal ICE detainees, the average ECCF inmate stays at the facility about 29 days. This is a significant length of time for any individual living under incarceration. Notably, 29 days is a limited period of time when seeking to provide quality lifestyle and medical care and support to those who will shortly reenter society, typically facing the same challenges that first entangled them in the criminal justice system.

ECCF provides critical medical and behavioral health services to those housed at the facility, as well as those who may fail to meet clearance for incarceration and face redirection during the general intake process. In fact, ECCF is often the de facto primary care provider of these individuals, many of whom are residents of Essex County. In addition to being responsible for the safe and dignified custodial care of its residents, ECCF maintains an obligation to the public health services of each community represented by its inmates.

The Essex County Correctional Facility Civilian Oversight Task Force – CY 2021

For more than one year, the Task Force has studied the Essex County criminal justice system, with particular attention to ECCF procedure and daily practices. In addition to collecting statements and interviewing a wide range of experts — county officials, corrections staff, formerly incarcerated individuals and their families, defense attorneys, clergy, service providers, advocates, and others — the Task Force hopes to continue a far-reaching community engagement process, including meetings with the faith community, expanded public input options, and other collaborations with community members to conduct in-depth data analysis, broaden the Essex County understanding of evaluated model programs and practices from across the country, and produce strong, exhaustive recommendations for improvements to ECCF policies.

The Essex County Civilian Task Force hosts a remote public meeting discussing addiction treatment and medication-assisted treatment at ECCF | January 30, 2021

Ultimately, the Task Force will submit a recommendations report to Essex County suggesting evidence-based policy improvements to procedure and ECCF services regarding health and wellbeing. After focusing on a review of medical, wellness, and mental health practices at ECCF, the Task Force will share its first recommendations report in Spring 2022, produced in collaboration with ECCF and experts in the correctional health field. This report is researched and written by the Task Force Medical Subcommittee in collaboration with experts in correctional health issues.

In addition to the forthcoming 2022 report on health services improvements, the Task Force engaged in a number of ongoing oversight activities to both establish an inaugural Task Force oversight procedure, preliminary goals, and overall awareness of ECCF status and potential areas for improvement. These activities include reception of public complaint submissions, internal Task Force meetings, coordination with ECCF staff and Essex County officials, and consultation with stakeholder advocates and experts.

The Task Force has heard from ECCF staff and leadership, inmates and detainees, members of the public including inmate family members and community providers, and legal and criminal justice advocates of the incarcerated. In addition to compiling relevant stakeholder statements and experiential data, the Task Force worked with ECCF to directly collect administrative data. Major Task Force activities included:

- Hosting three in-person public meetings
- Hosting four virtual public hearings
- Completing three visits to the Essex County Correctional Facility
- Meeting and collaborating with ECCF community advocates
- Meeting and collaborating with the Office of the Public Defender
- Meeting and collaborating with ECCF leadership and staff
- Monitoring the progress of the Essex County Prosecutor's investigation of ECCF
- Receiving public complaint submissions, conferring on public complaint submissions, referring concerning complaint submissions for Essex County investigation and reviewing Essex County's subsequent responses or explanations

COVID-19 & Public Health Emergency Protocol

The Essex County Correctional Facility

COVID-19 Protocol

In the Calendar Year 2021, the Task Force conducted the majority of oversight activities amidst the COVID-19 Public Health Emergency and State of Emergency, an unprecedented global pandemic. The Task Force began its initial activities with a keen awareness of the unique vulnerability of incarcerated individuals, and all those who routinely engage in visits or communications with ECCF.

Thus, the Task Force prioritized monitoring COVID-19 safety and health protocol at ECCF, as well as the effective and consistent maintenance and compliance of these new measures. Task Force members made inquiries to ECCF regarding issues like supplies, family visits, legal visits, testing, masking, medical monitoring, intake, housing, and more of the myriad of daily practices that intersect with critical public health policies.

Issues regarding the pandemic regularly surfaced throughout the Task Force's CY2021 efforts, leading to important inquiries into the pandemic's impact on access to medical care and programs, how social distancing is implemented without compromising mental health and safety, and how ICE detainees were handled. While certain aggregated data was challenging to collect from ECCF – due to the state of administrative technology and not for lack of ECCF efforts – the Task Force was able to work with ECCF due to an awareness of growing best practices in the medical field via Dr. Chris Pernell, Chief Strategic Integration and Health Equity Officer at University Hospital. The Task Force worked with ECCF to strengthen some of these policies.

ECCF uses a variety of testing measures to monitor and track infections within the facility. ECCF uses testing not only to test upon entry to the facility, but also to clear quarantines when necessary, to safely facilitate transfers to other facilities or agencies, and to prepare patients prior to hospital procedures or trips.

Rapid IgG/IgM Antibody Testing

Beginning in April 2020, ECCF initiated the use of Rapid IgG/IgM testing for cohorting patients only and not to diagnose active infections. People who tested negative for antibodies were presumed not to have been exposed and/or previously infected with coronavirus, and were housed separately from those who tested positive. The facility relied on antibody testing because at the time they report they did not have access to diagnostic tests. ECCF has administered 8,385 Rapid IgG/IgM tests through January 2021.

Rapid Antigen Testing

ECCF introduced the use of rapid antigen tests in November 2020 which were used for diagnostic purposes. ECCF has administered over 11,000 rapid antigen tests to the inmate population to February 2022. The main advantage of rapid antigen tests is the rapid detection of SARS-CoV-2, the virus that causes COVID-19, which provides a result on the order of minutes and can be performed onsite. Rapid antigen tests, while they are specific for the virus and detect a part of the virus called viral proteins, which make up the virus's structure, they are not as sensitive as molecular PCR tests which require a longer turnaround time for results and must be sent outside for processing.

Abbot ID Now Rapid PCR Testing

Beginning in April 2021, ECCF obtained the facility's first Abbott ID NOW rapid PCR test – a newer testing technology. This is a rapid molecular test used to detect the part of the SARS-CoV-2 virus called viral RNA (ribonucleic acid), which is the virus's genetic material. The turnaround time for this test is approximately 15 minutes, whereas an outside lab result of a traditional PCR test may take several days to be returned. ECCF now has ten Abbott machines for its patient population.

This allows ECCF the ability to clear large numbers of patients for safe transfer to court or clear quarantines when necessary. The facility reports as part of its COVID-19 strategy, CFG and Essex County has proactively pursued the latest testing technology as it becomes available on the market through Food and Drug Administration (FDA) authorization.

Vaccination

As of February 2022, ECCF has worked with the New Jersey Department of Health to administer a total of 1,637 doses of the COVID-19 vaccines among those incarcerated at the facility. ECCF has fully vaccinated 789 individuals with either Moderna, Pfizer, or Johnson & Johnson vaccines and has administered 112 boosters with either Moderna or Pfizer. ECCF continues to administer vaccines to the inmate population on a weekly basis.

COVID-19 Testing Policy

From the initial Task Force meetings in September and October 2020, Dr. Pernell and other members regularly requested information and statistics regarding COVID-19 infection prevention and control at ECCF. Dr. Pernell reinforced evolving best practices throughout the pandemic, especially the priority to provide PCR and rapid testing instead of relying solely on antibody testing. The Task Force's contributions were instrumental in ECCF adopting a PCR (molecular) testing policy in addition to the antibody (serological) testing initially made available.

Additionally, ECCF was one of the first jail facilities in the United States to utilize the rapid PCR test, allowing the detection of COVID-19 among both symptomatic and asymptomatic individuals. In April 2021, ECCF announced that CFG Health Systems, the medical provider at the Essex County Correctional Facility in Newark, would begin testing inmates and detainees for COVID-19 using the rapid PCR test.

Intake Policy

At intake, a nurse conducts a COVID-19 screening that evaluates exposure, risk of exposure, and vital signs. Individuals also take a COVID-19 test—initially a nasal antigen test, then followed by a rapid PCR test, if positive. At the height of the pandemic, following intake, individuals were housed in a quarantine area for 14 days, during which they were monitored daily by medical staff. ECCF was one of the first correctional facilities masking individuals, and each person is provided a mask upon entrance. However, masking at ECCF is only utilized when the inmates are mobile about the facility and outside of their designated cells or pods.

Due to logistical issues and security concerns, ECCF clarified the above masking policy to the Task Force that individuals within the general population and former ICE dorms are not masked at all times. Instead, individuals are grouped into pods and housed together based on mutual COVID-19 transmission status, and are masked upon arrival and when mobile about the facility or outside of their designated cells or pods.

ICE Detainees Policy

The Task Force recognized the high COVID-19 infection rate in ICE dormitories compared to county cell blocks and inquired how ECCF has been working to mitigate this. ECCF was one of the first facilities to petition ICE to start releasing detainees from dorms for the sake of their health because the medical staff identified the dorms as being unconducive to social distancing or other COVID-19 mitigation practices. Early in the pandemic, ECCF encouraged ICE – based on guidelines set out by the Centers for Disease Control and Prevention – to establish an internal assessment for identifying those with the highest risk of contracting severe illness from COVID-19. ECCF then submitted a list to ICE of those at risk. As a result of this, the numbers of those in dorms were cut in half; further, ECCF prevented admissions from several agencies, such as the Port Authority, federal authorities, and the U.S. Marshals.

Vaccination Policy

As described above, through February 2022, 789 incarcerated individuals have been fully vaccinated and 112 have received booster doses. The first doses of the COVID-19 vaccines were administered to the inmate population on January 5, 2021 and were given in accordance with the eligibility criteria established by the NJ Department of Health. By January 31, 2021, 100 doses were made available for ECCF staff. To incentivize vaccination among the incarcerated population, ECCF gives a $10 credit upon completion of the one-dose (Johnson & Johnson) or two-dose series (Moderna or Pfizer). The Task Force is continuing to gather data in the aftermath of the COVID pandemic health emergency which will be made public in on-going, future venues.

Visits and Tablet System Policy

As of the writing of this report, all family visits have been suspended temporarily, pending a date from the county health office. To mitigate the effects of this, ECCF reinstituted the two daily free, 10-minute phone calls for incarcerated individuals until March 31, 2022. All attorney visits, as recommended by the county health office, will continue with window visits (no verification of vaccination necessary, but masks required) and in-house lobby virtually conducted visits. Due to concerns regarding confidentiality while visiting with legal counsel, the Task Force has asked ECCF and Essex County if a discussion with County public health officials may occur to discuss the safety of in-person legal visits where all parties are masked.

Additionally, because of the Task Force's inquiries regarding tablet technology at the facility, ECCF has updated the software so all individuals can continue to use the tablets for phone calls, video visits, games, music, etc. As of March 2022, ECCF is also working on an application so tablet users can directly send complaints to and easily access information about the Task Force.

Medication-Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD) Program Policy

The Task Force and ECCF personnel discussed the intersection of the pandemic and substance use disorder at the December 5, 2020 public hearing. Dr. Zerbo referenced recent studies suggesting an increase in overdose deaths during the pandemic and potentially increased risk of COVID-19 contraction to individuals suffering from opioid use disorder. These statistics emphasized the importance of the recent MAT/MOUD program launched at the facility, which aims to prevent overdoses and relapse through medication-assisted treatment.

Health Services Policy

The medical staff continues to monitor all incarcerated individuals, checking for symptoms and signs of illness. Protocols are in place for those who may be immunocompromised, which include additional daily monitoring and a plan to separate them from the population should it be necessary. Further, the Inmate Advocate and Social Service Departments at ECCF make daily rounds in the housing units to attend to concerns and issues.

Because of the pandemic, mental health group therapy has been put on pause after March 14, 2020, and are set to resume when safe from a public health perspective. As of the writing of this report, classes conducted by volunteers and/or part-time workers continue to be suspended. The Task Force asked about telemedicine capacity for group work, to which ECCF affirmed its support of the idea and confirmed discussions of a programmatic day of mental health programs per unit, making the unit itself a therapy unit.

The Task Force, on behalf of the public, also inquired how those who have family who passed away due to COVID-19 receive support from the facility. ECCF offers counseling services for those who request it, and the mental health staff immediately refer people to counseling if a family member has passed from the virus. Additionally, those who test positive for coronavirus are immediately referred to mental health.

The Task Force continues to monitor COVID-19 protocols and best practices at ECCF, maintaining an ongoing dialogue with ECCF.

Sanitation Policy

The ECCF staff has been cleaning and disinfecting the facility rigorously. Appropriate disinfection solutions continue to be given to the cleanup crews and staff, with an additional storage unit placed on the premises to hold extra supplies (4- to 6-month inventory of supplies for needed items). ECCF also purchased an additional sanitizing machine for its Emergency Response Equipment, and handheld sanitation devices continue to be utilized to clean all attorney visit areas, mattresses, vehicles, etc. ECCF's food service provider, GD Corrections, sanitizes the kitchen area every hour.

Food Policy

GD Corrections continues to have 30 days of meals on hand. They have extra freezer space with 14 days of frozen meals available if needed. Additional staff have been transferred to ECCF to work in the jail kitchen, and a transportation plan is in place in the event public transportation should stop for employees. All food in the Officers Dining Room is grab and go.

Task Force Activities - Procedural Overview

Annual Report 2021

Task Force Activities - Administration

2021 Task Force Activities

Task Force Activities

Administration: The success of this newly established civilian oversight task force will strongly rely on the organizational foundation, structure, and standard practices deemed necessary for the Task Force to fulfill its commitment to the people of ECCF. As such, the Task Force has prioritized establishing preliminary goals and procedures, rigorously studying and debating how to best utilize its independence, access to ECCF, support from concerned and experienced stakeholders and community members, material resources, and the diverse expertises of the perspectives of its membership.

The Task Force, too, has found it necessary to internally discuss and debate its mandate in practice. Despite a mandate of four meetings and at least one public meeting annually, the Task Force has held regular internal meetings, as well as emergency meetings in response to current issues at ECCF. In initial factfinding efforts, the Task Force has hosted a total of seven public meetings since October 2020. The Task Force has additionally participated in a number of private consultations with civilian oversight experts and advisors, such as Judge Jonathan Lippman of the Independent Commission on New York City Criminal Justice and Incarceration Reform.

Such discussions have included:

- The abilities and boundaries of Task Force authority
- Identifying evidence-based systemic issues
- Ensuring an appropriate resolution of real-time individual cases reported to the Task Force
- Recommendations which may be made in the short-term for emergency response
- Recommendations which may be pursued in the long-term of ECCF operations
- Appropriate procedure for inviting and handling sensitive complaints submitted by the public and those currently incarcerated at ECCF
- Information requests and necessary fact-finding as Task Force members study ECCF culture, procedure, and operations in-practice
- Promoting awareness of and access to the Task Force to the Essex County community
- Best practices for public engagement during the COVID-19 pandemic

Task Force Administration – McCarter & English, LLP

McCarter & English, LLP is contracted by Essex County for the purposes of Task Force administrative and legal support. The Task Force added a summary of McCarter & English support services to the official Task Force website in April 2021.

In April 2021, the official Task Force website was modified to state:

"To assist the Essex County Correctional Facility Civilian Task Force in ongoing oversight activities, legal personnel and firm resources at McCarter & English, LLP provide administrative and legal support services under the direction of Executive Director Judge Jose Linares.

Legal professionals at McCarter & English assist the Task Force in drafting legal documentation and by-laws. McCarter & English prepares documentation and protocol recommendations for delivery to the County as requested by the Task Force. Attorneys review, consider, and monitor legal cases filed in Court on behalf of detainees, providing counsel during Task Force and Stakeholder meetings.

On behalf of the Task Force, McCarter & English acts as a liaison between the Task Force and Essex County officials and the correctional facility. McCarter & English marshals requests for documents, reports, witnesses and other information requests from either the County or the correctional facility. As requested by the Task Force, McCarter & English provides legal support to initiated an assessment of issues or events that may have been identified.

McCarter & English receives and processes Task Force communications and grievances, including public communications submitted to the Task Force email and voicemail. McCarter & English additionally assists in setting up Task Force meetings and events, document preparation and filing, and other administrative support services."

Essex County Correctional Facility – Custodial Procedure Training: Following the appointment of all nine members of the Task Force, ECCF staff and Essex County administration conducted an initial series of workshops regarding ECCF procedures and compliance obligations. These workshops allowed Task Force members to establish a common baseline understanding of the structured rules, regulations, and resources under which ECCF leadership operates in maintaining the safety and wellbeing of each individual ECCF houses.

Training Sessions

Rules, Regulations, Responsibility, and Rights regarding Inmates and Detainees – ECCF custodial policy maintains that staff and those housed at the facility treat inmates and ICE detainees with dignity and respect, while maintaining a safe, secure and sanitary facility. The Task Force studied the inmate handbook and dictated rights and responsibilities, as established by ECCF.

ICE Detainees and Distinction from Inmates – ECCF engaged the Task Force regarding the distinction between inmates and those individuals federally detained by ICE. While the Task Force is tasked with overseeing the treatment and wellness of all individuals housed at ECCF, including ICE individuals, ECCF administration assisted in outlining the limits of ECCF in providing federal documents and records.

Medical Monitoring and Grievance Process – ECCF briefed and provided in-depth contextual and practical explanations and administration policy regarding the mechanisms under which incarcerated individuals may seek timely medical attention, continuity of care, and general grievances and complaints regarding facility treatment. These mechanisms will be further outlined and supplemented with Task Force recommendations in the 2022 medical and behavioral health report.

Social Services – ECCF described policy, offerings, and organizational structure regarding the provision of supervised social services programs to inmates and ICE detainees.

N.J.A.C. 10A and Performance-Based National Detention Standards – ECCF is evaluated and accredited by several government and private bodies. ECCF briefed the Task Force on Federal and New Jersey State detention standards, as well as those of the American Correctional Association and the National Commission on Correctional Health Care.

Safety and Security Protocols – ECCF provided basic demographic and population information regarding those housed at the facility, as well as supporting staff and personnel. The Task Force was presented with emergency and other security protocol, facility maps, and other rules and regulations which underly the daily operations of ECCF personnel.

Confidentiality – Federal, State, and Local obligations in maintaining the privacy and dignity of individuals within ECCF include compliance with:

- The five titles of the Health Insurance Portability and Accountability Act (HIPAA) – Federal guidelines for the security and privacy of individually identifiable health information.
- The US Freedom of Information Act – Federal provisions of the public right to access federal records. *While detainees were housed at ECCF, certain records were not available to the Task Force due to federal exclusions from these provisions.*
- N.J.A.C. 10A – Protects confidential correctional personnel records from unwarranted examination
- Open Public Records Act (OPRA) – State statute governing the public right of access to government records in New Jersey. *Certain information may not be made public, including emergency or security information which may jeopardize the security of the facility or persons therein, and sensitive personnel information.*
- Common Law Right to Privacy – The New Jersey Courts recognize the four common law right to privacy torts: intrusion, false light privacy, public disclosure of private facts; and appropriation of name or likeness.
- Attorney General Guidelines & the New Jersey Constitution – New Jersey does not have a single comprehensive state protecting the privacy and security of health and medical information.
- Essex County Ordinance No. 0-2019-00017 – County provisions of Task Force authorities, mandating the Task Force establish confidentiality rules and procedure. *The Task Force must treat all matters under review as confidential, unless disclosure is necessary for the Task Force to perform oversight duties. This also protects the individual identities of ECCF employees and staff, which may not be made public by the Task Force.*

Task Force Contact: In the interest of collecting information and statements for the evidence-based identification and assessment of systemic issues in ECCF policy, the Task Force was provided a designated email and voicemail to which members of the public may remotely submit information or complaints regarding ECCF. JailTaskForce@admin.essexcountynj.org and the toll-free telephone number (973) 877-8037 are routinely promoted as methods of communication to the public. This contact information is listed on Task Force public notices, press releases, social media promotional posts.

This information is additionally provided to those individuals currently housed at ECCF. The Task Force has worked with ECCF administration to promote awareness of the Task Force and encourage communication and engagement amongst inmates and detainees – flyers inviting submissions and advertising contact information are posted in shared dorm spaces, and the tablets which are central to grievance submissions, medical requests, video family and legal calls, and other daily activities. The Task Force has not yet confirmed the availability of this flyer within the hardcopy of the traditional inmate handbook.

When the Task Force administration receives public submissions, or when a Task Force member receives a submission in their capacity as a member of the Task Force, such statements are logged and shared internally for the review of the full Task Force.

Task Force Activities -
Ongoing Monitoring & Requests for Information

Task Force Investigations & Public Complaints: The Task Force agreed on internal procedure for receiving and handling complaints submitted by the public, adapting this procedure to accommodate anonymous submissions by those who are currently incarcerated at ECCF. Complaints may be submitted anonymously to the toll-free Task Force voicemail or via email. ECCF now provides regular notice of the Task Force to current inmates, encouraging them to utilize the voicemail at no cost to the inmate.

The Task Force liaised with ECCF on these issues submitted by concerned members of the public and those currently incarcerated at ECCF. Following the submission of a complaint, the Task Force 1) solicited a report from ECCF in explanation of the complaint, 2) monitored an appropriate response and solution, as able, and 3) liaised with individuals who submitted the complaint, when deemed necessary.

Since establishing the Task Force email and voicemail in September 2020, the Task Force has received and solicited an ECCF inquiry in response to a total of 49 individual complaint submissions. The Task Force also worked with a number of ECCF inmates identified in complaint submissions regarding sick calls, administrative requests, special dietary needs, and access to communication with family members.

For further details, please see Appendix K.

Requests for ECCF Records and ECCF Administrative Information

While the Task Force may receive public submissions and statements which contain sensitive or personally identifying information, the Task Force also recognizes that currently incarcerated inmates and those otherwise housed at ECCF may report an immediate complaint to the Task Force without also using standard grievance or medical procedure to notify appropriate ECCF personnel who may materially respond to real-time problems.

In this event, the Task Force uses discretion when reviewing complaints from those within ECCF custody, keeping in mind concerns regarding privacy and potential retaliation. When the Task Force deems an internal ECCF administration response necessary for the wellbeing of individuals in custody, the Task Force forwards all such complaints to ECCF and Essex County administration.

After making ECCF aware of such complaints, the Task Force reviews an explanation of the event from ECCF administration, follow-up actions taken by ECCF personnel, and any provided commentary from relevant inmates. All responses are consequentially logged, and the Task Force may deem continued follow-up or ECCF administration engagement is necessary.

Occasionally the Task Force receives complaints regarding commissary logistical errors, sick visits or unreported medical problems, court questions, staffing complaints and mistreatment allegations, or other incidents which have been promptly addressed and rectified. Thus far, the Task Force has not identified systemic policy problems surrounding such reports.

Protecting Confidentiality of Public Submissions

Protecting the privacy and dignity of all individuals who may seek to share information regarding civilian oversight at ECCF is of utmost importance to the Task Force. To ensure reliable and consistent protection of confidentiality, the Task Force has carefully discussed and developed internal procedures when handling publicly submitted information or complaints.

The Essex County community and those individuals housed within ECCF must be able to confidently share pertinent information regarding ECCF.

Anonymity – Individuals housed within ECCF are offered the option of utilizing a toll-free call to leave an anonymous statement to the Task Force, should they wish to remain anonymous.

In addition to stringent internal debate, the Task Force is grateful to ACLU-NJ for advising the Task Force and Task Force administration on further supplementing the ability for those incarcerated at ECCF to communicate with the Task Force anonymously. These recommendations have included a physical lockbox located in the facility, in which individuals may deposit anonymous notes, as well as establishing a mechanism where inmates may submit virtual statements or otherwise meet virtually with Task Force members.

All solicitations for public submissions to the Task Force are accompanied by the statement:

"You may request confidentiality by stating the following: This statement is confidential. The Task Force will consider confidential submissions and provide a general recommendation."

Protecting Confidentiality of Public Submissions

Informed Consent – The Task Force has solicited public submissions of information or complaints via public notices, flyers distributed within ECCF, the ECCF inmate handbook and tablets, social media promotional pages, and press releases, always including an advisory regarding confidentiality:

> "Thank you for your submission to the Essex County Correctional Facility Civilian Task Force. Please know your submission has been received by the Task Force.
>
> Please be aware any information submitted to the Task Force is subject to being shared with the County or any other entity or agency deemed appropriate upon Task Force evaluation. If you have sent a question about Task Force activities, please expect a reply shortly.
>
> As a reminder, the purpose of the Task Force is to provide public oversight, transparency and accountability with respect to the policies, procedures, practices, supervision, management, and training at the Essex County Correctional Facility. As a result, all submissions receive full consideration of the Task Force. However, not all submissions will receive individual follow-up."
>
> Please find Task Force By-Laws [*link to website provided*].

Task Force Access to ECCF and Essex County Administration: Since the complete appointment of each Task Force member seat, the Task Force has maintained regular communication with ECCF leadership and the Essex County administration and Board of Commissioners.

COVID-19 Situational Awareness Reporting – Immediately, the Task Force received regular and continuous situational reports from the County Executive regarding the COVID statuses of ECCF staff, inmates, and others housed at ECCF. Such reports included data associated with positive tests, recovered individuals, releases, workforce and staffing, county inmates, state re-entry inmates, U.S. ICE detainees, U.S. Marshal inmates, Delaney Hall inmates, and other statistics associated with ECCF population changes.

COVID-19 safety protocol generally is limiting by nature due to the necessity of social distancing and vulnerabilities presented by indoor activities. The Task Force monitored and followed the dynamic changes in policy as COVID-19 transmission rates and cases fluctuated. Examples of monitored policies include masking guidelines and the resumption of window visits.

ICE Stakeholder Meetings – The Executive Director participated in monthly calls established by Essex County and ECCF administration for ICE detainee representatives and stakeholders. Here, ECCF shared ongoing conditions and responses regarding facility inspections, COVID-19 protocols, social services, and other administration activities. Stakeholders also had the opportunity to request information regarding challenges expressed by public defenders, detainees, and families.

Timely Issues at ECCF – As new information became available regarding issues at ECCF, the Essex County administration immediately shared such details with the Task Force. Such reports may notify the Task Force of the death of any inmate, an ongoing lockdown and expectations for the resumption of standard operations, litigation concerning former correctional officers, the conclusion of housing federal ICE detainees at ECCF, the transition of Union County inmates to ECCF, COVID-19 protocols and fluctuations, window visit policies under COVID-19 protocol, state and federal inspections, and other changes in ECCF operations or conditions.

Information Requests – Over the past two years, ECCF administration has made itself readily available to the Task Force to supply information and deliberate on facility conditions. The Task Force and staff have visited the facility with full access at will and have made numerous information requests to the Essex County and ECCF administration as needed. ECCF has supplied detailed responses and data-collecting support to the Task Force Medical Report Subcommittee throughout the process of researching, analyzing, and considering improvements.

Task Force Activities -
Public Stakeholder Collaboration

Public Stakeholder Collaboration: The Task Force continues to welcome engagement with members of the public and ECCF inmate advocates. In consultation with external partners, the Task Force made a number of short-term recommendations to the County regarding expanding public awareness of the Civilian Oversight Task Force to Essex County residents and those currently incarcerated within ECCF.

ECCF Medical Director discusses ECCF partnerships with Essex County medical providers at a Task Force public meeting | October 3, 2021

Independent Commission on New York City Criminal Justice and Incarceration Reform: In Spring 2021, Executive Director Linares, Task Force Chair McGreevey, and Task Force administration consulted multiple times with Judge Jonathan Lippman and representatives of the Independent Commission on New York Criminal Justice and Incarceration Reform.

In ordaining the Essex County Civilian Task Force, the Essex County Board of Commissioners and County Executive Joseph DiVincenzo took the same bold step in leadership made by the New York City Council toward the Rikers Island custodial complex. In 2016, the New York City Council appointed former New York State Chief Judge Jonathan Lippman to chair the Independent Commission on New York City Criminal Justice and Incarceration Reform. Under Judge Lippman's leadership, 27 leaders were selected to serve on the Commission from a variety of fields, including law, academia, business, philanthropy, and the non-profit sector.

The Rikers Island Commission independently produced an exhaustive report in response to the overwhelming reports of inhumane, violent, and dysfunctional treatment of people incarcerated at Rikers Island.

The Essex County Civilian Task Force, likewise, has initiated similar efforts to highlight expert and community-based solutions to identify and improve any systemic weaknesses faced by ECCF and the criminal justice system as a whole.

Engagement with individuals incarcerated or detained at ECCF: The Task Force is aware of the necessity of including robust input from those who have directly experienced incarceration at ECCF and those who are presently living at the facility. As such, the Task Force has sought methods of installing within ECCF open communication with those individuals and promoting awareness of the Task Force and how inmates may utilize the Task Force as a resource.

Toll-Free Voicemail: Inmates at ECCF have access to make a free telephone call to the Task Force phone contact, and they may leave a voicemail submission for the Task Force. The Task Force has worked with ECCF to ensure inmates may successfully leave messages, to encourage inmates to make such submissions freely, and to communicate to inmates that personally identifying information is not required and confidential messages must be explicitly described as such.

In-Person Public Meetings: The Task Force has arduously endeavored to build inclusive and sustainable protocols in line with COVID-19 public health safety requirements. This has included utilizing social media, digital news media, County stakeholder and press contact lists, and virtual meetings for the purpose of promoting awareness and enacting Task Force activities. While there is a unique benefit to remote outreach and communication with stakeholders, there are certainly many challenges to limited in-person activities through fluctuating waves of COVID-19 transmission.

The Task Force has resolved to prioritize in-person, outdoor meetings when able to ensure those who may not have online or virtual access or may not be as technologically literate may still participate in Task Force activities. The Task Force, thus far, has hosted three virtual meetings, which are streamed live to a link publicized in advance and are made available at a later date at facebook.com/EssexCountyCivilianTaskForce.

The Task Force certainly seeks to fulfill its mandate of hosting at least one meeting open to the public annually, and in fact hopes to invite significantly greater public collaboration when able. Past public meetings have fallen within two categories of Task Force factfinding and research, either:

1) Conducting issued-focused discussions between Task Force members and ECCF staff responsible for overseeing and administering relevant services. These discussions allow Task Force members to further study and engage ECCF staff and administration, while making available to the public the progression of such conversations and activities.

2) Inviting issue-based public statement submissions and public discussion. The Task Force has previously hosted meetings specifically for the purpose of public participation and engagement, inviting community providers, social services organizations, formerly incarcerated inmates and detainees, families, legal advocates, and other members of the stakeholder community who may wish to provide input for Task Force consideration and records. The Task Force hopes to facilitate further opportunities for community providers and partners to ECCF administration both during and following an inmates incarceration to directly engage and collaborate in considering challenges and potential solutions to challenges faced at ECCF.

In addition to the standard invitation for public submissions for Task Force consideration via the official email and voicemail service, the Task Force has additionally hoped to provide the opportunity for public comment during such meetings when time permits.

While in-person attendees may more easily offer comment or question, virtual attendees hoping to submit comments in real time have done so via leaving written comments on the virtual livestream or making submissions to the Task Force email. Task Force administration encourages members of the public to submit questions for real-time Task Force consideration via email, but the Task Force has found greater public participation via social media comments. Both avenues are monitored in real time, and the Task Force represents public questions when able.

Flyers and Promotional Materials: The Task Force has worked with ECCF to distribute flyers expressing the purpose of the Task Force, its independence from ECCF and Essex County, and Task Force contact information. These flyers are posted in shared dorm areas, distributed upon intake, included in the inmate handbook, and accessible within facility tablets. These flyers also contain directions for submitting anonymous information or requesting anonymity.

Task Force notices, announcements, and directions for viewing archived recordings and streams of past public meetings are publicly available on the official Task Force Website and a publicly available Facebook page. Presently, such announcements are distributed by both mediums, as well as via press release and local media publications and email to stakeholders who have provided contact information to the Task Force.

https://essexcountynj.org/civilian-task/
https://facebook.com/EssexCountyCivilianTaskForce

Tier Representative Records & Communication: The Task Force has reviewed the minutes and issues discussed during the regular meetings between ECCF inmate representatives, and now receives advance notice and minutes of such meetings as a standard practice. Typically, such meetings involve an inmate representative of each facility tier. These are paid roles.

As reviewed by the Task Force, issues discussed have included impediments to the efficient distribution of food and other recent logistical problems, lack of available staffers, tier representative wages, requests for expanded recreational time, lockdown and code statuses, commissary stock and order delays, technology or tablet issues impeding standard civil rights practices like access to the legal library or the transfer of funds, questions regarding COVID-19 protocols, and other breakages in inmate routines.

Additionally, members of the Task Force have met in person with such representatives and other available inmates and detainees.

Announced and Unannounced Visits to ECCF: The Task Force has also committed to visiting and touring ECCF, although many Task Force members have robust familiarity with the facility in their individual capacities.

As a body, the Task Force is invested in protecting the health and safety of members with regular consideration of COVID-19 rates of transmission. However, the Task Force is aware those incarcerated within ECCF face elevated vulnerabilities to contracting and recovering from COVID-19. Thus, the Task Force seeks to limit the number of Task Force attendees where necessary and was able to conduct its first site visit in July of 2021.

While certain Task Force representatives visit ECCF regularly, participate in leadership meetings, observe the facility, and assist in compiling ECCF administrative data, visits organizing the combined faculties of each member seat were additionally conducted in November and December of 2021.

The Task Force is also authorized to make unannounced visits to ECCF, with full access to facilities and without coordinating with ECCF administration. These visits do require one hour's advance notice in order to ensure those visiting may efficiently and safely gain entrance upon arrival. Two unannounced visits were conducted in December 2021, and an additional visit occurred in January 2022.

July 2021 – The Task Force toured general intake, the medical department, and the mental health department with ECCF officials and staff. The Task Force interviewed two ICE detainees, one man and one woman, regarding intake and the quality of medical services. At the time, the detainees discussed limited housing resources, noting unsatisfactory mattresses and limited women's hygiene products.

November 2021 – The Task Force met with ECCF administration in order to discuss potential systemic improvements to medical and behavioral health policies and improvements.

December 2021 – Alerting ECCF administration an hour prior to arrival, the Task Force visited ECCF twice to observe standard practices. Task Force members visited three units, including both locations where shocking violence resulted in the recent hospitalization of an inmate and the death of another.

Visit 1) A member of the Task Force noted an absence of flyers promoting the Task Force throughout the facility. The Task Force was able to meet at length with a young man incarcerated in one of the visited units. The Task Force subsequently engaged ECCF leadership to address concerns regarding sanitary living conditions and access to showers. The Task Force spoke with ECCF administration and noted ECCF concerns regarding workforce shortage due to COVID-19 transmission.

Visit 2) Task Force members spoke with two inmate tier representatives and two randomly selected inmates, engaged ECCF administration regarding behavioral health programming and recent incidents of severe violence, and walked through ECCF Special Housing Units ("SHU") and the medical department.

A member of the Task Force again noted a general lack of awareness and access to the Task Force despite previous promotional efforts. With this repeated occurrence, the Task Force will continue to work with ECCF to ensure a reliable mechanism that encourages and allows those housed at ECCF to freely contact the Task Force.

Inmate Representatives and Community Advocates: The Task Force consulted with oversight experts and ECCF community stakeholders, which included meetings with representatives from organizations like ACLU-NJ. ACLU-NJ has continued to submit comprehensive research materials and recommendations regarding criminal justice reform and the relatively new field that is public solicitations of civilian oversight. The Task Force is grateful for the ongoing guidance and will continue to integrate this insight as the Task Force acts to fulfill its mandate.

The Task Force benefited from such discussions regarding Task Force needs to provide public transparency and civilian oversight over ECCF activities – topics have included expanding public awareness of the Task Force and goals of reviewing systemic challenges, ensuring safe access to the Task Force and encouraging collaboration from those individuals presently housed at ECCF, engaging public stakeholders and experts in the field of civilian jail oversight, and maintaining strong transparency with Task Force administrative procedure and internal activities broadly.

Ongoing Monitoring: Since its inception, the Task Force has solicited information on ongoing events and operations at ECCF. There have been a number of significant events which the Task Force has determined required monitoring and requested information from ECCF. These have included, not by way of limitation, a hunger strike by ICE detainees then housed at ECCF, acts of violence and deaths of inmates, ECCF officers being criminally charged with misconduct, and significant challenges associated with COVID-19. These events, together with ongoing monitoring of complaints lodged with the Task Force, have caused the Task Force to make an inquiry and to monitor events. The Task Force shall endeavor to determine whether these events, either alone, or in conjunction with each other, give rise to systemic issues for which improvement recommendations will be warranted. To date, the Task Force has not issued any recommendations or reports related to these events, many of which are pending ongoing legal process. Outlined elsewhere in this report are the Task Force's requests for information from ECCF and the responses. The Task Force shall not interfere with ongoing investigations and litigation involving ECCF-related matters. Yet the Task Force has fully supported the independent investigation of signal events, including inmate deaths. In that vein, the Task Force has supported the commissioning of The Ambrose Group, LLC for such an investigation.

The Task Force has immensely benefited from the experiential data gained from discussions with the Union County and Essex County Offices of the Public Defender. These opportunities have offered insight as reported by public defenders and attorney representatives into the following:

Transition of Union County inmates to ECCF: The Union County Deputy Public Defender Rob Miseo has reported numerous attempts to initiate an ongoing dialogue with ECCF administration in the interest of implementing improvements to the living and safety conditions for individuals housed at ECCF.

As shared by the UCOPD and ECOPD, public defenders have reported "a steady drumbeat of complaints regarding the unsatisfactory conditions for Union County detainees at ECCF." In the several months since the new Memorandum of Agreement between Union County and Essex County, Deputy Miseo engaged ECCF administration regarding unsafe and unsanitary conditions witnessed for Union County pre-trial detainees in advance of their initial hearings under the Criminal Justice Reform Act ("CJRA").

These engagements culminated in a December 13, 2021 joint letter from the Essex County and Union County Offices of the Public Defender to the Essex County and ECCF administration, asking for the prompt rectification of reported unconstitutional conditions under which Union County detainees are held at ECCF.

For further details, please see Appendix A.

Noted concerns include:

Housing Accommodations: Public defenders reported an absence of appropriate housing accommodations for days at a time, detained in crowded and unreasonably cold bullpen-style holding areas. Beds are available only for a minority of detainees, forcing many to sleep on the floor with or without unsatisfactory rubber mats. ECCF staff have represented that there is no room for improved accommodations elsewhere in the facility.

Medical Isolation and Suicide Watch: Without adequate justification, detainees may be placed in medical isolation or "suicide watch." Numerous individuals who have been placed on suicide watch deny expressing any suicidal ideation. The isolation of these individuals has impeded them from meeting with OPD attorneys and staff, delayed their first appearance before the court and thus prolonging their temporary detention.

Trends of Escalating Violence: Public defenders have also long expressed concerns regarding increasing violence within ECCF, a concern which the ECCF administration echoes to the Task Force. Public defenders highlighted the October 2021 hospitalization of an inmate in critical condition and the death of an inmate in December 2021.

Dialogue and Engagement with ECCF leadership: Both UCOPD and ECOPD have sought to initiate an ongoing dialogue and collaborative effort to address such reported trends. While OPD leadership may directly contact ECCF administration for prompt rectification of sudden client emergencies and needs, the OPD notes the absence of a formal mechanism for public defenders to regularly engage ECCF.

The Task Force has communicated with Essex County administration, and is working with both the OPD and ECCF to institute regular stakeholder meetings for public defenders and legal advocates. Such meetings were previously enacted for representatives of ICE detainees and Essex County has expressed interest in reinstituting this channel of communication.

Facilitating communication between public stakeholders and ECCF administration: Ensuring meaningful, reliable, and accessible channels of communication between public stakeholders and the Essex County and administration continues to be a priority of the Task Force. The Task Force has heard complaints from several attorneys about a perceived lack of privacy during phone calls and video conferences with clients at ECCF. A lack of attorney-client privacy raises two serious concerns: an infringement of the inmates' constitutional rights; and the safety of inmate cooperators who, if overheard when relaying highly confidential information, are at heightened risk of inmate-on-inmate retaliation.

Addressing and remedying this issue has taken on increased urgency during the COVID-19 pandemic as ECCF has had to periodically curtail in-person attorney-client visitation, leaving video conferences as the only viable alternative. While ECCF has made cubicles available to inmates to facilitate video conferencing with attorneys, these cubicles do not yet afford complete privacy. According to inmates and their attorneys, passersby are able to hear the inmates' conversations, just as inmates are able to hear the passers-by in the corridor immediate outside the cubicles.

Task Force members raised this issue with ECCF administrators, who acknowledged that the video cubicles are not yet completely secure. They advised that the video cubicles have walls on three sides and a door at the back, but that the cubicles are nevertheless partly open.

Task Force Activities -
Ongoing Activities

Office of the Essex County Prosecutor Investigation: Following the announcement of the death of an inmate at the Essex County Correctional Facility on Friday, December 13, the Task Force continues to monitor the progress of the investigation of the Essex County Prosecutor and New Jersey Attorney General's Office. The Task Force remains in dialogue with ECCF and Essex County authorities and awaits the conclusion of the independent review Essex County has commissioned from The Ambrose Group LLC.

The Task Force shall not interfere with ongoing investigations and litigation involving ECCF-related matters. Yet the Task Force has fully supported the independent investigation of signal events, including inmate deaths. In that vein, the Task Force has supported the commissioning of The Ambrose Group, LLC for such an investigation.

In the interim, the Task Force has submitted information requests to ECCF regarding the conditions of the internal ECCF investigation and the incident itself.

The Task Force submitted this initial inquiry on January 10, 2022.

ECCF provided responses to this request on January 19, 2022.

ECCF provided an update regarding the ongoing status of investigation on March 28, 2022.

For further details, please see Appendix B.

Task Force Recommendations – Medical Report: The Task Force established a Medical Subcommittee with the goal of reviewing medical and mental health practices at ECCF with the goal of ultimately producing a thorough and data-based report of ECCF medical practices and recommendations for improvement. This report is researched and produced in collaboration with the following:

- Pamela Valera, PhD, MSW, ACSW, NCTTP | School of Public Health and School of Social Work at Rutgers University
- Chris Pernell, MD, MPH, FACPM | University Hospital
- Gloria Bachman, MD, MMS | Rutgers RWJMS Women's Health Institute
- Joseph Ranieri, DO | Center for Healing Light & Integrative Medicine
- Joseph Borges, MD, MHA | University Hospital
- Tanya Pagán Raggio-Ashley, MD, MPH, FAAP | Co-Chair, NJ Women's Reentry Commission
- Kaitlin Baston, MD, MSc, DFASM | Cooper University Health Care Center
- Emily Buirkle, MD | Rutgers University Comprehensive Addiction Resources & Education Center

Task Force Activities -
Public Meetings

Task Force Public Meetings

October 3, 2020 – Health & Medical Practices – The Essex County Civilian Task Force ("Task Force") held a remote meeting open to the public with relevant Essex County Correctional Facility ("ECCF") personnel regarding mental health services. Addiction and medication-assisted treatment were two topics of discussion moved to the third Task Force hearing due to time constraints. Items under discussion included mental health intake, medication distribution, mental health in segregated housing, and several questions submitted by the public.

ECCF Panelists:

- Dr. Lionel Anicette, ECCF Medical Director
- Sandra Grant, ECCF Director of Nursing
- Madaline Bell, ECCF Health Services Administrator
- Heidi Reifenberg, ECCF Quality Assurance Coordinator
- Alfaro Ortiz, ECCF Director

Health Expert Attendees:

- Dr. Erin Zerbo, Associate Professor, Department of Psychiatry, Rutgers New Jersey Medical School

Task Force's Next Steps: On behalf of the Task Force, Dr. Chris Pernell sent a number of requests and questions to the ECCF administration, including those regarding stats and demographics on those incarcerated, policies and protocols, as well as detailed information on services. ECCF provided a thorough response to all requests and questions within the month. *For further details please see Appendix C.*

November 12, 2020 – Mental Health & Addiction Resources –The Essex County Civilian Task Force ("Task Force") held a remote meeting open to the public with relevant Essex County Correctional Facility ("ECCF") personnel regarding mental health services. Addiction and medication-assisted treatment were two topics of discussion moved to the third Task Force hearing due to time constraints. Items under discussion included mental health intake, medication distribution, mental health in segregated housing, and several questions submitted by the public.

ECCF Participants:

- Dr. Lionel Anicette, ECCF Medical Director
- Dr. Dennis Sandrock, ECCF Mental Health Director
- William Anderson, ECCF Deputy Director
- Dierdre White, ECCF Social Services Director
- Pascale Augustine, ECCF Medication-Assisted Treatment to ECCF

Health Expert Attendees:

- Dr. Petros Levounis, Chair, Department of Psychiatry, Rutgers Medical School
- Dr. Erin Zerbo, Associate Professor, Department of Psychiatry, Rutgers New Jersey Medical School
- Dr. Joseph Ranieri, NJ Society of Addiction Medicine

Task Force's Next Steps: On behalf of the Task Force, Dr. Chris Pernell sent a comprehensive list of questions and data requests to the ECCF administration. The list of questions is attached hereto as Appendix D. Additionally, Dr. Pernell asked for slides to accompany any future ECCF presentations. Rosa Santana, on behalf of the Task Force, asked Dr. Sandrock to provide a list of medications that mental health has prescribed, as well as stats on which have been prescribed the most amount inmates and detainees. Dr. Pernell also asked for Dr. Anicette to provide statistics on the prevalence of substance use disorders and mental health issues at ECCF. Further, the Task Force recognized the need for a public hearing on SHU; Dr. Sandrock said he will provide information and statistics on those held in special housing. Finally, Governor McGreevey asked for ECCF to submit a list of providers or FQHC partners. *For further details please see Appendix D.*

December 5, 2020 – Addiction Services & MAT – The Essex County Civilian Task Force ("Task Force") held a remote meeting open to the public with relevant Essex County Correctional Facility ("ECCF") personnel regarding addiction and medication-assisted treatment services. Task Force members and ECCF staff discussed the prevalence of substance abuse disorder among those incarcerated, the intake and general screening process, the protocol for those suffering from substance abuse disorder and/or withdrawal, and the barriers that patients may face from intake to post-release. Additionally, ECCF personnel gave a presentation on the new MAT/MOUD program—shortcomings, successes, and goals for growth.

Public Participants

- Dr. Lionel Anicette, ECCF Medical Director
- William Anderson, ECCF Deputy Director
- Deirdre White, ECCF Social Services Director
- Dr. Dennis Sandrock, ECCF Mental Health Director
- Pascale Augustine, ECCF MAT Coordinator
- Joseph Morgan, ECCF Correctional Policy Officer & Navigator

Health Expert Attendees:

- Dr. Erin Zerbo, Associate Professor, Department of Psychiatry, Rutgers New Jersey Medical School

Task Force's Next Steps: On behalf of the Task Force, Dr. Chris Pernell and Dr. Erin Zerbo sent a number of questions to the ECCF administration after the public hearing. Questions ranged from those about mental health and substance use disorder protocols and staff training to those about available health services and requests for quantitative data. ECCF provided answers to each question within the month. *For further details please see Appendix E.*

January 30, 2021 – Addiction Services & MAT II – Summary of Hearing: The Essex County Civilian Task Force ("Task Force") held a remote meeting open to the public with relevant Essex County Correctional Facility ("ECCF") personnel to continue discussion regarding addiction and medication-assisted treatment services. Task Force members and ECCF staff focused on how patients qualify for MAT/MOUD, best practices in terms of medication and dosages, linkages to community health partners made for post-release, and barriers that patients may face specifically after release to continue treatment and receive services. In general, the discussion was framed around 1) the role of the criminal justice system in rehabilitation, 2) the limits imposed by and the capabilities of outside providers, and 3) what the current Task Force and ECCF team can do.

Public Participants

- Dr. Lionel Anicette, ECCF Medical Director
- Deirdre White, ECCF Social Services Director
- Dr. Dennis Sandrock, ECCF Mental Health Director
- Pascale Augustine, ECCF MAT Coordinator
- Joseph Morgan, ECCF Correctional Policy Officer & Navigator

Health Expert Attendees:

- Dr. Erin Zerbo, Associate Professor, Department of Psychiatry, Rutgers New Jersey Medical School

Task Force's Next Steps: On behalf of the Task Force, Dr. Chris Pernell began to form a Medical Report Subcommittee in the interest of further researching medical and mental health services at ECCF and offering ECCF improvement recommendations. *For further details please see Appendix F.*

May 22, 2021 – Public Accounts – The Essex County Civilian Task Force ("Task Force") held an in-person meeting regarding personal accounts of interactions with ECCF health programming and the medical department. Members of the public were invited to appear before the Task Force and offer statements, in addition to the Task Force's standard invitation for the public to submit written statements via e-mail. Specifically, four individuals shared public statements: a woman speaking on behalf of her incarcerated boyfriend, two formerly incarcerated men, and a Freedom for Immigrants advocate on behalf of someone in the facility.

Public Participants

- Andia Hibbert
- Alexis Kalteron
- Fernando Fernandez
- Tieku Annoi
- Tania Mattos

Task Force's Next Steps: The Task Force continued to prioritize and advance the Medical Report Subcommittee, collaborating with external experts and consultants in correctional health. *For further details please see Appendix G.*

June 12, 2021 – Grievance Procedure & Women's Health – The Essex County Civilian Task Force ("Task Force") held a remote meeting open to the public with relevant Essex County Correctional Facility ("ECCF") personnel regarding ECCF's grievance submission procedure and women's health services. Prior to the meeting, the Task Force received a chart from ECCF breaking down female grievances from January 1, 2020 to June 11, 2021, *attached hereto as Appendix I.* At the public hearing, the Task Force and ECCF focused on health issues and protocols unique to incarcerated women; the prevalence of trauma, substance abuse disorder, pregnancy, and other health concerns among women; and services provided to women from intake to post-release. ECCF staff also explained how grievances are submitted and addressed.

Public Participants

- Dr. Lionel Anicette, ECCF Medical Director
- Taneja Davis, ECCF Director of Nursing
- Pascale Augustine, ECCF MAT Coordinator
- Kerry McCann, ECCF Inmate Advocate
- Jill McNamara, ECCF Health Services Administrator
- Mia Perkins, ECCF Consult Coordinator

Task Force's Next Steps: The Task Force continued to prioritize and advance the Medical Report Subcommittee, collaborating with external experts and consultants in correctional health. *For further details please see Appendix H.*

October 2, 2021 – Community Health Partners – The Essex County Civilian Task Force ("Task Force") held an in-person meeting regarding community partnerships and public recommendations for strengthening coordination and services between the ECCF medical department and local organizations. Community partner health organizations were invited to appear before the Task Force and offer statements, in addition to the Task Force's standard invitation for participants to submit written statements via e-mail. About one month prior to the hearing, the Task Force received a chart from ECCF detailing contacts at the community partners of the facility. At the meeting, the Task Force and ECCF discussed how to strengthen community partnerships and foster warm hand-offs; how to address barriers such as lack of Medicaid or ID; the possibility of a Nurse Navigator to be hired at ECCF; as well as greater telemedicine capabilities. The hearing ended with comments from three members of the community, including representatives from We Care Partners, Kaleidoscope, and East Orange Substance Abuse.

Public Participants

- Dr. Lionel Anicette, ECCF Medical Director
- Taneja Davis, ECCF Director of Nursing
- Pascale Augustine, ECCF MAT Coordinator
- Kerry McCann, ECCF Inmate Advocate
- Jill McNamara, ECCF Health Services Administrator
- Mia Perkins, ECCF Consult Coordinator

Task Force's Next Steps: The Task Force continued to prioritize and advance the Medical Report Subcommittee, collaborating with external experts and consultants in correctional health. Medical Director Lionel Anicette commented that ECCF implemented a new policy requiring individuals receive a PCR COVID-19 test upon intake, replacing previous ECCF usage of antibody tests. This change in policy was made in response to Dr. Pernell's recommendations. *For further details please see Appendix J.*

August 2020
August 17 – Civilian Task Force Training
August 27 – Civilian Task Force Training

September 2020
September 3 – Civilian Task Force Internal Meeting
September 23 – Civilian Task Force Internal Meeting

October 2020
October 2 – Civilian Task Force Internal Meeting
October 3 – Civilian Task Force Public Meeting
October 15 – Civilian Task Force Internal Meeting

November 2020
November 11 – Civilian Task Force Internal Meeting
November 12 – Civilian Task Force Public Meeting
November 24 – Civilian Task Force Internal Meeting

December 2020
December 3 – Civilian Task Force Meeting
December 5 – Civilian Task Force Public Meeting

January 2021
January 28 – Civilian Task Force Internal Meeting
January 30 – Civilian Task Force Public Meeting

March 2021
March 18 – Medical Sub-Committee Meeting with Dr. Anicette
March 30 – Chair & Executive Director Meeting with Judge Lippman

April 2021
April 23 – Civilian Task Force Internal Meeting
April 26 – Chair & Executive Director Meeting with Judge Lippman
April 27 – Medical Sub-Committee Meeting with Dr. Anicette

May 2021
May 21 – Civilian Task Force Internal Meeting
May 22 – Civilian Task Force Public Meeting
May 26 – Civilian Task Force Meeting with ACLU-NJ
May 26 – Civilian Task Force Internal Meeting

June 2021
June 12 – Civilian Task Force Public Meeting

July 2021
July 15 – Civilian Task Force Visit to Essex County Correctional Facility

September 2021
September 22 – Civilian Task Force Internal Meeting

October 2021
October 2 – Civilian Task Force Public Meeting

November 2021
November 5 – Medical Report Sub-Committee Meeting
November 18 – Civilian Task Force Visit to Essex County Correctional Facility
November 24 – Civilian Task Force Internal Meeting

December 2021
December 6 – Civilian Task Force Internal Meeting
December 14 – Civilian Task Force Internal Meeting
December 15 – Civilian Task Force Meeting with Union County Office of the Public Defender
December 16 – Medical Report Sub-Committee Meeting
December 23 – Civilian Task Force Visit to Essex County Correctional Facility (*Unannounced*)

Task Force Activities - Appendices

Annual Report 2021

Appendix A

State of New Jersey

PHIL MURPHY
Governor

SHELIA Y. OLIVER
Lt. Governor

Office of the Public Defender
Special Litigation Unit
FLETCHER C. DUDDY, *Chief Counsel*
31 Clinton St., 12th Floor, P.O. Box 30299
Newark, New Jersey 07102
Michael R. Noveck, *Assistant Deputy Public Defender*
Tel: (973) 424-8942 · Fax: (973) 877-1615
Michael.Noveck@opd nj.gov

JOSEPH E. KRAKORA
Public Defender

December 13, 2021

VIA EMAIL AND CERTIFIED MAIL

Director Alfaro Ortiz
Essex County Correctional Facility
354 Doremus Avenue
Newark, NJ 07105
aortiz@eccorrections.org

Warden Guy Cirillo
Essex County Correctional Facility
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gcirillo@eccorrections.org

Essex County Executive Joseph N. DiVincenzo, Jr.
465 Dr. Martin Luther King, Jr. Boulevard
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joedi@admin.essexcountynj.org

Director Ronald L. Charles
Union County Division of Corrections
15 Elizabethtown Plaza
Elizabeth, NJ 07207
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Union County Manager Edward Oatman
10 Elizabethtown Plaza
Elizabeth, NJ 07202
eoatman@ucnj.org

Re: Conditions at Essex County Correctional Facility for Pre-Trial Detainees from Union County

Dear Director Ortiz, Warden Cirillo, County Executive DiVincenzo, Director Charles, and County Manager Oatman:

On behalf of the Office of the Public Defender (OPD), we write to demand that you take immediate action to address the unsafe and unsanitary conditions for Union County pre-trial detainees who are transferred to the Essex County Correctional Facility (ECCF) in advance of their initial hearings under the Criminal Justice Reform Act (CJRA).

In May 2021, Union County and Essex County entered into a Memorandum of Agreement providing for the transfer of Union County detainees to ECCF. This means that individuals arrested in Union County, and held in detention pending an initial hearing before a judge under the CJRA, see N.J.S.A. 2A:162-16(a), are committed to ECCF. OPD represents almost all of these individuals in their criminal proceedings.

During the several months that this agreement has been in effect, OPD has received a steady drumbeat of complaints regarding the unsatisfactory conditions for Union County detainees at ECCF.[1] Without limitation, these conditions include the following:

- Individuals are not provided appropriate housing accommodations; instead, they are detained in bullpen-style holding areas along with ten to fifteen others. This housing is not temporary—to the contrary, individuals are held in bullpens for days at a time. ECCF staff tell the detainees that there is no room for them elsewhere in the facility.

- Beds are not available in the bullpens. Individuals are forced to sleep on the floor or on metal benches. Only in the evenings are any mattresses provided, and even those are placed only on the floor in hard rubber "boats." The bullpens are also unreasonably cold.

- Detainees are placed in medical isolation or "suicide watch" without adequate justification. Numerous individuals who have been placed on suicide watch deny expressing any suicidal ideation. The isolation of these individuals prevents them from meeting with OPD attorneys and staff, and also delays their first appearance before the court, thus prolonging their temporary detention.

There has additionally been an increasing escalation in violence against Union County detainees at ECCF. The crowded bullpens lead to bullying among detainees, including through the theft of food (which is provided in limited quantities to begin with). Moreover, two recent, significant violent incidents have been publicly reported:

- In October, Jayshawn Boyd was severely beaten by other inmates. Video showed Mr. Boyd being attacked with a microwave oven, a broom stick, and a bottle of bleach for several minutes, with no correctional officers intervening. Mr. Boyd remains hospitalized. See https://www.nj.com/essex/2021/11/prisoners-beat-fellow-inmate-with-microwave-during-nj-jail-brawl-claim-says.html; https://www.nj.com/essex/2021/11/video-shows-nj-jail-inmate-viciously-beaten-with-microwave-repeatedly-stomped-in-attack-by-7-men.html; https://www.northjersey.com/story/news/essex/2021/12/08/essex-county-jail-protest-newark-nj-beating-inmate-jayshawn-boyd/6416112001/.

- On December 3, Dan Gelin died in custody. Public reports indicate that he was stabbed by another detainee and, instead of being provided medical care, was placed in a detention cell. He was later transferred to the hospital and pronounced dead. See https://www.nj.com/news/2021/12/attorney-general-investigating-inmate-death-at-essex-county-jail.html; https://www.nj.com/essex/2021/12/nj-jail-under-review-by-task-force-after-alleged-prisoner-beatings.html; https://www.nj.com/essex/2021/12/essex-jail-

[1] These issues appear limited to individuals transferred to ECCF from Union County; people held at ECCF based on charges out of Essex County do not report the same conditions.

inmate-charged-with-stabbing-death-of-another-inmate-he-now-faces-2-murder-charges.html.

We have repeatedly raised these issues to your attention in numerous telephone conversations. In addition, OPD Deputy Public Defender Robert Miseo toured ECCF on Thursday, November 4, along with Director Ortiz, Warden Cirillo, and others, where the conditions (and particularly the crowded bullpens with individuals sleeping on the floor) were viewed first-hand. Although ECCF administrators indicated their desire to improve conditions, in particular by installing bunk beds, we have seen no improvements since then; to the contrary, we continue to receive daily reports of unsatisfactory conditions at the facility.

The issues described above implicate numerous legal violations that must be immediately rectified.

First, the failure to provide appropriate, sanitary living conditions violates our clients' constitutional rights. It is unconstitutional to subject pre-trial detainees to punishment, which includes conditions of confinement that are not "rationally related to the[] purposes" of the conditions. Hubbard v. Taylor (Hubbard I), 399 F.3d 150, 159 (3d Cir. 2005) (quoting Union Cnty. Jail Inmates v. Di Buono, 713 F.2d 984, 992 (3d Cir. 1983)). Courts have specifically found violations of the Fourteenth Amendment where pretrial detainees are required to sleep on the floor. See Union Cnty. Jail Inmates, 713 F.2d at 994 (describing county's concession that requiring detainees to sleep on the floor violated the Fourteenth Amendment); Thomas v. Baca, 514 F. Supp. 2d 1201, 1216 (C.D. Cal. 2007) ("[P]risons may not deprive those in their care of a basic place to sleep—a bed; for like wearing clothing, sleeping in a bed identifies our common humanity . . . [T]hat a custom of leaving inmates nowhere to sleep but the floor constitutes cruel and unusual punishment is nothing short of self-evident"); Lareau v. Manson, 651 F.2d 96, 107-08 (2d Cir. 1981) (upholding district court conclusion that "forcing men to sleep on mattresses on the floors . . . do[es] not provide minimum decent housing under any circumstances for any period of time"); Duran v. Merline, 923 F. Supp. 2d 702, 714-17 (D.N.J. 2013) (denying summary judgment regarding claim of unconstitutional conditions where overcrowding required individuals to sleep on the floor); cf. Hubbard v. Taylor (Hubbard II), 538 F.3d 229, 235 (3d Cir. 2008) (describing use of floor mattresses as one factor in the "totality of the circumstances" test regarding due process violations).

Second, placing our clients in medical isolation or on suicide watch, without cause, also constitutes unconstitutional punishment. See Lareau, 651 F.2d at 107 (upholding injunction against "placing healthy or nondisruptive inmates in the medical or isolation cells"); see also Vitek v. Jones, 445 U.S. 480, 495 (1980) ("The interest of the prisoner in not being arbitrarily classified as mentally ill and subjected to unwelcome treatment is . . . powerful."). Improper use of medical restrictions further impinges on a detainee's right to access to counsel. See Barnett v. Centoni, 31 F.3d 813, 816 (9th Cir. 1994) (constitutional violation where person was denied visits and telephone access to counsel without penological justification); N.J.A.C. 10A:31-15.4(c) (requiring county correctional facilities to provide access for attorney visits). And particularly with respect to clients awaiting their first appearances under the CJRA, a delay in access to counsel violates the client's right to a pretrial release decision within 48 hours of commitment to the jail. See N.J.S.A. 2A:162-16(b)(1).[2]

[2] In one case, an OPD client was detained at ECCF for five days, even though no motion for pretrial detention was ever filed.

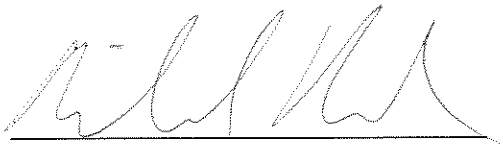
Third, ECCF's failure to protect detainees from violence violates their constitutional rights. "Prison officials have a duty to protect prisoners from violence at the hands of other prisoners." Farmer v. Brennan, 511 U.S. 825, 833 (1994) (cleaned up); see also Bistrian v. Levi, 696 F.3d 352, 367 (3d Cir. 2012) ("[A]n inmate who [is] not yet convicted . . . ha[s] a clearly established constitutional right to have prison officials protect him from inmate violence."). Conditions that "pos[e] a substantial risk of serious harm" give rise to constitutional violations. Farmer, 511 U.S. at 834; see also Shelton v. Bledsoe, 775 F.3d 554, 564-65 (3d Cir. 2015) (explaining that the constitution "protects against the risk—not merely the manifestation—of harm"). Overcrowding can itself increase the risk of violence that violates our clients' constitutional rights. See Duran, 923 F. Supp. 2d at 716 (describing evidence "that the overcrowded conditions [in the correctional facility] also led to inmate-on-inmate violence"). At ECCF, as described above, this violence has already led to the recent death of one pretrial detainee, and the severe beating and prolonged hospitalization of another.

Accordingly, we demand that you promptly rectify the unconstitutional conditions under which Union County detainees are held at ECCF. All persons, even those accused of criminal conduct, have the right to be treated with dignity and respect, and to be protected from violence. ECCF is not fulfilling its moral and legal responsibilities to our clients. To date, we have heard many promises of reform, but no meaningful action has been taken for months. This failure cannot continue.

Respectfully,

JOSEPH E. KRAKORA
Public Defender

FLETCHER C. DUDDY
Chief Counsel, Special Litigation Unit

BY: 

MICHAEL R. NOVECK
Assistant Deputy Public Defender
Special Litigation Unit

Appendix B

COUNTY OF ESSEX

DEPARTMENT OF CORRECTIONS
ESSEX COUNTY CORRECTIONAL FACILITY
354 Doremus Avenue – Newark, New Jersey 07105
973-274-7800 --- 973-274-6193 (Fax)

Joseph N. DiVincenzo, Jr.
Essex County Executive

Alfaro Ortiz, Jr.
Director

January 19, 2022

Gov. James McGreevey
Chairman
Hon. Jose Linares
Executive Director
Essex County Civilian Oversight Taskforce
McCarter & English, LLP
Four Gateway Center
100 Mulberry Street
Newark, New Jersey 07102-4056

Re: July Essex County Correctional Facility Tour by Civilian Task Force

Dear Chairman McGreevey and Executive Director Linares:

This letter is in response to the Civilian Taskforce request for information dated January 10, 2022.

1. Will either the investigation of the AG's office or the Essex County Prosecutor's Office involve a medical investigation to determine cause of death and contributing factors and examine the actions of any medical staff?

RESPONSE: The Essex County Department of Corrections cannot comment on the scope or the extent of any external investigation.

2. Has the medical team at the facility conducted a morbidity and mortality review of this case, in particular, and/or does it complete a proper M&M as a routine quality assurance protocol?

RESPONSE: Yes, the medical services provider, CFG, conducted an M&M review within 30 days of the death as part of the quality assurance/patient safety protocol.

3. Will the Task Force have access to the reports of the AG, Essex County Prosecutor's Office, any internal facility review as well as the report being compiled by the Ambrose group?

RESPONSE: The ECCF cannot comment on the scope or the extent of any external investigation. However, internal investigative and/or inspection results can be shared upon approval by the Essex County Administration.

4 Are the officers involved in the incident currently working in the facility?

RESPONSE: Yes.

5 If so, are they working in the same unit?

RESPONSE: None of the Officers have been restricted or reassigned.

6 If the officers are not working in the facility, are they suspended with or without pay pending the investigation?

RESPONSE: None of the Officers have been suspended at this time.

7. When was the last time officers searched the unit where the incident occurred?

RESPONSE: Each housing unit is searched by the officers assigned daily. However there have been at least three facility lock downs since September allowing for full facility wide searches involving search teams comprised of multiple Officers.

8. What type of training have the guards received to deal with similar incidents? How often are these trainings taking place?

RESPONSE: Correctional Police Officers are trained to deal with critical incidents during basic training at an Academy regulated by the Police Training Commission. In addition, all custody staff is required to complete annual refresher training as well as quarterly "line up" training.

9. What is the total number of inmates in the facility?

RESPONSE: As of 1/19/22 the total inmate count is 2297

10. How many Correctional officers are in the facility per shift; on weekdays? On weekends? The total number of custody staff

RESPONSE:
Note: All security custody posts are manned at the same level seven days per week.

TOTAL OFFICERS = 601
TOTAL SUPERVISORS=83

6 AM -2 PM OFFICERS=308
6 AM -2 PM SUPERVISORS= 40

2 PM -10 PM OFFICERS =185
2 PM-10 PM SUPERVISORS = 26

10 PM -6 AM OFFICERS = 108
10 PM-6 AM SUPERVISORS = 16

11. Is there a shortage of staff members in the facility?

RESPONSE: No

12. What is the facility doing to prevent incidents like this from happening again?

RESPONSE: We have redoubled our intelligence efforts to better enable us to proactively address security issues within the jail. We have also increased staff alertness to inmate activities to prevent violence in the facility. Additionally, we have contracted the services of the Ambrose Group to review our policies, procedures and operational readiness and to identify any needed changes in our operations.

13. What can be done better in terms of the inmates' care, custody, and control. How can the Task Force support?

RESPONSE: While we have taken assertive interim steps to reduce violence in our facility, we continue to search and monitor inmate behavior to identify any untoward behavior. We also await the findings of the Ambrose Group as well as input and recommendations from the Civilian Taskforce to determine any next steps.

Regards,

Alfaro Ortiz, Jr.
Director

CC: Chief of Staff to the County Executive Phil Alagia

Appendix C

October 3, 2020 Civilian Oversight Task Force Hearing

Summary: The Essex County Civilian Task Force held a hearing open to the public with Essex County Correctional Facility ("ECCF") medical personnel regarding policies and practices. Items under discussion included the medical department's facilitation of intake and triage, sick call requests and monitoring, chronic condition diagnosis and care, ICE detainee distinctions regarding delivery of care, language services, and several questions submitted by the public.

1. Welcome: Jeran Crawford; Judge Linares; Governor McGreevey
2. Welcome: Facility Director Alfaro Ortiz
3. Presentation: Dr. Lionel Anicette
4. Questions
5. Open Task Force Questions
6. Presentation: Heidi Reifenberg
7. Questions
8. Presentation: Madaline Bell
9. Questions
10. Presentation: Sandra Grant
11. Open Task Force Questions
12. Closing Remarks

Action Items:

- **Baseline diagnostic screenings**: Governor McGreevey noted ECCF and the Task Force may work together on baseline diagnostic screenings.
- **COVID Testing**: Dr. Pernell asked for the breakdown of testing based on type of COVID test.
- **Language Services:** Dr. Pernell asked for the percentage of individuals who speak a language other than English, or language line languages. Governor McGreevey asked for frequency of line use.
- **Nurse visits:** Governor McGreevey asks for these records or nurse screens, assessments, and sick calls per month to be provided to the Task Force.
- **Detainee protocol**: Governor McGreevey asked the medical department work with the Task Force to strengthen health care delivery with detainees
- **Masking protocol**: Governor McGreevey asked ECCF work with the Task Force to develop a protocol for facility masking.
- **Atypical cases**: Governor McGreevey asked if the medical team may work with the Task Force to determine such occurrences in real-time to determine best practices.
- **ICE**: Governor McGreevey asked for the year, month, and cause of death of the ICE detainee who died in ECCF custody prior to 2019. Dr. Pernell asked to provide to the Task Force how long this process typically takes and how often ECCF appeals ICE utilization management decisions.
- **Inmate Representative Meeting**: Rosa asked for the list of concerned delivered by the inmate representatives to ECCF staff during the recent inmate representative meeting.

Attendees

Essex County Civilian Task Force

Present:

Judge Jose Linares, Executive Director of the Task Force

Governor James McGreevey, Chairperson of the Task Force

Rosa Santana, fills seat designated to a recognized detainee advocacy group

Marshall Rountree, fills seat designated to a representative from a recognized inmate advocacy group

Rubin Sinins, fills seat designated to a member in good standing of the New Jersey Criminal Defense Bar

Eddie Cannon, fills seat designated to a demonstrated corrections expert

Imran Rabbani, fills seat designated to a formerly incarcerated individual

Rev. Pablo Pizarro, fills seat designated to a social justice advocate

Dr. Chris Pernell, fills seat designated to an expert in the medical field

Alessandra DeBlasio, fills seat designated to a member of the public

Absent: None

Essex County Correctional Facility ("ECCF") Personnel

Present:

Dr. Lionel Anicette, ECCF Medical Director

Sandra Grant, ECCF Director of Nursing

Madaline Bell, ECCF Health Services Administrator

Heidi Reifenberg, ECCF Quality Assurance Coordinator

Alfaro Ortiz, ECCF Director

Proceedings

October 3, 2020 Essex County Correctional Facility Civilian Task Force ("Task Force") Hearing was called to order at 10:00 a.m. by Task Force Chair Governor James McGreevey.

1. Welcome

Jeran Crawford; Phil Alagia; Governor James McGreevey; Judge Jose Linares

Jeran Crawford, New Jersey Reentry Corporation Site Director at the Newark Facility, introduced the facility hosting the October 3 Task Force Hearing. The New Jersey Reentry Corporation is a non-profit agency with a social mission to remove all barriers to employment for citizens returning from jail or prison.

Phil Alagia, the Chief of Staff to the Essex County Executive introduced the independent Civilian Task Force and emphasized the County's commitment to supporting the Task Force's independent activities in improving on Facility transparency and oversight.

Governor James McGreevey, Chair to the Task Force read a prayer and introduced Judge Linares.

Judge Jose Linares, Executive Director to the Task Force, explained his background and role regarding the Task Force, as well as the Task Force's goals and mission. Judge Linares was a trial attorney before becoming a judge, first in State court and then in Federal court. Judge Linares was ultimately the Chief of the Federal Court of New Jersey. Judge Linares is now again a practicing attorney at McCarter and English, where he is a partner.

Judge Linares explained the Essex County Board of Commissioners and the Executive Branch discussed with him the perceived and overlooked problems with ECCF and the ECCF system, as well as the necessity of public engagement in identifying successful and failing practices, and make recommendations on Facility improvements.

Judge Linares praised the establishment of the Task Force as good government and explained the mission of the Task Force. Judge Linares explained the mission of the Task Force is to gather information – which is being begun at the day's hearing – and to obtain information both from the public and Facility regarding existing concerns, and identify potential systemic issues to address. In the event a systemic issue is identified, Judge Linares explained, the Task Force will make recommendations on changes to governmental bodies like the Board of Commissioners and County Executive.

Judge Linares explained the intended benefit of positive recommendations addressing systemic problems, once implemented, would reach the individual. Judge Linares reiterated that the Task Force does not have the power to follow and resolve individual cases and problems. Judge Linares qualified this statement with the additional note that as the Task Force gathers information, certain individual concerns or complaints may be identified as recurrent issues or systemic in nature. Judge Linares explained that there may be individual matters which represent symptoms of broader problems requiring action.

Judge Linares explained his role and that of his partner Guillermo Artiles is to provide administrative support to this Board, provide legal assistance where needed, and help with direction and logistics.

Judge Linares introduced Chairman Governor McGreevey and his background in prison reentry services and advocacy. Judge Linares introduced the members of the Task Force and their designated seats.

Governor James McGreevey, Chair to the Task Force introduced Dr. Erin Zerbo. Governor McGreevey announced the Civilian Task Force's second hearing would take place on Thursday, November 12th, from 6 p.m. until 8 p.m. Governor McGreevey noted the second hearing would focus on addiction. Governor McGreevey announced a third Task Force hearing would take place on Saturday, December 5 from 10 a.m. until 12 p.m. Governor McGreevey noted this third hearing would focus on mental health, OB-GYN, and women's health care among detainees and inmates.

Governor McGreevey announced directions to the public for submitting questions to the Task Force.

2. Welcome: Alfaro Ortiz

Alfaro Ortiz, the Facility Director at ECCF, introduced the Facility and provided context for the day's hearing. Ortiz noted ECCF is the largest correctional facility in the Tristate Area –excepting Rikers—that the facility's maximum capacity is 2,423, current capacity is 1,897, and post-COVID capacity may be 2,000 or higher.

As described by Ortiz, ECCF overview includes: 357 inmates between ages 18 to 23; 604 inmates between ages 26 to 30; 697 inmates between 31 and 40; 367 inmates between ages 41 and 50; 31 inmates between ages 51 and 60; 620 custody staff members, supervisors and officers; roughly 200 ancillary staff members; 32 housing units and 7 dorms total; capacity of a housing unit is 32 inmates if single-bunked or 64 inmates if double-bunked; capacity of a dorm is 48 individuals.

3. Presentation: Dr. Lionel Anicette

Governor McGreevey introduced Dr. Lionel Anicette and described hearing procedure.

Dr. Lionel Anicette, ECCF Medical Director, thanked all present and his background in Newark and medicine. Dr. Anicette emphasized ECCF's commitment to improving regularly and working with community stakeholders to implement change.

Dr Anicette explained the regular duties of the medical services team at ECCF. They process approximately 2,000 people a month, from the twenty Essex County municipalities and elsewhere. The medical team triages those processed for housing and medication. Dr. Anicette mentioned the recent change of having medical team members processing alongside officers; individuals are seen within 1 or 2 hours by a nurse, an LPN, a nurse practitioner, or a PA. Dr. Lionel explained there are some individuals who are not fit to be incarcerated, and the medical team recommends treatment at a community partner like University Hospital.

Dr. Anicette explained that inmates cleared for incarceration are subjected to further medical, psychiatric, and suicidal ideation screenings. The medical team triages for housing, like in the event of communicable disease isolation. ECCF has a 42-bed infirmary, 4 negative pressure rooms, and a special needs area.

Dr. Anicette explained ECCF manages preexisting conditions and has an onsite pharmacy with all classes of medication. All levels of chronic conditions exist at ECCF, including heart disease, lung disease, HIV, and Hepatitis.

Dr. Anicette explained there are over 100 medical ECCF staff, many of whom from Essex County, including nurses, LPNs, RNs, Certified Nursing Assistants, nurse practitioners, physician assistants, MDs, and specialists. Special services available onsite include orthopedics, podiatry, and renal services.

4. Questions

Governor McGreevey asked Dr. Anicette to describe the medical intake process.

Dr. Anicette explained the typical individual is screened on arrival in order to clear for incarceration. Dr. Anicette noted there are often times when individuals have existing injuries needing immediate attention and a member of the medical staff will assess and either send the individual to a partner hospital via ambulance or admit to ECCF for further screenings.

Dr. Anicette explained all admitted for incarceration are subjected to a COVID-19 screening evaluating exposure, risk of exposure, and testing. The medical staff conducts a COVID-19 antibody test and tests vital signs. The medical staff will ask the individual if they have any immediate injuries or illnesses which need attention. Dr. Anicette stated there is always a medical provider onsite and a provider on-call 24 hours, 7 days a week.

Dr. Anicette explained those who are not in-need of medical attention are staged for an intake nurse, who goes through a multi-step questionnaire within 8 to 12 hours of facility admission. The intake nurse does a PPD test for tuberculosis and evaluates suicidal ideation and need for mental health counseling. Dr. Anicette stated there is mental health counseling on-call and onsite.

Dr. Anicette explained that after being cleared by an intake nurse, a physician or physician-extender, like a nurse practitioner or physician's assistant, would be called to place orders.

Dr. Anicette described bloodwork procedure: the only standard order is the syphilis exam, which is by State order; those listed with a chronic condition would receive appropriate sets of labs and referrals at that time. Dr. Anicette stated a physical exam by a physician's assistant, nurse practitioner, or MD would take place within the next 18 to 24 hours in their central processing unit.

Dr. Anicette stated that during all the aforementioned processes, individuals are housed in a quarantine area: quarantine was initially 3 days or 72 hours for the PPD test reading, and was extended to 14 days for the pandemic to account for the coronavirus incubation period. Dr. Anicette explained individuals are monitored daily throughout this period and necessary medication is administered within a 48-hour period.

Dr. Anicette explained the medical team communicates with administration for those in need of the infirmary, and individuals are transferred the same day. A registered nurse is in the infirmary at all times, and will take admission orders. An MD is present 16 hours a week, who will reassess individuals and modify orders. Individuals in the infirmary are assessed on a daily basis: those positive for TB receive X-Rays onsite, which is read by a radiologist who is on call 24 hours a day. The infirmary evaluates individuals for any other necessary ancillary services.

Dr. Anicette stated mental health staff provide their own screenings and review all processed charts for mental health issues. Dr. Anicette stated there are roughly 200 to 300 patients that arrive with bonafide mental health diagnoses, who are referred to the mental health department. A number of those reside in the chronic care unit. Individuals' labs are ordered after their first physicals and followed up on at first chronic care visit. Referrals are done at this time. Dr. Anicette described this as continuity of care from the moment an individual is cleared for incarceration and admitted into the general population.

Governor McGreevey introduced Newark City Council President Mildred Crump.

Council President Crump thanked Governor McGreevey and stated interest in the day's presentations.

Governor McGreevey invited Dr. Chris Pernell's questions.

Dr. Chris Pernell announced she is a Board-Certified Preventative Medicine and Public Health Physician and a fellow of the American College of Preventative Medicine who focuses on population-wide disease prevention and health promotion, and health equity as defined as every person having the opportunity to achieve their highest level of health.

Dr. Pernell noted the questions asked at the day's hearing are not comprehensive and more exhaustive inquiries have been submitted to ECCF for answers. Dr. Pernell described the Task Force's intent to look for system gaps and drive equity, improvement, and high-quality care.

Dr. Pernell asked Dr. Anicette, of the 2,000 individuals processed each month, roughly how many have an identified chronic condition, including physical ailments and mental or behavioral health diagnoses.

Dr. Anicette responded roughly 200 to 300 of the 2,000 individuals suffer from a substance abuse issue, and the same number from a bonafide mental health issues. Dr. Anicette noted some individuals are undiagnosed and mental health diagnoses are identified later. Dr. Anicette noted roughly 500 to 600 individuals have typical chronic conditions like heart disease, lung disease, or HIV. Dr. Anicette concluded there are usually about 700 to 900 individuals within the chronic care unit.

Dr. Pernell asked Dr. Anicette for the ECCF's top 5 most prevalent physical diagnoses and top 3 mental or behavioral health diagnoses.

Dr. Anicette grouped all diagnoses in the top 5, noting mental health's inclusion in general health. Dr. Anicette listed diabetes, hypertension, asthma, COPD, HIV, and Hepatitis. Dr. Anicette noted mental health diagnoses are commonplace.

Dr. Pernell asked Dr. Anicette which of those individuals with the prevalent conditions described are controlled or uncontrolled. Dr. Pernell asked Dr. Anicette how many medications do incarcerated persons on average take.

Dr. Anicette replied inmates are on average on two, sometimes a little over.

Dr. Pernell asked Dr. Anicette if inmates come in on two medications, or ECCF prescribes these medications.

Dr. Anicette replied that inmates do not usually come in on medication, and usually suffer from chronic conditions that are not treated or adherent to any medication regime. Dr. Anicette noted ECCF is often starting, initiating, and linking individuals with care on release. Dr. Anicette responded that inmates' chronic conditions are typically uncontrolled in their first incarcerated month, and controlled within their second incarcerated month.

Dr. Pernell asked how ECCF determines or assesses whether a condition is controlled, what guidelines the medical team follows, and for Dr. Anicette to explain these guidelines.

Dr. Anicette answered the medical team follows the US Preventative Task Force, Performance-Based National Detention Standards, and National Commission on Correctional Health standards. Dr. Anicette explained ECCF is accredited by those bodies and uses a number of guidelines and databases, which are

built into the electronic monitoring system. Dr. Anicette also mentioned ECCF developed an internal evidence-based medical screening guide used to teach and train staff.

Dr. Pernell asked for Dr. Anicette to make the aforementioned internal screening guide available to the Task Force.

Dr. Anicette agreed.

Dr. Pernell noted that based on a quality improvement health care model, all systems have gaps, are constantly evaluating where those gaps may be so as to immediately design processes to mitigate those gaps.

Dr. Pernell asked Dr. Anicette what the top conditions are among those with chronic care conditions, and if specific data may be made available to the Task Force.

Governor McGreevey asked Dr. Anicette how ECCF identifies HIV, Hep-B or Hep-C.

Dr. Anicette responded patients come in with health histories and are honest with the medical team.

Governor McGreevey asked if there's not a screening test.

Dr. Anicette responded there's not a universal screening, and ECCF has looked into this in the past.

Dr. Pernell noted there are recommendations around HIV and screening in the Preventative Services Task Force Recommendations, and this may be something to consider.

Dr. Pernell stated it's not clear to her what conditions are known and diagnosed, versus what conditions are newly discovered. Dr. Pernell related these answers to continuity of care and transitions of care. Dr. Pernell explained that, since the average length of stay for an ECCF inmate is 29 days, the Task Force and ECCF perspective should be from what the most effective care may be administered within 29 days, or how ECCF may effectively ensure people continue care or are connected to care upon leaving the facility.

Dr. Pernell asked Dr. Anicette confirm 200 to 300 persons are diagnosed with mental health conditions.

Dr. Anicette replied 200 to 300 is likely an underestimation and Dr. Sandrock can comment more accurately.

Dr. Pernell notes she wants to differentiate from those with substance abuse conditions. Dr. Pernell asks Dr. Anicette for the most common diagnoses of those 200 to 300 individuals with diagnosed mental or behavioral health conditions.

Dr. Anicette explains ECCF receives high rates of depression, anxiety, and schizophrenia.

Dr. Pernell explains the significance of demographics, Race, Ethnicity, and Language (REAL) data, and Sexual Orientation and Gender Identity (SOGI) data. Dr. Pernell noted that inequities within these populations, and asks if they are being mitigated, ameliorated, addressed, or furthered.

Governor McGreevey reiterated Dr. Pernell submitted further questions to ECCF and the nature of inquiry is ongoing. Governor McGreevey asked anyone present in-person with questions to submit to Vivienne for collection. Governor McGreevey invited Dr. Erin Zerbo to ask questions.

Judge Linares asked Dr. Anicette for an estimate of those treated by the medical team who are suffering from conditions which ECCF lacks the capability to treat.

Dr. Anicette responded he has not come across such a situation, and that if ECCF cannot treat a condition, the medical team finds a specialist or community partner that can. Dr. Anicette noted partners from Hackensack Meridian to Saint Barnabas, and ECCF's addition of physical therapy services. Dr. Anicette noted HIV consulting with the Newark Department of Health and Dr. Slim at the Peter Ho Clinic. Dr. Anicette emphasized the Facility has no issue calling in help.

Dr. Pernell asked Dr. Anicette what percent of those screened for incarceration are declared unfit for incarceration due to preexisting conditions which may not be treated at ECCF.

Dr. Anicette replied the percentage of those not cleared for incarceration tends to be in the single digits, but is significant. Dr. Anicette estimates 5% of people presented to the medical team are not capable of being treated in-house and are sent to a crisis center, or a trauma center.

Dr. Zerbo asked Dr. Anicette what substance use disorder screening is done during the screening process, and how this screening approaches a sensitive and stigmatized topic.

Dr. Anicette replied nurses do Clinical Opiates Withdrawal Scale (COWS) and the Clinical Institute of Withdrawal Assessment (CIWA) screening one-on-one, in medical offices. Higher level or mi-level MDs are contacted based on these results.

Dr. Anicette stated that with the Center of Excellence's help, ECCF has about seven providers certified to prescribed Suboxone, which has been initiated in the past few months. The program currently has about 60 patients enrolled, and the medical team hopes to more than double or triple that number.

Dr. Zerbo asked Dr. Anicette how long it takes for a nurse to sit down with an individual for a COWS and CIWA screening.

Dr. Anicette replied within 8 hours, as the medical team has less urgent care trips if withdrawal symptoms are discovered early.

Dr. Zerbo noted that, especially with fentanyl, people may take longer and longer to experience withdrawal symptoms. Dr. Zerbo asked Dr. Anicette how ECCF accounts for this delay if an individual denies a substance abuse disorder.

Dr. Anicette responded individuals are in quarantine at this time and nurses monitor them daily. Since quarantine is now longer at 14 days, individuals are screened again.

Dr. Zerbo asked Dr. Anicette asked how inmates may contact staff if experiencing withdrawal symptoms but long past the screening and quarantine process, and to detail how an inmate may access a nurse.

Dr. Anicette responded that inmates do not have to go through correctional officers for such events, but may as officers are trained for this occurrence. Dr. Anicette explained a nurse rounds every unit twice a day between 7 a.m. and 10 p.m., who makes a general announcement and is accessible to anyone who may wish to see the nurse. Dr. Anicette clarified there's a medical unit at every housing unit, and locations for private consultations with medical staff.

Dr. Anicette also noted inmates may access a tablet if they cannot reach a nurse, which Madaline Bell and Sandra Grant monitor all week.

Marshall Rountree asked Dr. Anicette if the screening process identifying the 200 to 300 mental or behavioral health conditions are self-reported.

Dr. Anicette responded the first evaluation is self-reported, and the second is evaluated by a nurse. Those who self-report more guardedly are sometimes referred to the mental health team due to their presentation.

Marshall Rountree asked Dr. Anicette again for the five most prevalent conditions.

Dr. Anicette responded depression, anxiety, adjustment disorders, chronic insomnia, schizophrenia.

Marshall Rountree asked Dr. Anicette if the initial screening process occurs during triage, within the first few hours of arriving onsite.

Dr. Anicette responded in the affirmative.

Rosa Santana asked Dr. Anicette questions on behalf of the American Friends Service Committee, Serge Demefack, and Ulla Berg, the Director of the Center for Latin American Studies at Rutgers University.

Santana asked Dr. Anicette: How is the jail addressing chronic conditions of the jail population during the COVID-19 pandemic? What is the jail doing if a detainee needs specialized medical care that the jail cannot provide, when the person's health condition is not serious enough to take him or her to the emergency room? For example, dental care.

Dr. Anicette answered that the pandemic modified ECCF operations; consultations are more challenging due to COVID testing requirements, though professionals remain in the facility. Dr. Anicette stated the ECCF dentist, hygienist, and oral surgeon still operate. Dr. Anicette reiterates ECCF has successfully maintained all inmates during the pandemic.

Governor McGreevey asked Dr. Anicette questions from Ulla Burke and Matt on how ECCF is managing inmates with COVID-19, how the screening process is impacted, how ECCF is preparing for a second wave, and to review the high infection rate in ICE dormitories compared to County cell blocks

Dr. Anicette replied all ECCF departments are involved in COVID-response, and that ECCF was one of the first facilities to petition ICE to start releasing from dorms for the sake of detainee health. Dr. Anicette acknowledged the dorms are not settings conducive to social distancing or other COVID mitigation practices. ECCF petitions ICE based on CDC guidelines and an internal assessment for identifying those at highest risk, which Dr. Anicette agrees to supply to the Task Force.

Dr. Anicette stated ECCF submitted a list early on to ICE of those felt to be at particular risk of contracting COVID. Dr. Anicette says the numbers of those in dorms are at half of where they were at the start of the pandemic due to this action and ECCF stopped admissions from a number of agencies. ECCF communicated to the Port Authority, federal authorities, the US Marshalls, and others contracted with ECCF that the facility would not admit beyond a specific number.

Dr. Anicette described ECCF COVID practices as including: temperature checks on arrival onsite; masking; social distancing; increased staff; universal administration of vitamins; telemedicine as needed; additional temperature checks through facility.

Dr. Pernell asked Dr. Anicette to clarify masking policy.

Dr. Anicette responded surgical masks are offered upon facility entrance and are single-use, noting that ECCF began masking inmates prior to most other correctional facilities.

Governor McGreevey asked Dr. Anicette if there is a difference in inmate versus ICE detainee protocol.

Dr. Anicette responded in the negative, noting ICE detainees are often prioritized due to their higher risk of contracting in a dorm setting.

Rosa Santana asked Dr. Anicette mental health questions submitted to the Task Force, which Governor McGreevey asked to hold until the subsequent hearing focusing on mental health. Santana also asked what ECCF is doing on programs cut due to COVID-19, for the number of those released over the past two months for COVID-19 health reasons, and for the number of swab tests administered to detainees each month since July.

Dr. Anicette responded he is not at privilege to release either of those numbers, but can say that ECCF has had on COviD-19 related mortality since the start of the pandemic.

Dr. Pernell asked Dr. Anicette to clarify his inability to provide the number of swab tests administered, and to provide what types of COVID tests are administered.

Dr. Anicette reiterated he is not at privilege under the advisement of ECCF legal counsel. Dr. Anicette replied ECCF does nasal pharyngeal, anterior nasal swab, and saliva-based tests.

> Action**:** Dr. Pernell asked for the breakdown of test usages, to which Dr. Anicette agreed.

Alessandra DeBlasio asked Dr. Anicette what improvements ECCF would like to make.

Dr. Anicette replied he would like to create more community linkages and partnerships for referrals, and change the public view of the facility.

Governor McGreevey asked Dr. Anicette if there's a screening test that represents best practices.

Dr. Anicette replied ECCF may do universal HIV testing in the State system, and the issue with universal Hep-C screening is a litigious situation. Treatment for one patient may range $90,000 dollars, though costs have come down some.

> Action Item: Governor McGreevey noted ECCF and the Task Force may work together on baseline diagnostic screenings.

Governor McGreevey invited Rubin Sinins and Rev. Pablo Pizarro to ask questions, to which they both declined. Governor McGreevey asked a public question regarding language resources available to detainees.

5. Open Task Force Questions

Judge Linares pointed out that to the extent all information may not be provided this day, the Task Force will meet again, and follow-up, and address what can or cannot be provided to the Task Force.

Madaline Bell, the Health Services Administrator to ECCF introduced herself and responded regarding language resources. Madaline Bell explained there is a language line interpretive service available to all health care staff at all times; staff are trained on how to call the language line and medical providers reference interpreters used in relevant medical records. Madaline Bell pointed out the number of multi-lingual ECCF staff, which Dr. Pernell qualified as not formally certified for medical interpretation.

Madaline Bell responded to additional language line questions from Alessandra DeBlasio: the language line is used immediately and accessible immediately; staff use the line when an individual cannot communicate in English.

Action: Dr. Pernell asked for the percentage of individuals who speak a language other than English, or language line languages. Governor McGreevey asked for frequency of line use. Madaline Bell agreed in addition to supplying the 7 language line languages to the Board.

Governor McGreevey asked a public question to Sandra Grant on the total number of nurse visits per month.

Sandra Grant, Director of Nursing responded on average about 1,460 nurse screens occur per month, about 815 assessments per month. Sick calls are in excess of 2,000 visits per month.

Action: Governor McGreevey asks for these records to be provided to the Task Force.

Governor McGreevey asked a public question regarding the length of time an individual may see a dentist or physician, which Dr. Pernell asked to be clarified distinguishing triage versus full assessments.

Sandra Grant responded a nurse will respond within 24 hours, to which Dr. Pernell responded protocol requires triage within 8 hours. Sandra Grant responded in the affirmative, noting inmates are sometimes asleep or inaccessible. Dr. Pernell asked what the protocol may be in the event a sick call regards an urgent or emergent issue, to which Sandra Grant responds within 8 hours.

Governor McGreevey asked a public question regarding ICE refusing to pay for CAT scans and other coverage denials, including those related to a detainee head injury anecdote.

Dr. Anicette responded head injuries are urgent and emergent and seen immediately. If a provider deems emergency care and follow-up, including CAT scans or imaging, which University Hospital will perform without ICE authorization. Ice authorization is not necessary for emergency care, but further management treatment requires ICE coordination. Dr. Anicette noted answers are typically received within a week and that results may be appealed.

Action: Dr. Pernell asked to provide to the Task Force how long this process typically takes and how often ECCF appeals ICE utilization management decisions, which Dr. Anicette agreed to provide.

Governor McGreevey asked Dr. Anicette to return to the earlier public question from Matt regarding difference in infection rates among ICE detainees versus inmates. McGreevey asked a public question regarding when inmates wear masks, as legal services often witness inmates within the facility without masks. Governor McGreevey asked additional public questions regarding how many inmates or detainees died in jail, and before April 2019.

Dr. Anicette responded he believed infection rates mimicked the external population. Dr. Anicette responded inmates are cohorted and masked when they leave their dorms, to which Governor McGreevey asked if this represented best practices. Dr. Anicette noted there are few best practices for jails, but inmates are grouped and cohorted based on risk of exposure.

Madaline Bell responded no inmates have died since 2019, but one detainee died since ECCF began their ICE contract.

Action: Governor McGreevey asked the medical department work with the Task Force to strengthen health care delivery with detainees. Governor McGreevey asked ECCF work with the Task Force to develop a protocol for facility masking. Governor McGreevey asked for the year, month, and cause of death of the ICE detainee who died in ECCF custody prior to 2019.

Dr. Pernell noted health care standards regarding congregant settings include patients outside of their individual rooms must be masked at all times in health care settings and staff must be masked at all times, and patients masked with each other must be masked at all times.

Dr. Anicette pointed out ECCF follows a cohort procedure and there are logistical masking issues unique to correctional settings, but welcomes a dialogue and recommendations from the Task Force. Dr. Anicette points out that inmates live in their dorm settings as homes, and civil rights begin to become of concern if requiring inmates wear masks in their dorms.

Dr. Anicette notes a priority of protecting health care workers and mitigating exposure.

6. Presentation: Heidi Reifenberg

Governor McGreevey invites Heidi Reifenberg to present, noting the Task Force has heard from Sandra.

Heidi Reifenberg, Quality Assurance Coordinator and Medical Monitor introduces herself and notes she has maintained this position for 14 years. Heidi Reifenberg notes three meetings per week with medical staff, where one is a special needs meeting regarding individual or chronic cases. Client services meetings occur once per month, in which the medical vendor presents new and updated health services. Continuous quality improvement meetings are held once a month, where new studies and audits undertaken by ECCF are discussed.

Heidi Reifenberg explained the medical team uses an electronic medical record for almost 18 years now, where the health care staff can see all past medical visits and recorded intake of an inmate, and can also run reports. Heidi Reifenberg explains her office completes audits of medical records and can check if chronic care visits or physicals are due for any individual. Heidi Reifenberg also reviews sick calls to ensure timely responsiveness and monitoring sick calls daily, comparing them to corresponding electronic medical records. Heidi Reifenberg checks for paper triage, to check if a sick call is urgent, and an assessment must be done by a registered nurse within 8 hours.

Heidi Reifenberg explains she conducts audits of medications, urgent/emergent encounters, mental health visits.

7. Questions

Governor McGreevey asked Heidi Reifenberg if she can provide the level of compliance with medicine and dosage, in terms of regularity and distribution delays, which Heidi Reifenberg agreed to provide.

Dr. Pernell pointed out these are routine performance indicators, and the Task Force needs access to these regular assessments. Dr. Pernell also asks Heidi Reifenberg how often a detainee may enter ECCF with a non-formulary drug and what the response is, to which Heidi Reifenberg refers Dr. Pernell to Dr. Anicette.

8. Presentation: Madaline Bell

Governor McGreevey invited Madaline Bell to present.

Madaline Bell describes her role as Health Service Administrator as ensuring the successful delivery of health care services, summarily: ensuring adequate staffing, training and custody orientation, and specific role orientation; appropriate supplies;

Madaline Bell states ECCF has multi-layered and multi-disciplinary staff available; some have been lost since the pandemic, but ECCF has continued recruitment and maintained optimal staffing levels. Madaline Bell states many of staff have worked in a correctional setting prior, and many have not.

9. Questions

Dr. Pernell asked Madaline Bell if there was ever a point ECCF lacked adequate PPE and what the system of determining adequate PPE levels may be, and if that system considers a potential surge.

Madaline Bell responded there was never a point PPE was not available for staff members or inmates or detainees if they needed. Madaline Bell says reports are submitted daily to corporate staff on need levels and emergency packs are ready and available as needed.

10. Presentation: Sandra Grant

Governor McGreevey invited Sandra Grant to present.

Sandra Grant stated ECCF nurses work very hard, particularly throughout the pandemic and also act as patient advocates.

11. Open Task Force Questions

Governor McGreevey asked two public questions to Dr. Anicette regarding providing or withholding insulin to an insulin-dependent diabetic, and the authority on inmates referred to the hospital.

Dr. Anicette responded an individual diagnosed with diabetes would not need to request their medication, but if they happened to, that request would be evaluated by a medical provider in triage. Dr. Anicette noted he and medical determine hospital and urgent/emergent referrals, not officers. If officers disagree, the medical team may explain to the Warden and Facility Director, who typically follow the advice of the medical team.

> Action: Governor McGreevey asked if the medical team may work with the Task Force to determine such occurrences in real-time to determine best practices.

12. Closing Remarks

Governor McGreevey invited closing comments and questions from Task Force members.

Rev. Pablo Pizarro asked Heidi Reifenberg if the tablet is language specific, or if translation must be authorized by ICE. Heidi Reifenberg responded there are about 10 languages on the tablet and may be accessed automatically.

Rev. Pizarro asked again about differences between ICE detainee and inmate treatment, to which Dr. Anicette reviewed earlier statements. Dr. Anicette further explained ECCF has an active relationship with the ICE representative who reviews ECCF medical appeals to ICE, and that there is a staff role dedicated to liaising with ICE.

Governor McGreevey asked Dr. Anicette to clarify that ICE must authorize utilization for non-urgent management cases for a detainee. Dr. Anicette confirmed, and noted there are continued assessments and a detainee is not allowed to deteriorate should their condition worsen. Dr. Anicette noted this is similar to private insurance authorization.

Rubin Sinins noted that he found the hearing informative and praised Dr. Pernell's questions.

Rosa Santana noted that despite detainee transfers and decreased detainees in ECCF, ICE detainee advocates have seen an increase in ECCF admissions of ICE detainees from County Marshalls. Rosa Santana asked Dr. Anicette if there will be a cap with regards to COVID. Rosa Santana also pointed out ICE discussions of community raids, and if ECCF is concerned about increased ICE admissions.

Dr. Anicette responded he cannot speak to the administrative side, but from the medical department's facility procedure, there will not be a situation where any dorm is filled. Dr. Anicette explained the medical department's role is to keep detainees healthy and advocate for their health. Dr. Anicette also announced a coming campaign on providing flu vaccines for detainees.

Governor McGreevey invited concluding remarks from the Task Force.

Alessandra DeBlasio offered concluding remarks stating ECCF should reach out to the Task Force if they require assistance or outside resources.

Imran Rabbani offered concluding remarks regarding proactively listening to inmate concerns and responding to needs as experienced by incarcerated individuals, and the success of Dr. Pernell's questions.

Dr. Anicette noted ECCF continues inmate representative meetings, which involves meeting with representatives from each inmate unit. ECCF takes input from these representatives under the governance of the Deputy Director, and explains to each representative what actions ECCF is taking.

> Action: Rosa asked for the list of concerned delivered by the inmate representatives to ECCF staff during the recent inmate representative meeting.

Governor McGreevey invited Dr. Pernell to state concluding comments.

Dr. Pernell offered concluding remarks regarding achieving a state of excellence and address health inequities in covenant with the community.

Dr. Zerbo offered concluding remarks regarding specific concern with substance abuse and mental health concerns, which are disproportionately represented in correctional populations. Dr. Zerbo noted previous work with Dr. Anicette and community linkages, and training staff with the evidence-based standard regarding opioid use and other substance use disorders. Dr. Zerbo reiterated the need for community partners to expand access to treating inmate patients, and that working with the Civilian Task Force will help get ECCF the resources it needs to provide the best care.

Marshall Rountree offered concluding remarks noting known health care gaps and ECCF practices are not always enacted successfully, perhaps through no fault of policy intentions. Marshall Rountree emphasized candor in describing facility issues ECCF stakeholders know to exist so as to address them.

Dr. Anicette thanked the Task Force for their comments, and acknowledged improvements can be made, though atypical situations are often amplified over successful practices. Dr. Anicette pointed out poor mental health supports generally result in incarceration and again advocated stronger community linkages, both in preventing and keeping individuals from returning to incarceration.

Marshall Rountree asked what are perceived ECCF barriers to ideal community connections and linkages.

Dr. Anicette offered an example in "Project Connect," which would have profiled all in the facility for medical, social service, psychiatric services, and linked to services based on those needs – supporting the issue of short correctional stays and continuity of care.

Governor McGreevey stated the Task Force hopes to bring in community-based groups and map out how to provide these services, and take part in this mapping, in partnership with ECCF.

Governor McGreevey offered concluding remarks, inviting public to send Task Force emails and sharing the date of the second task force meeting.

Chair Governor James McGreevey adjourned the meeting at 12:00 p.m.

Appendix D

Nov 12, 2020 Civilian Oversight Task Force Hearing

Summary: The Essex County Civilian Task Force ("Task Force") held a hearing open to the public with relevant Essex County Correctional Facility ("ECCF") personnel regarding mental health services. Addiction and medication-assisted treatment were two topics of discussion moved to the third Task Force hearing due to time constraints. Items under discussion included mental health intake, medication distribution, mental health in segregated housing, and several questions submitted by the public.

1. Welcome
2. Panel Introduction
3. Presentation: Mental Health Overview
4. Questions
5. Public Questions
6. Closing Remarks

Action Items:

- **Follow-up list of questions:** Governor McGreevey asked Dr. Pernell to compile a more comprehensive list of questions and data requests for Dr. Sandrock and send to Alexandra.
- **ECCF presentation materials:** Dr. Pernell asks for slides to accompany any future ECCF personnel presentations.
- **Prescribed psychiatric medication breakdown:** Dr. Pernell asked Dr. Sandrock to provide stratified data on types of medications and diagnoses in the mental health department, to which Dr. Sandrock responded he does not have the ability to do so. Rosa Santana asked Dr. Sandrock to provide a list of medications that mental health has prescribed, which ones have been prescribed the most among inmates and detainees.
- **Substance use disorders and mental health conditions breakdown:** Dr. Pernell asked for Dr. Anicette to provide these statistics on substance use disorders and mental health condition prevalence at ECCF.
- **Individual SHU cases:** Dr. Anicette offered to speak with the Task Force about specific SHU cases and context in a different setting.
- **SHU data breakdown:** Dr. Sandrock stated he is able to compile information on the number of people in SHU, the number of people with mental health conditions, those admitted to SHU housing, those referred to mental health post-intake.
- **ECCF providers:** Governor McGreevey asked for ECCF to submit a list of providers or FQHC partners.

Attendees

Essex County Civilian Task Force

Present:

Judge Jose Linares, Executive Director of the Task Force

Governor James McGreevey, Chairperson of the Task Force

Rosa Santana, fills seat designated to a recognized detainee advocacy group

Marshall Rountree, fills seat designated to a representative from a recognized inmate advocacy group

Rubin Sinins, fills seat designated to a member in good standing of the New Jersey Criminal Defense Bar

Eddie Cannon, fills seat designated to a demonstrated corrections expert

Imran Rabbani, fills seat designated to a formerly incarcerated individual

Rev. Pablo Pizarro, fills seat designated to a social justice advocate

Dr. Chris Pernell, fills seat designated to an expert in the medical field

Alessandra DeBlasio, fills seat designated to a member of the public

Absent: None

Essex County Correctional Facility Personnel

Present:

Dr. Lionel Anicette, ECCF Medical Director

Dr. Dennis Sandrock, ECCF Mental Health Director

William Anderson, ECCF Deputy Director

Dierdre White, ECCF Social Services Director

Pascale Augustine, ECCF Medication-Assisted Treatment to ECCF

Health Expert Attendees

Present:

Dr. Petros Levounis, Chair, Department of Psychiatry, Rutgers Medical School

Dr. Erin Zerbo, Associate Professor, Department of Psychiatry, Rutgers New Jersey Medical School

Dr. Joseph Ranieri, Past President, NJ Society of Addiction Medicine

Proceedings

November 5, 2020 Essex County Correctional Facility Civilian Task Force Hearing was called to order at 6:00 p.m. by Task Force Chair Governor James McGreevey.

1. Welcome

James McGreevey; Judge Jose Linares

Governor James McGreevey, Chair to the Task Force, introduced the second Task Force public hearing and noted the attendance of Chief of Staff to the County of Essex Phil Alagia, who also oversees ECCF. Governor McGreevey explained this second public hearing focuses on mental health services, addiction treatment, and medication-assisted treatment ("MAT"). Governor McGreevey introduced Judge Linares.

Judge Jose Linares, Executive Director to the Task Force, introduced the second Task Force public hearing as a continuation of the first hearing on October 3, and noted the support of Chief Alagia regarding information and access. Judge Linares noted Governor McGreevey's and Task Force members advocacy work.

Governor McGreevey added that Task Members are working on producing insights on ECCF activities as well as providing improvement recommendations based on best practices of other facilities.

Guillermo Artiles, Task Force administration, took roll call. All Task Force members were present.

2. Panel Introduction
   Dr. Lionel Anicette, William Anderson, Deirdre White, Dr. Dennis Sandrock, Pascale Augustine,

   Governor McGreevey noted the attendance of subject matter experts and introduced Dr. Erin Zerbo, Dr. Petros-Levounis, and Dr. Ranieri. Governor McGreevey asked Dr. Anicette to describe his departmental organizational structure.

   Dr. Lionel Anicette, ECCF Medical Director, described the departmental structure as a triad, including himself, mental health services, and social services. Dr. Anicette introduced present medical team colleagues. Dr. Sandrock directs the mental health department at ECCF and oversees services, as well as interfacing with those responsible for medication-assisted treatment services. Deirdre White runs social services at ECCF.

3. Presentation: Facility Mental Health Overview

Governor McGreevey invited Dr. Sandrock to present.

Dr. Dennis Sandrock, ECCF Mental Health Director, introduced his background, role at ECCF, and offered background on mental health services at correctional facilities generally. Dr. Sandrock said there are 4 full-time mental health workers with master's degrees, a full-time mental health director, a full-time psychiatrist, a full-time Advanced Practice Nurse (APN) and a part-time APN for weekend hours.

Dr. Sandrock explained ECCF currently prescribes about 530 individuals' medication, about 60 of those individuals designated by ECCF

Dr. Sandrock explained upon arrival at ECCF a medical provider asks mental health screening questions at pre-book to determine mental health status and presence or absence of suicidal ideation. If any of these assessments are positive, a master's prepared mental health provider or the mental health director, who is a doctoral level psychologist, would meet with the individual.

Dr. Sandrock explained some individuals have challenges adjusting to incarceration and improve after being reassured by mental health staff. Mental health staff do not clear for incarceration those with serious mental health conditions which cannot be addressed on-site. These individuals must be screened and cleared at a hospital.

4. Questions

Dr. Chris Pernell asked Dr. Sandrock to elaborate on what ECCF designates a serious mental health condition warranting an external referral.

Dr. Sandrock described an example of an agitated individual presenting specific plans for self-harm. Dr. Sandrock explained that such an individual who refuses ECCF mental health services and is actively planning self-harm would likely be refused for incarceration.

Dr. Pernell asked Dr. Sandrock to clarify if those with suicide ideation with a plan are immediately referred off-site, or if an additional mental health symptom must present.

Dr. Sandrock responded the intensity or risk of an individual's emotional and mental state is determined by mental health staff.

Governor McGreevey asked Dr. Sandrock how many individuals are referred off-site each year.

Dr. Sandrock estimated once or twice a month.

Judge Linares asked Dr. Sandrock to explain pre-booking the mental health screening process, regarding off-site referrals. Governor McGreevey asked to clarify the chronology of the process. Marshall Rountree clarified Judge Linares' inquiry as focusing on pre-booking and asked if individuals must present certain mental health symptoms to be assessed by a mental health provider.

Dr. Sandrock responded there is a pre-booking process for all incoming individuals where mental health or medical staff may assess an individual's presentation as unfit for incarceration. After, an intake nurse will begin a medical and mental health intake screening in the intake area.

Imran Rabbani asked Dr. Sandrock if there is a separate pre-booking process for ICE detainees and if there is a standard tool of assessment, as opposed to the judgement of a mental health provider.

Dr. Sandrock explained the first point of contact for an individual on arrival at ECCF is with a nurse, who collects information on the individual's medical history and psychiatric history, substance abuse history, and suicidal ideation. This information is recorded in the electronic medical records system ("EMR"), which prompts the nurse based on inputted information. The nurse determines referral to either medical or mental health based on an individual's responses to these prompted questions.

Dr. Pernell asked Dr. Sandrock to clarify who completes the pre-booking screening. Dr. Sandrock responded the front desk is staffed by a health care staff member who may follow standardized prompts. Dr. Anicette responded the staff member is always a licensed practical nurse or above.

Alessandra DeBlasio asked Dr. Sandrock if the pre-booking process is the same for ICE detainees, to which Dr. Anicette responded in the affirmative. Alessandra DeBlasio asked for the panel to touch on how medical and mental health respond if an individual does not speak English, Spanish, or Portuguese. Dr. Anicette responded the facility uses a translation line, which includes all known languages. Dr. Anicette noted ECCF did process an individual who spoke a language only known to 10,000 people, and a translator was found within 2 days.

Dr. Anicette clarified that someone who arrives at the facility who is actively suicidal and determined by medical staff that necessary treatment is beyond ECCF suicide watch procedure, they are not cleared for incarceration.

Marshal Rountree asked where refused individuals in crisis are sent. Marshall Rountree asked if these are contracted agreements or if ECCF has flexibility on partner crisis centers.

Dr. Anicette responded local crisis centers and three have been used in the past. Dr. Anicette explained ECCF's chartered center is Beth Israel Hospital, but patients that present acutely are sent to University Hospital Crisis Center. Beth Israel sometimes sends a provider for on-site screenings and that a charter means ECCF has preferential treatment to their crisis center. Dr. Anicette answered ECCF may still utilize services from other crisis centers.

Rosa Santana asked Dr. Sandrock to clarify statistics from his presentation.

Dr. Sandrock explained 60 of those 530 individuals medicated by ECCF are designated forensic inmates and receive closer care. There are housing areas dedicated to forensic inmates. Dr. Sandrock stated a little over a quarter of the 2,000 current ECCF inmates receive mental health services.

Dr. Pernell asked Dr. Sandrock to clarify how many of the 530 individuals prescribed medications are being prescribed for mental health diagnoses.

> Action: Dr. Pernell asked Dr. Sandrock to provide stratified data on types of medications and diagnoses in the mental health department, to which Dr. Sandrock responded he does not have the ability to do so.

Dr. Sandrock clarified the 530 individuals refers to those prescribed mental health medications, but there may be those taking additional medication for a medical condition. Dr. S

Governor McGreevey asked Dr. Sandrock to describe typical ECCF pharmaceutical regimens and outliers. Governor McGreevey asked Dr. Sandrock when a comprehensive mental health evaluation and medication prescription occurs on incarceration.

Dr. Sandrock responded a mechanism is place with the nursing staff allows the nurse to verify a medication an individual is currently taking by contacting the individual's pharmacy or physician. The nurse will begin the process of ordering the individual's medication. Dr. Sandrock noted for individuals presenting more serious mental health symptoms, the intake nurse review intake information and will initiate a suicide watch for the individual or alert the mental health director for direction. During ECCF regular hours, the nurse may involve any of the mental health staff.

Dr. Sandrock explained individuals are started on whatever medication they may be taking on arrival at ECCF until they see an ECCF prescriber, who decides on continued treatment. Dr. Sandrock explained mental health referrals are either urgent, emergent, or routine: urgent requires immediate attention; urgent requires attention within 24 hours; routine requires attention within 72 hours. This order is organized via the EMR.

Dr. Sandrock explained a further screening step involving those who do not report mental health conditions. However, the mental health staff review all nursing intakes for any mental health condition history

Governor McGreevey invited Dr. Pernell to ask questions.

Dr. Pernell responded there remain gaps in understanding regarding the standard mental health intake process. Dr. Pernell reviewed the intake process: pre-booking screening is done by at least a licensed LPN; a nurse determines if the individual is in crisis; routine intakes continue to a more comprehensive medical and mental health nurse intake.

Dr. Pernell asked Dr. Sandrock if at this point in the nurse assesses where an individual will be housed, and how this is determined. Dr. Pernell asked Dr. Sandrock to clarify how many of the 530 individuals prescribed medication includes substance abuse treatment.

Dr. Pernell asked Dr. Sandrock to clarify the aforementioned limitations of the EMR regarding stratifying treatment. Dr. Pernell pointed out that substance abuse disorder is included as one of the most prevalent conditions at ECCF, and hopes to determine the level of need and appropriate response.

Action: Dr. Pernell asks for slides to accompany any future ECCF personnel presentations.

Judge Linares asked Dr. Sandrock to clarify at what point a mental health professional becomes involved in the process and what triggers this engagement.

Dr. Sandrock responded that a mental health professional may be engaged at pre-book, if a person is not communicating or presenting suicide ideation. If this occurs during regular hours when mental health staff are on-site, a mental health staff member will immediately address the individual. Dr. Sandrock explained a mental health professional may be engaged during the nurse intake, if the nurse determines the need, during the time mental health staff are on site. Dr. Sandrock explained a mental health professional must attend routine health referrals among the general ECCF population within 72 hours, and emergent referrals within 24 hours with immediate initiation of suicide watch. An urgent referral would be engaged immediately during regular hours or immediately the next day during off-hours.

Governor McGreevey asked Dr. Sandrock to clarify the protocol for following up with an individual who has been seen by a mental health professional. Governor McGreevey asked a public question regarding the procedure for continuity of mental health treatment and care.

Dr. Sandrock explained the mental health staff are assigned to housing areas and responsible for providing services to those areas. Dr. Sandrock noted a mental health professional often completes daily intake. There is an EMR procedure that follows referrals, submitted information, medication, and follow-ups. Dr. Sandrock pointed out one challenge is those suffering from serious mental health conditions often will not self-administer their medication.

Governor McGreevey asked if someone who had received mental health services would be followed up with by mental health within 48 hours, or if the individual must themselves solicit an appointment. Dr. Sandrock answered the EMR would flag the individual for follow-up, and that the individual may also alert an officer, a member of the mental health staff or nurse in the hallways, or initiate a request via a tablet.

Imran Rabbani asked Dr. Sandrock what the corresponding protocol is for those housed in Special Housing Unit (SHU) or protective custody. Imran Rabbani asked how frequent a mental health

assessment is provided to an inmate in segregation housing. Marshall Rountree asked for clarification on how often a mental health professional assesses all inmates in SHU.

Dr. Sandrock responded there is a mental health staff member designated to these areas, and forensic inmates are automatically seen more frequently. Dr. Sandrock answered there are daily nurse rounds in SHU in addition to mental health staff. Dr. Sandrock explained individuals are referred to mental health before being moved to SHU and may request mental health services at any time in addition to standard monthly assessments. Marshall Rountree clarified that individuals in SHU are not regularly evaluated by mental health professionals outside of the monthly assessment.

Dr. Pernell asked for clarification on daily nurse rounds, which Dr. Sandrock confirmed occur twice daily. Dr. Pernell clarified, at minimum, an individual in SHU has access to a nurse daily, which Dr. Sandrock confirmed. Dr. Pernell asked when an individual with a mental health diagnosis would be assessed by a mental health professional, which Dr. Sandrock confirmed occurs at least once a week.

Marshall Rountree asked Dr. Sandrock to confirm that the staff member making daily rounds is not a mental health professional, to with Dr. Sandrock replied in the affirmative. Marshall Rountree asked Dr. Sandrock to confirm that a routine inmate in SHU without a previously diagnosed mental health condition would not be automatically seen by a mental health professional, to which Dr. Sandrock noted the monthly mental health assessment.

Guy Cirillo added correction officers also assess for mental health symptoms and have protocol for engaging a mental health individual.

Governor McGreevey asked Dr. Sandrock to clarify why a greater amount of mental health contact isn't required for individuals in SHU. Dr. Sandrock responded a mental health referral is included prior to SHU admission. Governor McGreevey pointed out the day's scope is focused on the opinions of ECCF medical professionals.

Governor McGreevey asked if Dr. Sandrock has an ideal system or protocol design in mind for increasing mental health care and access at the facility. Dr. Sandrock answered additional mental health staff; Dr. Pernell asked if Dr. Sandrock has enough staff. Dr. Sandrock explained additional staff at other facilities always increase access and highlighted recreational services like TVs.

Marshall Rountree highlighted the Isolated Restricted Confinement law that went into effect in August, which requires certain mental health activities regarding SHU inmates. Marshall Rountree asked if the facility is aware of the law, and if any procedural modifications have occurred to meet new requirements.

Dr. Sandrock responded there are different parameters for prisons and jails.

Imran Rabbani asked Dr. Sandrock if in his opinion a 30-day interim period between mental health assessments for individuals in SHU is adequate. Imran Rabbani noted segregation is detrimental to mental health and has experience with facilities providing regular mental health assessments.

Justice Rountree noted he is unsure if the 30-day interim period complies with present law and that those who require mental health assistance often cannot advocate for themselves.

Dr. Pernell added baseline information is necessary, such as the percentage of inmates with mental health diagnoses, percentage of cooccurring substance abuse disorder, or other baseline ECCF mental health data. Dr. Pernell added there is a concern those inmates who cannot advocate for themselves are receiving adequate mental health care services.

Dr. Sandrock answered he may provide these statistics now that he is aware.

> Action: Governor McGreevey asked Dr. Pernell to compile a more comprehensive list of questions and data requests for Dr. Sandrock and send to Alexandra.

Rosa Santana pointed out ICE detainees are often afraid of requesting mental health care because they are scared of being placed in SHU. Rosa Santana added ICE detainees are often prescribed sedatives which cause them to sleep the whole day.

> Action: Rosa Santana asked Dr. Sandrock to provide a list of medications that mental health has prescribed, which ones have been prescribed the most among inmates and detainees.

Dr. Anicette responded the Isolation Act is incorporated in present SHU procedure. Dr. Anicette offered the example of an individual who was refused clearance for SHU based on mental health, and stated someone violently suicidal would be placed in SHU and seen once a month. Dr. Anicette stated common mental health conditions like depression or anxiety are not usually cleared for SHU. Dr. Anicette stated no one is prescribed medication to sleep all day, but some patients present insomnia or psychiatric issues that require anti-psychotics. Dr. Anicette reiterated chemical restraints are against medical policy.

Dr. Anicette responded to fear of SHU restraining a detainee from making a mental health complaint, noting their first objective is to the safety of a detainee, including keeping a detainee from harming themselves. Dr. Anicette pointed out that Dr. Sandrock has limited and reduced the number of those placed in SHU. Dr. Anicette stated ECCF policy folks had meetings with medical and mental health when the Isolation Act went into effect, and changes were made immediately. Dr. Anicette offered the example of the new policy that no individual may be in segregated housing for more than 20 days.

Dr. Anicette also noted ECCF has adequate staff, and more are often being added, but additional staff would still be welcome and utilized.

> Action: Dr. Anicette offered to speak about specific cases and context in a different setting.

Governor McGreevey invited Drs. Pernell, Levounis, Ranieri, and Zerbo to ask questions.

Phil Alagia, Chief of Staff to the Executive, invited the Task Force to put together questions for submission to the County, which would help facilitate filling requests for information.

Dr. Pernell reiterated public presentations should include summaries of the relevant data.

Judge Linares invited the County and ECCF to volunteer their ideas for facility improvements and ideal changes.

Governor McGreevey invited additional questions on mental health.

Dr. Joseph Ranieri asked about idle time in prison and how much counseling and biopsychosocial modalities exist for those with mental health or cooccurring disorders.

Dr. Sandrock agreed prisons involve more downtime than outside life, but noted people do not usually stay very long. Dr. Sandrock stated ECCF was enacting mental health groups up until March 14, due to the onset of the COVID-19 pandemic. Dr. Sandrock stated these groups would be resumed when safe from a public health perspective.

Governor McGreevey asked Dr. Sandrock to clarify that individuals are selected for groups. Governor McGreevey asked Dr. Sandrock if there is capacity to increase groupwork with regards to improving

mental health. Dr. Ranieri asked Dr. Sandrock is there is capacity to utilize telemedicine for groupwork services.

Dr. Sandrock affirmed his support of groupwork, and noted that video court visits and other forms of intake often impact capacity for groups. Dr. Sandrock stated he and Dr. Anicette have discussed a programmatic day of mental health programs per unit, making the unit itself a therapy unit.

Deirdre White, Director of Social Services, added that ECCF is slowly restarting group services and is currently running about 12 groups. Deirdre White stated they are working on recruiting for anger management courses and substance abuse groups.

Dr. Pernell asked what groups are currently running.

Deirdre White responded a women parenting group, a life skills group for special needs services, and a life skills group for the Marshall services.

Dr. Ranieri asked if there are resources for telemedicine to facilitate these groups, noting there are volunteer social workers who may assist in the future.

William Anderson, Deputy Director, responded ECCF is working towards increasing telecommunication capacity among inmates. Deputy Director Anderson stated the tablet system did not previously have the required technology, but the facility is in the process of upgrading this tablet system. ECCF plans to hold sessions with social distancing or from a cell with these services.

Governor McGreevey invited Dr. Zerbo to ask questions.

Dr. Zerbo asked what the course of a day in segregated housing looks like and how much social contact is received in a 24-hour period.

Deputy Director Anderson responded inmates and detainees in SHU receive at least 2 hours out of cell-time per day, which includes opportunities to shower, make telephone calls, watch TV, or engage specific recreation areas. Deputy Director Anderson added a new system in the SHU area allows officers to monitor and ensure inmates are existing SHU regularly and at their dedicated times, with particular regard to new Isolation Act compliance.

Dr. Zerbo asked Deputy Director Anderson to clarify that inmates are in their cells for 22 hours a day.

Deputy Director Anderson explained that this depends on the location of an inmates SHU cell. Deputy Director Anderson described one side of SHU has 16 cells that houses 31 inmates, and that this side has access to 2 televisions. Deputy Director Anderson explained this as the area where the facility places inmates for social interaction. Deputy Director Anderson acknowledged there is an additional side with only one window facing outside, and usually people requesting protective custody or placed sanctioned detention are housed here.

Deputy Director Anderson noted detention can only be 20 days, to which Marshall Rountree clarified 15 days. Deputy Director Anderson agreed 15 days and added that inmates are sometimes in detention for 20 days. Marshall Rountree responded this is not in compliance with State law as it currently stands, to which Deputy Director Anderson agreed.

Dr. Zerbo began to ask an additional question on segregated housing, which Governor McGreevey asked to be held until a planned hearing focused on segregated housing. Marshall Rountree and Chris Pernell

asked for clarification that the Task Force was holding a hearing on segregated housing. Governor McGreevey replied in the affirmative.

Governor McGreevey invited mental health questions from Dr. Zerbo. asked for lived experience from Imran or Marshall regarding mental health in the facility.

Dr. Zerbo explained that socially isolating individuals corresponds with mental health defects. Dr. Zerbo referenced a study that demonstrated individuals with no mental health history may start hearing voices or experience other symptoms within 30 days.

Dr. Zerbo added these individuals may keep these experiences private. Dr. Zerbo asked for clarification regarding correctional officers' rounds practices and the ability of SHU inmates to advocate for themselves.

Dr. Sandrock explained the doors in SHU include large windows, allowing individuals to see the entire person on the other side. Dr. Sandrock stated he feels as though he's making contact with a person when speaking through these doors and nurses' rounds are made twice a day.

> *Action*: Dr. Sandrock stated he is able to compile information on the number of people in SHU, the number of people with mental health conditions, those admitted to SHU housing, those referred to mental health post-intake.

Dr. Zerbo asked where those under suicide watch are sent.

Dr. Sandrock responded that SHU is not completely segregation and there many are cells that can be seen by inmates and officers.

Dr. Pernell asked Dr. Sandrock to clarify the differences between levels of suicide watches and how the facility assesses an appropriate suicide watch designation. Dr. Pernell asked Dr. Sandrock to compile the most comprehensive and large-scale data he has access to so as to identify trends across populations.

Governor McGreevey noted questions from the public and apologized for technical difficulties, as well as the lack of time for a discussion on Medication-Assisted Treatment. Governor McGreevey invited questions from Marshall Rountree, then the doctors, then the public.

Marshall Rountree clarified that while there are different types of segregated housing, the Isolation Act covers all of these conditions. Marshall Rountree stated the law requires a physician to visit SHU inmates in County prisons once a week.

Dr. Sandrock responded in the affirmative.

5. Public Questions

Dr. Pernell suggested public questions due to time.

Governor McGreevey invited Guillermo Artiles to read Facebook comments.

Guillermo Artiles asked on behalf of the public if protocol has changed regarding patients released from jail to continued mental health services.

Dr. Sandrock responded the protocol has not changed, but there is an organization ECCF to assist with discharge planning due to the pandemic and current CFG services constraints.

Deirdre White responded there are many individuals already linked to mental health services on entry to ECCF. Deirdre White says Social Services may follow-up on this linkage upon release, or the Essex County Prosecutors Office may link released patients to services.

Governor McGreevey asked if there is a situation where mental health advocates released patients, or that an individual may be better served by a residential treatment facility outside of the jail.

Dr. Sandrock responded many of these people are quickly sent for residential treatment immediately. Dr. Sandrock added he has no issue offering a summary of treatment to a new provider following a patient signing a release.

Dr. Anicette added there is a special needs meeting on a weekly basis, regarding patients who cannot advocate for themselves and where the medical department communicates with public defenders, judges, IOPs, or others on behalf of those patients.

> Action: Governor McGreevey asked for ECCF to submit a list of providers or FQHC partners.

Guillermo Artiles asked on behalf of the public how many inmates suffer from mental health and addiction issues.

Dr. Anicette responded there is an overlap of cooccurring patients; the facility has on average 300 to 400 patients with psychiatric conditions, some of which are chronic and some which are situational. Dr. Anicette responded the facility has about 200 to 300 patients suffering from substance abuse disorders. Dr. Anicette estimated altogether about 400 to 500 in the population suffer from mental health or addiction issues. Governor McGreevey asked for this number in a percentage, and cited a CHC Columbia University statistic estimating 48% to 50% of those incarcerated in New Jersey suffer from mental health conditions. Dr. Anicette responded in the affirmative based on ECCF.

> *Action*: Dr. Pernell asked for Dr. Anicette to provide these statistics on substance abuse and mental health condition prevalence at ECCF.

Dr. Sandrock noted individuals with cooccurring substance abuse and mental health conditions.

Governor McGreevey invited Guillermo Artiles to read Facebook comments.

Guillermo Artiles asked on behalf of the public regarding protocol on those entering the facility experiencing withdrawal and what related training officers receive.

Dr. Anicette responded withdrawal symptoms are assessed during intake, usually within the first few hours of entering ECCF. Dr. Anicette stated prior to the initiated MAT program, medical placed these individuals on detox protocol, which was Librium-based. Dr. Anicette explained those placed on that protocol are now being shifted to Medication-Assisted therapy, which started about 3 or 4 months ago. Dr. Anicette said about 100 patients so far have shifted from detox to MAT protocol. Dr. Anicette explained time at ECCF determines which protocol a patient is assigned to; those with long stays are shifted to MAT, those with shorter incarcerations are placed in detox.

Dr. Anicette explained all officers receive training, mainly on suicide prevention, though training is evolving.

Dr. Sandrock noted the benefits of MAT in correctional mental health settings. Dr. Sandrock noted there is daily contact for those going through withdrawal with mental health staff.

Governor McGreevey invited Guillermo Artiles to read Facebook comments.

Guillermo Artiles asked on behalf of the public regarding mental health services for those incarcerated whose family members may have passed due to COVID-19.

Dr. Sandrock responded those individuals may easily request counseling for such an event. Dr. Sandrock noted mental health staff immediately refer inmates to mental health counseling if a family member has passed from COVID-19. Dr. Sandrock noted there is increased individual contact due to decreased group services. Dr. Sandrock noted inmates that test positive for coronavirus are also referred to mental health.

Governor McGreevey asked Dr. Sandrock if this information communicated in multiple languages.

Dr. Sandrock responded there was medical information shared early on by everyone in the facility.

Dr. Anicette added inmate representatives also communicate to inmates facility activities and events.

Deirdre White added the courts have not allowed inmates to attend family member funeral services, and social services has established video-viewings of up to 30 minutes for those inmates upon request. Deirdre White added a mental health professional follows-up with such individuals for a wellness check.

Deputy Director Anderson answered there are about 500 tablets in the building, about 16 to 10 in various units. Deputy Director Anderson mentioned the facility is working to increase the number of tablets and provide one to each individual inmate. Dr Pernell asked for the timeline on this goal, to which Deputy Director Anderson responded he could not.

Governor McGreevey invited Guillermo Artiles to read Facebook comments and asked questions remain focused on mental health.

Guillermo Artiles asked on behalf of the public how long inmates are held in the holding area prior to seeing a nurse. Dr. Anicette responded ECCF's goal is no more than 4 hours and the facility has instituted new screening tools.

Guillermo Artiles asked on behalf of the public how often psychiatrist notes are reviewed. Dr. Sandrock said peer reviews are done annually by a mental health professional's clinical supervisor, in addition to a weekly team meeting. Dr. Anicette noted there is a level of routine oversight on a daily or weekly basis.

6. Closing Remarks

Governor McGreevey confirmed there are no further public questions regarding mental health, to which Guillermo Artiles responded in the affirmative. Governor McGreevey invited closing comments from the Task Force.

Dr. Pernell thanked the ECCF panel and again requested a broad data overview ahead of future hearings.

Governor McGreevey offered closing comments, noting the next public hearing would focus on addiction services and that the Task Force is committed to holding a public hearing which allows the public to candidly share relevant experiences receiving health care at ECCF. Justice Rountree asked Governor McGreevey to clarify the planned hearing on segregated housing, to which the Governor responded in the affirmative.

Chair Governor James McGreevey adjourned the meeting at 8:00 p.m.

Appendix E

Essex County Civilian Task Force Public Hearing on Addiction Services & MAT
December 5, 2020

Governor Jim McGreevey (JM) called upon Dr. Lionel Anicette to speak.

Dr. Lionel Anicette (LA) explained that 60% or more of inmates are presenting substance abuse disorder upon intake, and only roughly 10% of facilities throughout the nation are receiving the level of care that would meet the MAT level of care. With the help of a number of notable people, they've been able to initiate and launch a state-wide initiative. Mentioned that Dr. Zerbo & staff did in-servicing and education a while back; the warden helped get the funding. Money has been made available, but Essex County said they only want it if they're going to use it properly—by bringing in both medication and personnel.

JM: What percentage of individuals both on the detainee side and on the jail side have addiction.

LA said they are seeing roughly 400-500 patients coming in on a monthly basis suffering from substance abuse disorder.

Dr. Chris Pernell (CP) asked what percentage that is.

LA: Roughly 30-40% depending on the intake. At one point, ECCF was the largest detox center, detoxing hundreds of people every month. Realized they need to elevate their game.

JM: These numbers are smaller compared to other state/county facilities, which are often well over 50%.

LA clarified that he is referring to patients being ***admitted*** with known abuse problems; the number goes up once admitted and investigations happen.

JM asked what happens if an inmate is admitted and is in the throes of detox.

LA responded that they would be treated immediately. Nurses are trained to detect substance abuse disorders with their screening tools. Based on the scoring, they will reach out to the provider in the facility to get orders at intake, within 4 hours of coming to the facility.

CP asked to clarify if the screenings are conducted by a nurse.

LA said yes, LPNs.

CP asked of those screened and in the facility, what percentage/number is in treatment.

LA: Roughly 100%. Nurses will put in orders and hydrate the detainees, starting treatment right away.

JM: What happens besides getting an IV if going through withdrawal?

LA: Receive specific medication that treats whatever substance they are addicted to. *He said he will share the protocols & specific information with Dr. Pernell and Dr. Zerbo.* If the patient is unstable and showing low vital signs, low BP, etc., they will get admitted to the infirmary and seen by a provider there. Based on that evaluation, if found unstable, then transferred to University Hospital for further management. If subacute, they will be put in the 42-bed infirmary with IV, meds, etc. and managed there; then, they will be placed on watch where there is an RN 24 hrs a day, MD 16 hrs a day.

JM asked if detainees are automatically admitted to the infirmary if showing withdrawal symptoms.

LA: No, only if showing moderate to severe symptoms. Depends on severity of symptoms and the last time they did drugs. Typically they are arrested for a day or two, so their day of intake is not their first day of withdrawal.

JM turned the conversation over to Dr. Pernell, Dr. Zerbo, and Dr. Ranieri for questions to Dr. Anicette.

Dr. Erin Zerbo (EZ) asked to be specific about opioid withdrawal and how that is handled, what options are available, etc.

LA: What has been historically done is a detox withdrawal program. Now MAT, which is relatively new. Patients are screened to see if they're eligible for the MAT program and then started on suboxone usually within 1 or 2 days. First immediate concern is stability; look at hemodynamics to see if the patient is stable enough to stay in the facility. If not stable enough, they have to go to the hospital. If subacute and we can manage, then they will go into the infirmary where IV hydration can be done and medication can start. Now with suboxone, it can be administered within 24 hours.

CP asked how many inmates are on suboxone.

LA answered 120 patients out of roughly 300 identified patients who are eligible for MAT.

EZ asked if someone is getting their initial assessment from a nurse, why not give them a dose at that time?

LA: The main goal is stability. We are looking at patients in real time, coming 2-3 days after first withdrawing and compensating for that time. No issue with starting suboxone, but it has to evolve, considering how new the program is. If we were to administer at intake, they would do the training, implementation, ensure the resources are there (suboxone is not easy to access). Even with the 120 patients they have, there are supply issues. Great idea [to administer at intake], but major developments must occur in terms of medical and testing.

JM asked if it would make sense/if it's best practice to administer at intake.

LA: Yes, but it's not always the best drug for everyone who comes in. We need to determine what drug is in the detainee's system and recent history. LA would then promote using medication upfront, which the ER has done for a number of years, but this is not the right way in a hospital setting; those patients were getting one dose and being sent back and forth with no waivers. Recently got people trained in waiver to do it. Most people who get their waiver for suboxone don't actually use it; we need to get our staff up to date on suboxone waivers. Instead of mandating, they are trying to get folks to understand that it's the best practice, which has been done for 120 patients. The next step is to evolve and take it to the intake process, which is a fast-moving process. They have a plan they want to launch and roll out.

CP asked to explain differences between the nurse intake, differences in who is providing the screening, the time the nurse intake happens, etc.

LA: The screening is done by a licensed practical nurse 4 hrs after the booking time. Based on the scoring system, that LPN is going to contact the doctor on site (PA, nurse practitioner, or MD) for orders. Not a big lapse in time—maybe 15, 20 mins.

JM: The task force wants to establish best practices in terms of referral and pharmacology. What would constitute best practices and how many people walk through the facility in a given month in the midst of detox?

LA: About 400-500 people a month. This is the issue. Some of them are only there for one or two days, so what has to happen is a) stabilize them and provide care and b) find a way to link them up so when they leave there is some type of maintenance. He said that truthfully, they want to get the patient in front of a judge to be released from the facility. If we can get urine screening implemented in the intake process for everyone who meets the criteria, it would be beneficial. Actively being discussed with the custodial administration.

JM asked if they were looking for best practices in addition to urine screening, what kind of panel that urine screening would look like.

LA: Multi-screen panel, maybe 16 to 18, that includes K2, fentanyl, benzos, etc. They would try to do that about 400 to 500 times at least in the intake area, which would complicate the process, but it's important to do the urine screening and reading early coupled with looking at the history. This would be a great launching pad, but the question is where do we go next—how long is the patient staying in the facility, where do they go, etc.

EZ asked to look at the worst-case scenario where someone had been medicated with something else before arriving at the facility and then put in gen population. How backed up does the team get with the evals?

LA: It's too premature to think about backup because this was launched for just 3 months. This is the assessment phase still. There's no one at the facility who isn't getting detox but needs it. Some with mild withdrawals may be contained in quarantine for 2-3 weeks; in the meantime, they are stable and sober. When presented with MAT, they may not want it.

CP asked how opioid patients are treated—are they all detoxed completely and then offered MOUD or can they be started on maintenance MOUD and avoid detox?

LA: If someone is on maintenance from the outside on suboxone, their goal is to get that person on suboxone ASAP. They have to verify the provider and dose and will continue. Most patients are not in programs or maintenance or methadone. They're coming in using street drugs. Our goal is to stabilize and not lose lives. Key areas of concern: If a male is on methadone, we have not found a true great avenue in terms of getting them on methadone maintenance. In the past, we have prioritized pregnant methadone-dependent women so they were sent to the methadone programs. We have to align ourselves to a methadone program, which will allow more access. We have a better grasp on suboxone in terms of how to roll out and implement it, but the issue there is supply. We've done a good job on training in terms of providers, but in terms of nurses doing the intakes we will have to change that as well as where we store medication—logistical issues.

EZ: MOUD is medications for opioid use disorder, the new term for MAT, which is medication-assisted treatment. Same thing. We are talking about three medication: suboxone (or buprenorphine), methadone, and extended-release naltrexone (vivitrol, the injection). Suboxone and methadone are blockers and opioids themselves; naltrexone is a blocker, so you have to be fully detoxed for 7-14 days, normally given at discharge. Experts have looked for ways to treat opioid abuse without the use of medication but have fine extremely high relapse rates + protractive withdrawal, which goes on for months. If you put people on one of these drugs, mortality rates drop from 6x the general population to less than 2x. There are enormously high death rates without these medications, so professionals try to administer these ASAP. There have been ODs inside jails and prisons if they're not in MOUD. Worried as well about people who finish detox, not on MOUD, and now in the general population – those people are still at risk for overdose if they're not on a medication. We must make sure people have the education & know they can get on medication.

JM asked Dr. Zerbo to talk about the rate of overdose once out of jail.

EZ: People released from prison setting are 129x more likely to have an overdose death than someone in the general population. Those who are incarcerated are in the highest vulnerable group out of those we study, and the transition from leaving facility to back to society is the danger point because they lose their tolerance and return to their community.

JM asked Dr. Zerbo to speak to the higher rate of overdose deaths during COVID.

EZ: Studies are coming out now showing about a 20 to 50% increase in certain geographic areas. Other studies show that those with opioid use disorders are 10x as likely to get COVID than those without. MOUD is a dramatic treatment and very obvious public health measure.

JM asked if one arrives at the facility who had MAT on the outset but no prescription, what happens.

LA: The nurse will contact the provider, verify the doctor who placed the person on medication and the dosage, then start medication. This is done regularly and is an easy protocol to follow. The

type of patient Dr. Zerbo is discussing is more difficult, with no link to care. MAT must be rapidly attending to that patient to see where we can start the MOUD, then link them to a program so there's a seamless transition from jail setting over to the community center.

CP: How many patients come in who are already on MOUD?

LA: Not a high percentage, maybe 5-10%. Most still using illicit substances.

CP: Had there been overdoses in the facility in the last 5 years, and if so, can we talk about the clinical outcomes?

LA: Still unfortunately drugs being traded, so nurses are trained in first aid in terms of Narcan (nasal). More K-2 of late, not so much opiates. Narcan used about 3-4x a month responding to emergencies. Luckily have not lost a patient, but some have needed multiple doses of Narcan. Response time is usually 1-2 minutes.

Dr. Joseph Ranieri (JR): Currently involved with methadone maintenance, in the southern part of NJ. Some counties do not offer methadone bc of operational problems, but this could be inhumane because it's difficult to treat a withdrawal. In the 48-36-hr realm, it's moderate to severe, and after 4 days, symptoms can get pretty bad. From an operational standpoint, the system needs to find vendors to assist local county jails to help with this problem.

LA: We've had to send pregnant women to University Hospital to service them with methadone. Truthfully, when they get there, they're placed on suboxone most of the time. Suboxone is easier in terms of getting an endorsement and receiving the necessary info, but for methadone it's so facility centered. It's hard to transfer data over from facility to facility. We've worked with one methadone center in Jersey City but it's not always open and can't handle all cases. So we run into an issue bc inmates don't schedule their appointments; if they come in on a Saturday, we have to make critical decisions because you're focused on the ability to keep the fetus alive—so we have to send them to a hospital.

JR: With the relaxed govt regulations, if you found a vendor who would work via telemedicine, suboxone is really easy; as long as there's a medical provider with a DEA license at your facility—they don't need a waiver—no face-to-face examination is needed. With methadone, if I was to have a contract with your institution, I'd need to see the first visit face to face. These operational regulations pose an issue. Quite a number of patients are developing precipitated withdrawals of fentanyl (lasts more days than heroin); if you give suboxone too soon, you develop precipitated withdrawals as if they were given Narcan. So, more patients are moving toward methadone, because you can start that within hours taking your last dose of fentanyl.

JM: We need to delineate clinical best practices.

LA: We need to have an algorithm so we can put these cases in different categories and apply protocols effectively. More staffing & medication is needed as well.

Justice Rountree (Justice): Have you collected any data on people with dual diagnoses out of this population?

LA: Yes. Almost all of them have dual diagnoses. It's not just the MAT group, but it's also social services and mental health services that have to collaborate as a team for a multidisciplinary approach.

Justice: For urine screening, is this for people who voluntarily become involved in the program?

LA: One of the issues is that I didn't want my medical team to be involved with any type of punitive actions against our patients so we can collect and use data clinically, not criminally. If the nurses receive an order to run a urine screening, it's because we're trying to figure out where the patient needs to fall in terms of treatment—not for other opportunities for punishment. That's why I'd like to make this an option, not a mandate. We'd like to offer it 100%, however, to everyone who is eligible. If he/she refuses, it will not be punished.

JM: Is there a way to restrict the flow of information between the medical team so you're making medical decisions to screen and treat without turning that information over?

LA: This program (MAT) gives us the avenue to make this HIPAA-protected information.

JM: Is there a way to make medical determinations without it being conveyed to law enforcement?

LA: I believe so. Once the person submits to the test, we must receive consent that the test will be used for certain things and not others. It wouldn't be open to any investigations that happen, even if it's relevant.

JM: As a condition of parole, I have to do a urine screening. Theoretically, can you keep that info in your care?

LA: Absolutely. We don't have a contract with parole, unlike other agencies. We don't get involved in forensic evidence. This isn't uniform in the state of NJ but should be.

CP: Of the 120 population, can you subset which cases are on which drug in particular?

LA: For exact stats, I'd have to speak to the MAT coordinator on the call. Right now, the majority, about 90%, are on suboxone. I believe there's just one pregnant woman on methadone. We don't have patients on vivitrol at this time.

JM: Can you share what happens next?

LA: The patient would have a referral to the MAT program after being stable for a couple days, so the coordinator or colleague will interview the patient to see where they fall in terms of eligibility for the programs. Based on this, the same day or the next day the provider will be contacted to write a prescription. This is roughly 2-3 days after initial contact. Then the patient is monitored in terms of how they respond to their medication (which can be adjusted), and the

professionals will begin creating a treatment that involves linking up the patient to access to care on the outside. Patients are given 3 days of medication by physical supply or prescription upon discharge (3 days because this is contractual with the pharmacy—we've tried to write for more).

EZ: Should this be looked into as something to fix because with a waiver you can write a prescription for as long as you want?

LA: Absolutely.

JM: People should be given 4 weeks now with the pandemic. It's especially difficult for people without an ID or Medicaid, which is the case for many in MAT. Would you be open to providing for two week's worth of supply?

LA: Yes, we'd like to work out the logistics with all of the stakeholders involved. I think 2 weeks will be at least a decent amount, but not the ideal.

JM: Even if they have the prescription, the question is what is the reimbursement stream to pay for the prescription? Without Medicaid, this is an issue. 2 weeks ought to be a best practice.

LA: I would agree.

JR: From an operational standpoint, the methadone issue will take a while to be addressed. There is microdosing that could be given of buprenorphine to those who are on methadone maintenance—essentially transitioning from methadone to buprenorphine. Not the best approach, but it's an alternative.

LA: We've explored that and that's probably an avenue we're going to dive deeper into because the transitioning is brand-new territory that should be explored. One best practice we saw in Albany was a methadone van that would be come to a secure area at facilities, and they'd administer the drug. The van would be considered an extension of the license of the methadone center.

JR will write up what would be a best practice.

LA: Those here at the facility have reached out to a number of folks and have been able to remove the code (?) that blocks patients from their Medicaid. This happened in the last 4 weeks. Now our patients look like viable patients to community centers.

CP read public question: Are we considering using the once-a-month dose of suboxone after being released from the facility?

LA: The answer was yes months ago. We put it into our budget, and we're trying to ramp up the process to get to that point. Those will be patients that we've already hopefully had linked up.

JM brought up the evidence strongly linking vivitrol to treating alcoholism.

LA: That's also in our plans. It's a little different with alcoholism; we try to put people in groups to help treat. COVID has stymied the effort, but that is definitely in our plan to put vivitrol front and center. We've had trainings at least 3x with vivitrol, the staff is well versed. The issue is that patients must abstain for 7-10 days. But for folks who are eligible, we absolutely want to give them access to that care.

JM: With all the physicians on this call, it would be great to set forth a template for best practices to minimize the risk of overdose and death. On top of everything already discussed, I would advocate for 2 weeks of anticholesterol, cardiovascular medication. When patients leave the facility, do they have a thumbnail sketch of their medical history and their pharmacological regimen?

LA: They have access to it and their treaters have access to it. If they're logged in the program, we've already transitioned them and endorsed their case profile to that community center. There's no issue with them calling to get it afterward.

JM: Would it make sense to provide a synopsis particularly on the pharmacological side of what somebody's regimen is?

LA: That's a great idea; it's just a question of how to logistically implement it.

LA introduced Pascale Augustine (PA) and Joseph Morgan to present the MAT program.

PA: We provide Narcan training for our clients every Monday, and they also get a free Narcan.

MAT Presentation

- Before the MAT program, inmates experiences withdrawal symptoms were placed on the detox protocol
- As the number of those on the detox protocol increased, the ECCF administration realized a MAT program was necessary
- MAT currently consists of methadone, suboxone, and vivitrol
- MAT department
    - October 2019: EC Corrections Administration met with community partners to discuss the inception of the MAT programs
    - Community partners were informed of services needed for those re-entering society to help reduce recidivism and prevent relapse
    - They were selected based on licensing with the DMHAS; ability to service outpatient, inpatient, halfway house, co-occurring services, Medicaid recipient, recovery coach
    - 17 community providers currently located in Essex County
    - April 2020: MAT program launched with the hiring of the MAT Discharge Planner (Rosco)
        - Role: case manager who works with inmates and community partners to assure a warm handoff is completed; works with clients to identify clinical need and communicate that need to their corresponding community partner
        - 5 clients admitted into MAT at that time

    - May 2020: MAT Officer/Navigator was deployed (Morgan)
        - Role: ensure program safety and daily distribution of meds; community involvement with clients (treatment programs, intervention, education, etc.); corresponding with attorneys and judges upon request by the client's legal team/prosecutors' office with permission of client (consent form)
            - The consent form is optional and can also be revoked if signed
        - 45 clients admitted into MAT at this time
    - August 2020: MAT Coordinator hired (Augustine)
        - Role: works with medical team and community partners to assure services are provided; assists in expanding services provided to clients during course of incarceration; works with Social Services and Mental Health Departments to facilitate appropriate program services; provides quarterly training EC correctional police officers and civilian staff in substance use disorder awareness
        - 85 clients at this time
- MAT program service
    - Individual counseling, community partner referral, Narcan training, group therapy, medication monitoring, community monitoring, urine drug screens, treatment plan/discharge plan, co-occurring services (look for places that provide multiple services that the client needs)
- MAT participant
    - We've serviced 159 clients
    - Since August, new admissions are 24-35 clients per month
        - 33 clients have been referred to a community partner with a warm hand-off upon release
        - 16 have refused MAT services
        - 7 were re-incarcerated

JM asked about capacity to build upon this program's success.

PA: The overall goal is to be fully staffed and then revisit increasing our client roster. Our cap right now is 125, but that isn't to say we would refuse to treat a client.

JM: What does "fully staffed" mean?

PA: As many staff as people. At least 2 or 3 discharge planners (2 full time and 1 part time), at least 3 or 4 CADCs/LCADCs to help manage the caseload. To provide adequate services, the caseload can be between 25-30 people. Would like the possibility to advocate for Medicaid to not be discontinued once the client is released from the facility.

JM asked for Pascale to explain the difficulty of what happens to Medicaid when people are discharged.

PA: We actually solved that problem. If a client has Medicaid when they enter jail, it is discontinued while they are incarcerated. So now we recognize this person needing services and we reach out to community partners; before, we looked for grants to cover the costs of treatment

until the client's Medicaid is reactivated. Met with authorities and was able to get a designated person to send a list of clients to get their Medicaid reactivated immediately (this is for those who had Medicaid to begin with). This list will also ensure that clients' initial application for Medicaid is not hindered. We also partnered up with two homeless shelters to eliminate some concerns for those who are homeless and being released.

CP: Can you give a breakdown of how many people need to have Medicaid reactivated vs. those who don't have Medicaid and need to apply for coverage?

PA: About 99% need their Medicaid reactivated.

JM: This is very different from the folks coming out of state prison. That's why presumptive eligibility is so important.

EZ: Have you thought about doing this for all inmates, so they don't have difficulty reactivating Medicaid upon release?

PA: This is something I can follow up and ask.

Facebook Question: Will you talk about treating these people while incarcerated vs. in the community and help them to avoid incarceration altogether? Prisons are not the right place to treat people suffering from drug abuse.

PA: That is true. However, that's why we try to help planning to start their recovery in the jail as much as possible and then give a warm hand-off to the community partners. We then monitor them for 9 months. One thing we stress to clients is if you do relapse, still call us.

JM: So if I'm in jail for x and I'm in this great program that you guide and I just don't know what's ethically appropriate for this program because it's grant-based, can you write a letter to the judge saying I'm abiding to protocol and meeting standards?

LA: Absolutely. We do that across the board, but with the drug coord, especially. They would like that level of formal feedback when their clients are in the institution.

JM: Could there be advocacy on behalf of Pascale and medical directors to possibly reduce a sentence for someone who's cooperating with protocol?

PA: We do that. We generate a general letter that doesn't disclose too much, but we try to communicate (with a consent form) how the service works and how we will continue to monitor the client. Sometimes the judge says no and decides the individual will remain incarcerated.

JM: Individuals are far better off being treated residentially or in their community. I've seen judges change their decision and being open to a diversion. If we have a robust program that makes all of the necessary connections, then I think we can go to the assignment judge and criminal judges and tell them we can report to them in real time the condition of the program participants.

PA: I'm open to that.

JM: I think keeping people out of prison but providing treatment and real accountability and measurable outcomes changes the course of these young people's lives.

PA: That's our overall goal.

LA introduced Officer Joseph Morgan.

Joseph Morgan (Morgan): When I get to the facility, I make the inmates are housed in their proper location. Then I meet with medical staff and administer the medication to each inmate, which takes about 6 hours with over 100 inmates. After, I get with each inmate's individual public defender, and we speak about basic things they need done like signing consent, getting medical records, lawyer call, etc. The first half of my day is security, making sure everyone is safe. I deal with folks coming directly into the facility, so I allow people to actively withdraw and vent if they're acting out.

Justice: Are you present at intake, or are you with your team?

Morgan: I'm literally at intake. My office is 5 feet away from the intake nurse's office.

Justice: How do you select, or do you select, those you interact with?

Morgan: Anyone who comes in who's actively withdrawing or detoxing gets put on withdrawal protocol; a list is generated every day. Pascale and Trina will go through this list and interview them, but I've walked past an inmate who doesn't look good and have asked if they need help, and they've said yes, they're withdrawing. I'll ask if they communicated that to the nurse, and if no, I'll bring them back to the nurse and introduce them again to the MAT program.

Justice made a point about calling those in the facility "people" rather than "inmates."

LA agreed and spoke on the stigmatization and how his patients often express fear of the stigma of getting on treatment and participating in programs. Importance of approaching patients as people who are not lesser than.

Morgan: If there's an inmate being bullied or intimidated, I will step in and I'll make sure they're placed in the right unit so they're not intimidated by inmates or officers. In the afternoon, I communicate with the legal teams for the 100+ people on the roster. We generate a basic letter. I offer facts, not opinion.

JM: Can you advocate for people participating properly to be diverted to the judge?

Morgan: Yes, we give all the factual information. Out of the 100 clients, it's less than 1% who are not complying with the program behind the wall. When people get into the community, I have a cell phone for people to contact me whenever. To speak on the AA and NA community, I'm basically like a sponsor.

JM: How many people do you work with?

Morgan: About 100 people inside the facility.

JM: How long are they there for?

Morgan: It varies. About 3 months on average.

JM: During that point in time, you'd see them at intake, but once in the program, they're in their respective pods right?

Morgan: Yes, I see them every day, Monday through Friday.

JM: Are they ICE detainees as well as inmates?

Morgan: The federal ICE detainees who came in with prescriptions prior to being incarcerated, I'll continue their medication.

PA: For the program, we serve both ICE and feds, whether on maintenance or whether they meet the requirements for the program. We don't have many ICE clients though. We don't turn away anybody.

Justice: Is the program itself in a particular part of the jail?

PA: The majority are in one location, but as far as spacing goes, we do have clients in different locations.

Justice: Is it safe to say that one day it might be in the law library space, one may be in a classroom, and they may move?

PA: We do have different sections of the jail depending on housing. As far as the office itself, we're located in main medical. We go to the clients; the clients don't come to us.

CP summarized the intake & referral process and asked where the clients with mild withdrawal symptoms are housed who may later show symptoms.

PA: Every client has access to a tablet, and the MAT department also has tablets, so if someone is seeking treatment, they could request services to meet with us. As far as location for those with mild symptoms, Dr. Anicette can explain more.

CP: So are inmates and detainees given education about if they develop symptoms, they can confidentially share these concerns through tablets?

PA: Yes, they're provided education and information on how to get services.

LA: They're held in the quarantine area for about 14 days.

Justice clarified that everyone who comes into the facility is held in the quarantine area.

Morgan: Also, for the clients who reach out to the unit officer, my phone number is readily available, and the unit officers reach out to me daily and let me know if someone they think might be eligible for the program.

CP: What type of training do unit officers receive so they are able to identify and assess when a person is displaying symptoms?

Morgan: Quarterly training on how to ID withdrawal symptoms, suicidal people, stigma, etc.

CP brought up language barriers and how that is handled in terms of information sharing. She then read a question from the public: Are judges trained in drug abuse in general and how that could lead to criminal behavior?

PA: That's when the language hotline would be used. The facility with partnered with for Narcan administration can provide Spanish services.

JM discussed how in criminal court, diversion is very difficult to achieve (re public question about judges).

JR: How do we duplicate this EC program to other facilities in South Jersey?

JM: This is a larger policy question, but we'd like to create a best practices report.

EZ: It sounds like this MAT program will be rolled out in other jails. For the 1% of those who don't comply with the program, are they able to continue on MOUD medications? The reason for renaming the program is to emphasize how there doesn't have to be psychosocial treatment and can just be medication alone. Are those who don't comply discontinued from their medications?

PA: Those who don't comply just want to stop on their own. It's a choice, and if they change their minds, we will help them with community partners without it having to be help from us.

CP: So if a person doesn't want to stay in with the MAT program, they can still receive MOUD treatment without being a part of the program?

LA: Yes.

Public Question: Can this type of program work for other types of addiction such as gambling?

JM: Why don't we hold that so we can ask a gambling addiction expert.

Public Question: Why aren't we looking into holistic treatment?

JM: I think that is the goal of what we're trying to do.

Morgan: At the Veteran's Administration, I'm a whole health and wellness coach, and I bring that to the correctional facility. All of our clients, if they choose, can join the mindfulness run, which is run by clients for clients. At any given time we also have a fitness instructor in the program who brings that knowledge to other clients.

CP: We didn't discuss today substance use disorders broadly, as well as medication for tobacco and alcohol abuse disorder.

Appendix F

Essex County Civilian Task Force Public Hearing - MAT II
January 30, 2021

Remarks about the late Eddie Cannon by Governor Jim McGreevey, Judge Jose Linares, Director Al Ortiz.

Director Al Ortiz (AO) introduced new psychology director of the facility, Jason Fleming.

Judge Linares (JL) reiterated the uniqueness and importance of the task force's work and thanked everyone involved.

Governor McGreevey (JM) introduced the topic of meds and dosages as it applies to suboxone, vivitrol, and other pharmacological products. Introduced doctors on the call.

Dr. Lionel Anicette (LA): Since our meetings, we've been able to integrate some of the ideas and recommendations into our program, which is ever evolving.

JM asked the LA to talk about what he has done with Dr. Erin Zerbo on MAT and how they're providing for a fully integrated model.

Dr. Chris Pernell (CP) asked LA to preface answer with percentages/prevalence rate of substance use disorders in the facility and of those, who by criteria would be able to have MOUD.

LA: We do have a high prevalence of patients who fit the criteria for MOUD therapy. This is self-reported, and we're looking at about 30%. Upon further eval, it's much higher, probably double. When you're coming into a facility after arrest and police custody, it's not the ideal time to do prolonged intakes that would be needed to drill down the problem. But as we sit down with and further review the patients, it's closer to 60% of people who suffer with substance abuse disorder. Probably 80-90% of these people have at least 2 drugs they're abusing. This is a needy population in terms of healthcare that is underserved. Many of our patients don't have prior providers and have been self-medicated using illicit substances. Right now we have an ability to interface with these patients and stabilize them. Our program is geared toward withdrawal, stabilization, and detox. Now we're shifting over to the MOUD and MAT format, and it's been well received by our patients. Right now we have 113 patients being officially placed in the MAT program. As far as the MOUD program, launched concurrently, we haven't been able to track those numbers for you (will give at a later date). MAT is for all substances; MOUD is just for opiates.

JL: How are patients linked to the outside programs? As I understand it, EC is not a long-term facility, so whatever we do with regard to addiction is only for a short period of time, which often doesn't work long term.

LA: Average length of stay is 6 weeks, and bail reform actually complicated things a bit because patients are not in the program as long as they used to be. Our discharge planner has a multipronged approach. For patients who have been sentenced to the jail where they will serve a definite sentence, the discharge planner will connect them with a program with a definite discharge date and will start sending records and actually discussing the case with the case manager at the referral site.

She can do that for the bulk of her 113 patients on her roster right now. We also have a discharge planner who is our ACA coordinator who can help place patients who are not formally in MAT but need MOUD where they're on medications, so they can place these patients in a situation where they're able to get access to Medicaid and access to programs that they're eligible for, like programs provided by the Newark Dept of Health. A number of people leave and we don't have prior notice that they're going to leave.

CP asked for the percentage of people leaving without management.

LA: I would say about 70%. The turnaround time because of bail reform has drastically changed. Our goal is to actually have providers come into the facility and start monitoring and recruiting patients into their rosters before they leave so when they do, there's a connection.

Justice Rountree (Justice): That 70% doesn't see a discharge planner.

LA: Exactly. So that's our goal, to know what happens to that 70% the day they leave the facility. Our goal is to put literature and contact numbers in their hands so they can call, but that's for the self-motivated patient. Many are not. Our team is focused on what to do with these patients. One of the avenues we've found we can pursue is to bring likeminded community groups to come into the facility and start interfacing with people right at intake and in early days.

JM: To go back to Justice's question and the judge's point, what could the task force do to improve the hard hand-off between the facility and the treatment community?

LA: What we're looking to do is to facilitate what patients' needs are. One thing is an ID. If there's an equivalent that they can use to bring to the places we're sending them, that would facilitate access. If there was also a way to bridge a gap between patients and welfare agencies to give them access to an ID, that would also be helpful. We have a pharmacy that works with us to give them discharge medication, so that bridges the gap and doesn't require an ID. If we could create a connection right after that short bridge, that would greatly help. Regarding telemedicine, we recently reached out to a provider who said they can set up a cell phone linkage with our patients so the day they leave they can make a phone call and create a tele-link. But some don't have access to phones, so I know some programs that allow people under a certain level of income to receive a smartphone. That would be a major plus.

JM: What happens if a patient is not being connected to a provider upon release, to ensure they're not lost?

LA: It would be ideal if right at intake, there's a provider even on a telemedicine portal connecting with a patient and asking for their information and offering their services. It would be ideal to have this linkage created within 48 hours.

Dr. Erin Zerbo (EZ): When you're saying 70%, are you saying that of everyone at the jail, 70% walk out unsure about how they're connected?

LA: Yes.

EZ: And the 30%, are you saying that of those admitted in the jail, 30% report having substance use disorder that is addressed at intake?

LA: Yes.

EZ: What percent of people also go into withdrawal in the next 3 days after that?

LA: We start treating withdrawal within 4 hours of coming into the building, so we're not sending patients out to the hospital for withdrawal; we are aggressive with that and with hydration. The nurses are well versed, we have providers 24/7 for orders, our pharmacy is stocked. The issue of them leaving is far more prevalent.

JL: Best case is to provide a portal at intake where an outside provider gets immediately engaged. Then the problem still exists of self-motivation. But at least we make it available for them.

LA: Transportation is also an issue.

JM: The other problem is a place to get the medicine, even if there is a prescription, as well as payment.

Rosa Santana (RS): What if they can use the bracelet that they're given at the facility? I know other jails do that—show their bracelet to a pharmacy to receive their prescription.

CP: Is that similar in nature to the relationship you established with the Walgreens?

LA: Yes.

CP: So what is the opportunity to have other participating pharmacies, and how do we facilitate that? Because that lowers the barrier to treatment.

LA: It's a negotiation. Social services also provides a letter of incarceration that gives more information. They also can help with IDs in some cases.

Imran Rabbani (IR): Have you engaged with other Walgreens locations to develop those partnerships?

LA: We haven't been able to do that, but we do have connections with other agencies.

JM: Doesn't that person need to be registered with Medicaid and have an ID?

LA: No. That pharmacy doesn't need anything.

JM: How does the pharmacy get paid?

LA: The pharmacy calls us back and verifies the prescription with us and gives us the invoice. We supply up to three days' worth of the medication, which is short. This is why we need the other linkage to care.

JM: What they need is 3 years, so we have to work on that mechanism to make sure that we link people to a provider at the outset.

EZ: Why is it 3 days?

LA: That's what we're being funded for.

CP: So the facility is funding a 3-day supply, that's the critical description here.

LA: Yes.

EZ: Are we talking about people whose Medicaid was inactivated because of the jail stay, and I believe it's one night or 30 days before it's activated? Or people with no Medicaid?

LA: These are people with nothing. They're leaving with absolutely nothing.

EZ: For people who need their Medicaid reactivated, are we having the same issues, or does the reactivation work now within a couple days?

LA: It's within 24 hours for those who are identified.

JM: For the older guys with Medicaid, it's easier to get them back on, but for a lot of the younger guys coming in and out, they've never been on Medicaid. So it's a real problem for that population. Bluntly, they go back to the street without MAT.

JL: We are looking at the EC jail system internally and what they can do there. We need best possible protocols for people upon release. So much can be done on the jail side of things, while other changes must be made with outside entities. Our focus is on the jail.

JM: But there are states that do this.

CP: What I'm hearing is how do we help to instigate best practices, and where are there opportunities to begin that linkage in a more effective and efficient manner? Three consistent barriers: govt-issued ID, enrollment in/reactivation of Medicaid, barriers in getting medication from pharmacies. While the facility can't solution through the end point, it can set foundation that enables a person being released to have more efficient linkages to care. On-site help for govt-issued IDs, better access to social services upon release, Medicaid enrollment being handled… I think it's appropriate to ask what the role of the facility is in this, then ask what the role is of the other agencies.

JL: Agreed. Further, these best practices are further hampered by the timing, such as in a 48-hr turnaround period.

JM asked EZ to share what she thinks best practices are.

EZ: My vision would just be that someone comes in, it's an inviting atmosphere at intake, people feel like they're allowed to share with nurses. Then starting medication right away, even if not connected to a community provider. All three drugs should ideally be available to them. If they're in withdrawal, immediately should start the methadone or suboxone, and titrating, not doing anything where you detox and enroll them in a program later. Instead, get them on a maintenance dosing that should be at the level that they need without an arbitrary cap for 8 or 12 mg. For outpatients we do 16 mg a day typically. Just the idea to not have a cap for buprenorphine. Instead, we look at the individual and titrate to what they need. For outpatients we do that based on cravings and self-reporting.

JM: So what is a common dosage that is best practice?

EZ: What we normally say is 16 mg for buprenorphine. Most people take 8 mg twice a day or all at once. What we find is 16 mg occupies about 90% of the opioid receptors, so it's very protective against an overdose. So if someone does heroine or fentanyl, there aren't that many open receptors for the fentanyl to bind to, and fentanyl is incredibly strong, 50-100x stronger than heroine. The reason we're seeing so many ODs is bc people have all of these open receptors if they take nothing, so if they take something they think is heroine but has fentanyl in it, it's filling up so many receptors and stops their breathing. So the buprenorphine can fill instead, and it's stickier to the receptor so it doesn't let go even if fentanyl comes in. The idea is, if you have at least 16 mg, you have better protection against OD. Some may only need 8 or 12 mg to satisfy their craving, but it makes me nervous if they're walking back into their community in front of all this fentanyl and they don't have 16 mg on board. We also know people can OD inside the facility, so again we want the 16 mg for most people. It's important to know that those with the most severe addictions are self-medicating with multiple drugs, so they will in turn have multiple prescriptions because their brain chemistry is all over the place.

JL: Maybe the TF should consider getting input from outside providers that could perhaps share with us ideas on how they can provide this linkage at the time of release so there's a smooth transition on what they can provide with those who are released. I'd like to hear what they think they can do to help those released continue treatment.

Justice: How would this process work out?

Alessandra DiBlasio (AD): None of these people get into Essex on their own. They're put in there by the criminal justice system. Is there a possibility for probation? So when they leave, they're not just on their own; many go back out on probation, so there's opportunity to get criminal justice people involved too.

JM: Great point. So three things: We got the criminal justice system and their connections, we have to look at providers on the outside, and three we have the team we have right now. Could we talk to Dr. Fleming and Dr. Sandrock as to what happens?

LA introduced Dr. Fleming and Dr. Sandrock.

Dr. Jason Fleming (JF): As the new guy, Dr. Sandrock can answer your questions better. But I hope we all want the same thing. We're coming at it from different angles. We're all working with different parameters and different resources. Many of the TFs I've been involved with have often been a waste of time because it's adversarial. So when you ask what we can do to help, I'm going to be coming from, "This is an issue that the TF has identified as a problem. What are we going to do about it, rather than what are you on the inside going to fix that you can't really fix?" We need the TF to be supportive of this ultimate goal. We as a TF have to put pressure on other people to let ECCF do our jobs most effectively.

Dr. Dennis Sandrock (DS): I want to echo the comments made by Dr. Fleming. Regarding AD's question, we need a little in-reach into the jail, and this is where the criminal justice system comes in. I think we should set up a mechanism where we let the criminal justice system know, whether it's the public defender or pre-trial services, that there is treatment needed for an individual and if we had the time to connect them with services, that would make the return to the community better. We've done this with those with serious mental health problems. For the transition period from the facility to the outside, we need to use our resources to make the connection work.

JM: Could you provide for Justice and the TF a list of providers in the community that provide for addiction treatment services?

DS: Yes, I think Pascale would have a more comprehensive list than us.

Pascale Augustine (PA): Yes.

DS: Yes, we would be able to generate that. I do think a part of this conversation would help with having someone representative of the criminal justice system because if the system had a way of being aware of the plans being made for someone, they will work with us.

JM: We will do that down the line, but I think it's important to have a baseline as to what we have now.

JF: We talked about best practices. My question to the group is do we have evidence and research on what other states and facilities who may be encountering the same issues as ECCF are doing? So we're not reinventing the wheel?

CP: The TF has always been very clear that we'd like to elevate best practices, but I think what we need to be able to establish as a baseline is what is happening at the facility and what do you see as immediate solutions, opportunities for improvement? You must customize best practices for the particular facility in discussion.

JL: It is also helpful to hear about funding issues for example because part of what we can do down the line is explore these issues further and see where funding can come from. It's good to identify needs to implement these practices.

JM: I'll send a list of best practices to the TF and everyone on this call. Dierdre, can you and Pascale share a little bit about the administration of the program?

Dierdre White (DW): Prior to MAT, the social service department was monitoring the substance abuse, so I'm happy we have this program now.

PA: What we've done is expand the addiction program. So we have the non-medicated individuals on MAT who don't receive medication assistance, then those who are on medication. As LA mentioned, we have a screening tool during the intake process. If someone doesn't meet the requirements, they will not be placed on MAT but will instead be placed on Dierdre's program, which has no medication. They receive the same other services, and we help them connect with community partners. What we started doing differently recently is the treatment intervention process. If we have individuals who have tested positive for substances since being in jail or have behavioral problems, we meet with them and try to engage them and see what is going on so we can try to modify the treatment plan. Hopefully upon release, the intervention we created while they were incarcerated will continue and will reduce the recidivism/relapse rate. Trena Roscoe and Joe Morgan work very closely together. Ms. Roscoe uses a questionnaire to help prepare a discharge plan.

JM: Is there a way to create the linkage better?

DW: My dept works closely with the public defender's office. We get a lot of referrals to assist inmates with getting assessed for substance abuse treatment. While inmates do reach out to my dept for services, I often go back to the public defender's office because while we're working on a linkage plan, the courts may not always be in sync with that plan.

PA: If we know a client is going to be released, about 2-3 days before, we try to connect them and give them a referral form. If they don't have an ID, we connect them with a program that has Chapter 51, which is a grant for Essex County that pays for IDs.

CP: How available is this grant program/how often does this successfully happen?

PA: We haven't encountered people without IDs yet since we started the MAT program, so we don't have a number. But we do have this available in case we encounter someone without an ID.

Justice: For perspective to that point, this is just the 30% who did see a discharge plan.

PA: If we have a client referred to us and we didn't have a chance to meet them because they were released, we do reach out to them and try to connect with them. If we are successful, then we will make the referral.

Officer Joe Morgan (Morgan) shared an anecdote about someone placed on MAT then released a few days later. That person was provided with all numbers he needed and information on programs. He wasn't aware he left because it was the weekend. The individual signed a consent form to release info so the admin could speak to his family members. Morgan found his brother's number and found the individual and reconnected with him and gave him all the info he needed to

get reconnected to services. They lost contact a week later, so from time to time Morgan would go back to where he first found the individual. Eventually, this individual was reincarcerated and is now taking MAT very seriously. There have been many instances where Morgan would be reconnected with people released back into society.

Justice: That's above and beyond effort. I don't think this is sustainable or fair to ask of you, but this is commendable.

Rosa Santana (RS): I think we also have to look into if this individual was fearful of going back to services because the person connecting with him was connected to law enforcement. This is something that happens in the community, so I wouldn't recommend parole officers doing this. I've had situations where people feel like they're getting harassed by parole officers. It's important to keep this fear of the system in mind and focus on the community.

Morgan: The MAT is volunteer. This is not drug court. We're not there to rearrest you; we're there to offer services. I usually have a good relationship with people, and they often reach out to me first.

CP: We're looking to find efficiency and effectiveness sustainable. We continue to hear if there is an opportunity during intake to immediately connect a person to resources in the community so that's established before being released within 24-48 hours. There's a gap, especially with bail reform. There is a program in NY that provides IDs to those incarcerated in jail; could we do something similar in the county so we can immediately identify those without an ID and get them one? The more we can work on upstream issues (before the point of release), the more the challenges downstream will be mitigated.

AD: To Rosa's point with probation and pretrial, I don't think we avoid them. I think we bring all of them in and let them know the individual has serious issues so they won't be violated.

JM: When folks come in, mindful of bail reform, is there a better way to make a connection with an outside provider?

Trena Roscoe (TR): As the MAT team, we do a team approach with Morgan, myself, and Pascale. If the client meets the criteria for the MAT program, I try to meet them at intake to get them when they first come in, which can get difficult because of the bail reform in place. We don't always know when they're going to court and when they're going to be released—that is the downfall. Because it happens so fast. This is how we lose people, often with a 24-hr wraparound.

JM: Would it be possible to automatically capture the information needed at the get-go?

CP: In addition, have you ever mapped out the workflow? Because that'll be helpful to identify gaps and issues, and we can solution in a better way.

PA: We also have to keep in mind that clients have been referred to us and when we meet with them, they're often not interested in services. Further, if someone meets criteria, they may not be physically prepared or cognizant enough to answer the questions. Third, some of the info they give

us in terms of contact info, etc. are wrong. So as much as we'd like to try to connect them with a proper program, there are these issues even if we do map out the workflow.

JM: I think what Dr. Pernell is saying is we're just trying to create the best system, so the workflow map would help. Part of this is just to work with the team cooperatively to see where there are areas for improvement.

CP: What I frequently hear in these meetings is anecdotal studies, estimates of percentages, etc. It would help everyone to have the workflow map with diagrammed barriers and accurate information. We need to structure this more systematically and work on the upstream factors that contribute to recidivism and difficulty in getting treatment.

Regional Manager for CFG Medical Operations at EC introduced herself. She said this systematic workflow requested by CP is a conceptual discussion that's been held with PA and will gain momentum on that with the entire team to get it done. In terms of hard data, they will design a system and build on the labor-intensive tracking system in place and will polish it up to hopefully meet the request of the panel.

EZ: Regarding Morgan's story—when the individual was released on that Saturday, I assume he wasn't given a supply of medication?

Morgan: To take home with him, no. He'd have to visit the pharmacy the next day, so that's when I stepped in and found him to get him on track to get it. I often physically walk people to the pharmacy to show them where and how to get their medication.

EZ: Many of these people have such a mistrust of the system, so it's beautiful that you make the personal connection with them. Sometimes it's repeated engagements that makes a difference and builds trust. One additional thing we can think about is, when you meet him in the community and recommend him to go to the program, there are barriers to the program and stigma. Given it's covid right now, there's so much telehealth. Maybe if you find him in the community, you can get on the phone with a provider right then and there, and an eval can be done over the phone and a bridge prescription can be made. Personal connections and trust are critical to the system and warm hand-offs.

PA: We do work with a partner to bridge this gap, who can provide telephone screenings.

JM: The other problem is that folks are connected, and they'll only be connected for a limited period of time.

PA: So that's why we also work with the recovery mentor. There's a hotline on the tablets, but prior to one's release we try to get them connected to a mentor and get them to build a relationship.

Justice: I heard "community linkage" mentioned here multiple times, and I'd like to go back on a factual basis. As someone deeply engaged in the Newark community, I'd like to know who are the community linkages we're referring to.

PA: Greater Essex, Center of Excellence, NJCRI, Hope Center, etc. (she listed a bunch)

Justice: I wanted to mention the connections with state entities and law enforcement; we have found that these entities aren't always best practices in terms of wellness.

JF: As a TF, my primary question is what power do we have as a TF to enact the change we want to see? I agree on everything we need in terms of internal information. What concerns me, though, is that in the task forces I've worked with, there is a general mistrust that they're not doing their jobs. With that said, I hope with this information you asked for, we put pressure on others to help.

JM: I think we sincerely want to do is make ourselves better. One last idea: I would like if Dr. Pernell and Dr. Zerbo would be able to be invited to the process in mapping. What I'd love to do is to have another committee to look at the mechanism, the sequencing as you talked about, dealing with the ID licensing issues. We'll break up the TF so one side is medicine, and the other side is the criminal justice and the logistics side, and invite everyone to contribute. This way, we have real tangible items.

LA: Agreed; there is a common goal.

Rubin Sinins said he'd like to talk on the bureaucratic side about the role of the defense lawyers.

Director Al Ortiz (AO) said he is awaiting info from the Board of Health for NJ regarding vaccinations for inmates. The EC right now is taking spare vaccines and bringing them to the jail. They have 33 so far. The medical dept determines who to vaccinate, but we'd like to get everyone vaccinated.

CP: So the criteria used to determine who's eligible is set out by the NJ Department of Health?

LA: Yes.

CP: So it's just when there's someone eligible; it's when there's excess doses. How many have been vaccinated?

LA: 33 to date.

RS: Have correction officers received vaccinations, and are they mandated?

AO: Yes, we're vaccinating. We have 100 doses. We want everyone vaccinated, staffers included.

CP: Just to clarify, your officers meet criteria to get vaccinated?

AO: Yes.

CP: Are you observing an original concern or fear? Are they responsive to your education?

AO: The officers are now buying into the vaccine. We have 100 new doses, and now there are more people asking for it.

EZ: Are people getting their second doses?

AO: We gave the first dosage on January 5 and will give the second on February 5. There is an additional 100 distributed to the staff on the 5th. There will be another date set for a second one.

CP said she has educational videos of her speaking on the vaccine online.

Appendix G

Essex County Civilian Task Force Public Hearing – Public Accounts
May 22, 2021

Introduction of task force members – Governor McGreevey, Judge Jose Linares, Rosa Santana, Imran Rabbani, Alessandra DiBlasio, and Dr. Pernell.

Public Statement #1: Andia H. from Trenton, NJ

- Boyfriend picked up by ICE in August 2020 and has been fighting his case for months
- Early April 2021, he broke his hand in an altercation and was sent to lockup (SHU) and not a hospital; later was given pain meds from the infirmary, and the hand was wrapped for a couple of days
    - He was told multiple times he'll go to the hospital but never went – never mentioned hospital, as far as she knows
    - He's in construction but now can't do anything
    - Unsure how many times he saw a nurse
    - Didn't see him for a couple of weeks because of SHU
- A few weeks ago, during a video call with their daughter, a correction officer attacked him while on video
- He sat in lockup without a shower or medical attention with mace in his eyes, no food, no calls
- Contacted the facility and explained the situation, and their answer was that the boyfriend was in an altercation before going out for the video call (timing-wise, this is not possible)
- He's put in requests to speak with ICE officer and to get medical help, but nothing has happened despite the nurses saying he'll go to the hospital
- He's been in SHU for about a week now
- He knows many people who have been assaulted by COs as well
- His attorney has made little to no effort regarding this issue; she's a private attorney
- *Will follow up with the task force and speak to ECCF again about this issue*

Public Statement #2: Fernando Fernandez from the Dominican Republic

- Arrested in 2017 and stayed in ICE at ECCF for 15 days, then transferred to Elizabeth for a year, then back to ECCF
- After 6 months (in 2018), he got a rash all over his body—not contagious, but severe
    - This had never happened to him before; didn't happen to anyone else around him
    - Itchy and painful
- Taken to in-house doctor, explained to doc, then taken back to his room. About 2 weeks later, he went back to doctor and told the doctor that he needs to see a specialist
    - Doctor had no idea what the rash was, no diagnosis
    - Tried about 3 or 4 topical creams; nothing helped
- Doctor said he needs permission from ICE to go to the hospital; took about 5 months
    - Received a diagnosis here, but never explained what it was
    - He was prescribed a daily medication for the rash, but he would have to wait about 1-2 weeks to get the medicine; the medication helped
    - Each refill lasted him about a week and a half, then he'd need to refill and wait almost a week; happened twice

    - He was allowed showers every day, which allowed him to apply the cream daily (but he was allowed to shower at this frequency before too)
    - Treatment took about 1 month to get rid of the rash
- Was told by lawyers he can complain about this once he's out of ECCF but nothing he can do while there; people in the past have been beaten up by COs for complaining
- Lawyers never followed up with the jail
- Eventually got out of ECCF with the help of lawyers in 2020, but still wears an ankle bracelet
- *Follow up with medical director and ask if there was a diagnosis; will also give lawyer info to task force*

Public Statement #3: Prophet from Ghana

- Arrested on December 9, 2018, in JFK Airport coming back from Ghana
- Dormmate is Fernando Fernandez (at ECCF)
- Taken to Elizabeth Detention, spent 8 months
    - Fell sick when detained because of, he thinks, the food at Elizabeth
    - Had cholesterol issues, diabetes; severe stomach pain, vomiting, couldn't sleep
    - Was given Tylenol repeatedly
    - Had a lot of anxiety because he wasn't sure what was going on
    - About 2 months into his 8-month stay in Elizabeth, symptoms developed
    - 2 months later, sent to University Hospital in Newark; endoscopy and colonoscopy
    - Didn't receive results or diagnosis (sent to the doctor), but received a prescription
    - Submitted grievance for mental health services, but was transferred before anything happened
- Transferred to ECCF, spent 10 months
    - Inhumane treatment; similar issues with Elizabeth
        - Elizabeth is worse, however ("bully facility")
    - SHU is traumatizing; many got sick
    - Many unsure if they would be released or deported
    - Never submitted grievance for mental health services
    - Was never told how to submit complaints
    - Had other health issues (constipation, rash, etc.) because of food and water
    - Itchy body after shower
    - Could continue medication at Essex
    - Was told by nurse he actually doesn't have high cholesterol or diabetes, yet was being prescribed medicine for those
    - Prescription was for one year of refills, but when he called to refill after a month, nobody answered; couldn't go directly to pharmacy bc no insurance
- No attorney throughout the process because no money; couldn't get pro bono attorney
- Had to represent himself

Public Statement #4: Freedom for Immigrants advocate on behalf of someone in the facility (Mr. F)

- Mr. F experienced sexual abuse and harassment, racial discrimination, reliatory use of SHU, and medical neglect at the hands of COs
- January 2020: reported to the public about medical neglect

- Abuse began in March 2020
    - On March 8, 2020, an officer asked him for his name and number then pushed him; the sergeant came and locked him in cell for two hours; he was then sent to SHU
    - Charge sheet didn't include name of the officers involved
- Racist, homophobic, and transphobic doctored versions of photos of him given to Mr. F that only COs would have access to
- Multiple hunger strikes
- August 4, 2020: attorney filed former complaint; no response given by the due date
- August 14, 2021: attorney spoke with a lieutenant, who said the assertions were unsubstantiated and the prosecutor's office at the county declined charge yet refused to release details or records
- Continued sexual abuse (one instance of a strip search/humiliation in county shower where multiple COs videotaped the whole encounter)
- Transferred out of ECCF to Bergen for no reason
- Suffers from neck injury from March 2020 encounter; migraines with just pain meds given although he can't turn his head
- Pending complaint with ICE
- In the FFI advocate's experience, ECCF is the worst in terms of CO treatment
- *Left written statements with task force and will give contact info; will give info on 3 other similar cases; will give list of facilities that handle detainees better*

Appendix H

Essex County Civilian Task Force Public Hearing – Grievance Procedure & Women's Health

June 12, 2021

Governor Jim McGreevey (JM) and **Dr. Lionel Anicette (LA)** discussed how women are underserved in the criminal justice system.

LA:

- Stats
  - 10-15% of incoming inmates are women; average of 94 women in the facility at a time
  - Over 50% of women are suffering from drug addiction
  - Over 80% on medication
  - Over 60% on psychotropics
  - STDs
  - Pregnancies
  - Pre-existing health conditions
  - Mental health
  - Social service aspect—dealing with housing and welfare of children
  - Poverty, lack of needs
  - *Will provide more concrete numbers*
- The facility tries to do a rapid assessment to see who's in urgent need, especially with bail reform
- At intake, 21-point mental health screening; comprehensive review of systems to see who is pregnant, who's suffering from detox, STD screening
- From here, housing is determined (hospital, infirmary, quarantine then connected to social services or mental health services)
- Rare to find that we don't have at least 1 or 2 services being tapped into from day 1 of incarceration

Dr. Chris Pernell (CP) asked about race/ethnicity demographics and the specifics of the screening process

- **LA**: tend to be young women, avg age 25, Black and Brown minority women mostly (over 90%); reconnecting them to services is a common issue because once incarcerated, Medicaid is suspended
- *Will follow up with more specific details*

JM asked about information on these women's backgrounds and precipitating factors (coming from homes or shelters? Nature of offense? History of domestic violence or sexual abuse? Trauma?)

- **LA**: we break down the intake assessment in terms of past trauma; Prison Rape Elimination Act speaks to their history of DV or sexual abuse; substance abuse section on addition, current usage, etc.
- *Will follow up with more specific details*

JM asked where the women are going to

- **LA**: once incarcerated, women are worried about Child Protective Services coming in and jeopardizing their ability to parent

JM asked for the women walking through the facility, what are the points of entry and the points of service; secondly, asked for an understanding of the clinical/managerial structure so we can understand how women are treated in a clinical setting

LA:

- Typical day for a woman coming into facility
    - Custodial staff at intake conducts screening to see if they need immediate care
    - Medical staff at pre-booking who work with custodial staff to see if this patient is safe to enter facility or need urgent care
    - If she passes this point, she can shower, receive toiletries, etc.
    - Then an intake nurse will do a comprehensive review of mental health, sexual abuse history, medical/chronic conditions, STD screenings, etc.
        - Medical, psychosocial, mental health
    - Goal is to complete this within the first 4 hours of entering
    - Then the nurse contacts the provider (physician assistant, NP, or MD available 24/7 in house), and the charge nurse supervised by the director of housing determines the housing level of the patient
        - Hospitalization, infirmary care (10-bed female infirmary, 4 negative pressure rooms for people who are contagious)
    - If that is not needed, then she goes to the quarantine area; mental health services are available 7 days a week to see if she can be placed in general population or forensics center
- **JM**: If a woman is pregnant, at one point does someone decide she needs OBGYN services?
    - **LA**: within 4 hours, we will know if she is pregnant (via pregnancy test) and needs services
- **CP** asked for a graphic representation of the workflow and asked about custodial staff & their credentials
    - **LA**: they are "medically trained officers" designated by the National Commission on Correctional Healthcare; specially trained to recognize signs and symptoms of distress but working in concert at the same time with one of the medical staff (a pre-booking provider), who may be a medical assistant or LPN

JM asked about the level of oversight and testing at the municipal level

- **LA**: there is none; if one of the 21 municipalities brings a woman, she has not been medically assessed; we don't know if she's been in withdrawal or how long she's been in the precinct; this is customary nationally

Bernadette C. (BC): When they go to the hospital, are they going to the ER?

- **LA**: crisis center or medical emergency room

JM said it would be helpful to have LA's recommendations at the municipal level

- **LA**: it would make a major difference in terms of how stable the patients are when presented to the jail
- **CP**: it's important for TF to understand the conditions of women when they arrive

JM asked about women detoxing in real time at the municipal jail

- **Kerry McCann (KM)**: she does see them at the municipal jail; women detoxing without medication, then referred to MAT program
- **JM** brought up women detoxing who are pregnant

Nurse Taneja Davis (TD):

- At intake
    - Services provided are individualized
    - Women are very vocal and make their needs known from the start; nurses' jobs to prioritize needs
    - Emotional support needed
    - Referrals made to social services
    - COVID test is first (nasal antigen; if positive, then PCR), then BP taken, urine screening if she is able to urinate
    - Sent to hospital if further assessment needed
    - Pregnancy test with a urine dip stick
        - If they indicate they are diabetic, finger stick

BC asked what percentage are HIV positive and at what point HIV screening is done

- **LA**: we know the numbers; ranges from 40-60 across whole population (determined mostly through them knowing before they come in, some through screening); working on doing HIV screening at intake

Jill McNamara (McN):

- Ensures care delivery system is operating smoothly
- Works with LA and TD closely
- Many of the women are also victims; marginalized; many do not want community services
- Effort to connect with community partners
- Newark Beth-Israel for OBGYN services; ACA coordinator helps with this
- At 24 weeks, admitted to infirmary; any sign of labor à woman sent to hospital through emergency department

JM asked what happens if she is released while at Beth

- **McN**: ACA coordinator assists with linkage to Medicaid; works with clerk's office to get ID; the woman can keep her appointments with OBGYN even after release
- **LA**: every pregnancy in the jail is considered high risk; sees OBGYN each week; it is hard to get appointments, so that's why we try to get a lot of services in-house (like ultrasounds)
- **TD**: OBGYN comes in Monday, Wednesday, Friday
- **BC**: how many of these women had a prenatal visit prior to seeing you?
    - **TD**: sometimes we get them at 8 months, so they've seen someone; majority has received care; but they will go to an appointment at Beth-Israel so they can find out their delivery date; our OBGYN will then follow up
- **CP** asked if there are barriers to prenatal care while incarcerated
    - **TD**: no barriers identified

- **LA** said it's difficult to get feedback from outside providers

LA brought up how he has had to facilitate pregnancy terminations and how that has to be done in conjunction with outside providers

CP: do you have awareness of women having communication barriers with outside providers (in terms of health information)?

- **TD**: a male and female CO accompanies the woman at appointment
- **LA**: the officer is not to interfere or restrain the inmate from having an open relationship with the doctor; the women come back and immediately talk to a nurse at the facility; there are good, open relationships between nurses and the inmates

CP asked if women are shackled during labor

- **LA**: we do not shackle any pregnant women unless it is absolutely necessary

LA: Women are given pregnancy diets, prenatal care, ultrasounds; most had no prenatal care prior

JM asked about the children at home when women are incarcerated

- **LA**: social services dept would answer better, but they typically have family to look after them; social services would connect with them

Pascale Augustine (PA) on women & MAT

- 16 women in program, none pregnant, all on suboxone
- Since program inception, 3 pregnant women (2 were there for one day – went back to methadone program), 1 delivered while in jail – facility worked closely with drug court and her family to get custody of the child after delivery; she was able to go treatment facility for addiction then continued to work at seeing her child)
- 3 MOUs
    - MOU with Partnership Maternity in Essex County, which provides counseling services and health care services via Zoom
    - MOU with Victims of Crime – group therapy for trauma, 6-12 week curriculum
    - AA/NA women speakers via Zoom by the end of the month for the women
- Weekly handouts
- Try to talk to family members
- 9 months of monitoring upon release
- MAT for pregnant women
    - Referral out of Kaleidoscope (MOU); will receive methadone; can continue upon release
    - **LA**: methadone is the standard, many come already on it; less risky
- **BC**: withdrawal should be avoided at all costs because it could kill fetus; suboxone requires moderate withdrawal to start

CP discussed the work she accomplished at state prison re women's health

KM on public grievances

- Initial requests (sick call?) are reviewed 3x a day by medical staff; if not answered appropriately, triage first then referred to higher level of care
    - Inmate initiates
- Grievances can be added if not answered appropriately or adequately; there are 5 days to respond
- Urgent emergent – if issue is an emergency (broken bone, eye injury, chest pain, etc.), inmate will let someone know right away and get sent to medical
- Reviews grievances and sends to proper team to respond; system keeps track of whether they are responded to; triaged within 24 hrs
- **CP** asked for more detail
- **LA**: sometimes sit call and grievances get mixed up in the system; sit calls are for medical reasons, for more urgent matters

Facebook questions - **LA**

- Average # of deaths; 2 deaths last year, 1 COVID and 1 natural circumstances
- About 1 or 2 suicides in the last 5 years
- Low levels of morbidity and mortality
- Preventable deaths do not occur
- Patients with pre-existing conditions come in and do not survive
- *Will provide 4 or 5-year review about causes of mortality*
- Facility has liberal policies for religious people

Appendix I

FEMALE GRIEVANCES JANUARY 1ST, 2021 - PRESENT

AVERAGE DAILY POPULATION 94

GRIEVANCE TYPE	NUMBER SUBMITTED	STATUS OF GRIEVANCE	AVERAGE PER MONTH
Account Grievance	10	All Closed	1.6
Classification/Appeal	6	All Closed	1
Commissary	31	All Closed	5.1
Custody	46	1 Pending	7.6
Phones	4	All Closed	0.6
Kitchen	4	All Closed	0.6
Laundry	2	All Closed	0.3
Mail room	6	All Closed	1
Medical	22	All Closed	3.6
Mental Health	0	NA	NA
Religious	7	All Closed	1.1
Social Services	11	All Closed	1.8
Visits	0	NA	0
Total	**149**		

Appendix J

Essex County Civilian Task Force Public Hearing – Community Healthcare Partners
October 2, 2021

Governor Jim McGreevey introduces TF members, Kathy Davis and Dr. Lionel Anicette.

Dr. Lionel Anicette (LA) and Dr. Sheila Curry-Bran (SC) on how to strengthen community partnerships (mental health, addiction treatment, psychological, etc.):

- **SC**: making sure we keep communications open like these public hearings; longevity, proper hand-offs, and communication are all important; dealing with the whole person
- **LA** on the current state of hand-off (barriers, etc.)
    - Vast system with many dynamics
    - Large population of underserved individuals coming in daily
    - 40-60 people entering every day via admissions at ECCF
    - 2,300 people in the facility; 339 of these with confirmed preexisting mental health conditions (mood disorders, psychosis, etc.)
        - Became wards of the county, no linkages to healthcare in their community
        - Much of this is self-reported
        - Many co-occurring (mental health counseling, substance abuse management, and behavioral management)
        - 250 have substance abuse disorder; actively withdrawing once arriving in jail
        - All 339 have at least one more co-morbidity (COBD, hypertension, etc.)
    - Emergent care at police precinct
    - Within 1 hour of booking at ECCF, seen by health professional
    - If we find that individual is not suitable to be in jail, we send them to one of the local hospital partners – Beth-Israel, University Hospital, St. Michael's
    - About 1,000 people of the 2,300 have at least one physical health co-morbidity
    - 38 HIV patients; sometimes rises up to 60 people at a time
    - 39 people with diabetes; peak of 80 in the past
    - 14 patients with moderate to severe renal disease
        - 3 patients who are dialysis dependent; renal diseases
        - Able to do dialysis in house
        - First session done at local hospital; their protocol is not to allow outpatient dialysis (will not give a referral; patients have to be admitted every time they go to the hospital)
    - Of those with physical or mental health diagnoses, about 10-15% are connected to service; loose linkages to the community

JM brought up insurance/lack of

- **LA**: Medicaid is suspended while in jail; social worker can help reactivate Medicaid within 24 hrs of discharge, but this does not always happen
- **JM**: many have maxed out their services
- **LA** also brought up lack of ID
- **JM**: what we have to do is ensure a community-based service that helps inmates get Medicaid

- **Dr. Chris Pernell (CP)** brought up how many broken links there are in the transition process from jail to community; importance of finding these gaps and addressing them

LA brought up bail reform and how that affected social service workers; released within 24 hrs and now social service workers have to rush get everything they need to help the inmates; we're missing someone who can intercept individual at time of discharge (to interview and evaluate) because that time is now unpredictable

- **CP** asked if this person should be an employee at the facility or a community partner
- **LA** said a mix of both; time is limited by office hours for community partners, so access is an issue
- **JM**: one thing we can do is harden the relationship between the correctional facility and the TF à we can process the IDs, Medicaid application, etc.
- **Kathy Davis (KD)**: that would definitely be helpful; we should put the burden on the agency
- **JM**: link the individual to agency, then they are linked to a service
- **LA**: additional of ACA coordinator was helpful, but they only work for 20 hrs; we need someone to face 40-60 people a day at discharge

CP asked for data to help summarize the process

- Roughly 40-60 discharged on daily basis
- ACA coordinator has a huge caseload
- MAT program: 125 patients

LA:

- If the patient is incarcerated and we're trying to get an appointment for them, it's difficult; resistance in giving appointment spots to this population
- Can range from 2-4 weeks to 6 months for an appointment, depending on the service
- Often given narrow window of appointment times; typically 9-1
- Facility ends up having to prioritize which patients need the appointment more
- Dentistry is a key area where we don't find many services except for severe cases; nearly impossible to get a root canal; patients are discharged from facility before they secure an appointment
- This is why we need to bring medical services in house
- Was able to contract with optometrist, physical therapist, podiatrist, oral surgeon (limited hours – we need more), OBGYN
- Looking to find community providers to share a provider for the services that are hard to find appointments for

JM asked LA to talk about the work being done with Dr. Zerbo and Rutgers

LA:

- Dr. Zerbo has been very helpful with the MAT launch
- Has been able to get all of the full-timers ex-waivered for suboxone (providers with training that give 32 hrs a week to prescribe the medication)

- Suboxone mitigated many of the negative outcomes of substance abuse (morbidity & mortality avoided)

JM asked if a Nurse Navigator would be a helpful addition

- **LA**: absolutely; would facilitate a warm endorsement that patients need and build necessary good relationships with patients; could bring paperwork and other materials partners need; can work to ensure Medicaid

CP asked LA to look at a given week or month and see how many times barriers to scheduling outpatient services are apparent, to show sense of urgency; broader access in community, more people to come in house à multidimensional solution in process; addition of Nurse Navigator or navigation capacity to help direct patients to appropriate settings of care

LA: we can break down a month's worth of visits and look at how long it took to secure appointments; also, if we can add telemedicine access (we just started this two months ago) that would be helpful

- Patients are comfortable with telemedicine and we're using partners that we know
- There is a facilitator there on site during these calls
- This is with video and phone capability
- Services: routine sick calls (physical and mental health)
- Need for specialist telemedicine access

SC: are the facilitators during the telemedicine calls also trained?

- **LA**: yes, they are medical assistants with training; 100 people on medical staff, as well as social services department; not enough staffs for the number of patients

JM: we need a framework on both inside and outside services; metrics to look to quality improvement in creating linkages; organizational integration; asked LA for a review of policy & procedures, quality, review practices, electronic documentation and reporting procedures (health information exchanges)

SC on telemedicine:

- Developments in literature that talks about telemedicine as being more than just having someone look at you; there is equipment now available
- For example, having an aide put stethoscope on you and relaying information to the doctor
- Engaging doctors in the community

JM asked about the induction of MAT in the facility.

LA: the access to care is the biggest issue there; right now 125 on suboxone, methadone, and vivitrol, but upon discharge, getting those patients access to care depends on if they qualify; our ability to give them medication before they leave is limited; Nurse Navigator would be essential

Audience member: Helena Muhammad

- Concerned about smooth transition; she's worked at Hudson County Jail
- Managed smooth transitions

- Weekend releases are deterrents to community linkages; advocate for people to be released during the week
- Many social workers do not work during weekends, so difficult to navigate
- Same numbers happening on the weekdays continue on weekends; 40-60 discharges over weekends, so more challenges occur then
- **Justice Rountree (JR)**: I'd ask people to think about having to spend extra days without their freedom; get on the front end of the problem
- Women need screenings once a year, not just physicals
- Women have more unique needs than men
- Racism and prejudice among POC

Audience member: Herbert Glenn, We Care Partners

- Programs in de-escalating trauma surrounding incarceration for both inmates and families
- Develop ways in which we can have 1-on-1 religious/spiritual counseling with incarcerated individuals; advance tracking and doing what we can to connect to services; bridge gap in families so encouragement can be enforced
- Wants to work with ECCF

Audience member: Yvonne Blake, Kaleidoscope and East Orange Substance Abuse

- Supporting agencies must help to meet women's health needs
- Importance of full physicals
- **LA**: Kaleidoscope provides appointments from 7-9 so they can attend court if they need to
- Vivitrol requires patients to go to them for injections, cannot be administered in house
- Connect services so it's seamless for those being discharged
- Partnering with community family reunification services

LA: 800 individuals vaccinated, most fully (mostly J&J, then Moderna); everyone gets an antigen test at intake; PCR capabilities in house; 10 machines in the building now

- **CP**: vaccination percentage isn't at 50% yet

Appendix K

Task Force Complaints & Responses

August 2020

- The Task Force received a report describing multiple incidents involving three detainees in the custody of ECCF.
    - Action(s) Taken: The Task Force wrote a letter to Phillip B. Alagia, Chief of Staff at the County of Essex, requesting relevant information and results of the administration's own inquiry into the matter.
    - Response from ECCF: Following review of the incident, ECCF provided that the Essex County Prosecutor's Bureau of Professional Standards concluded insufficient credible evidence for criminal prosecution. No civil disputes have been pursued.

November 2020

- The Task Force received a complaint about an inmate whose belongings were confiscated.
    - Response from ECCF: County provided explanation regarding confiscated contraband.
- The Task Force received a complaint regarding an incident.
    - Response from ECCF: The inmate was evaluated by a dentist and referred to an oral surgeon.

January

- The Task Force received multiple reports about hunger strikes at the facility.
    - Action(s) Taken: The Task Force requested, received, and reviewed updates from the administration regarding the matter. The Task Force sent a letter to Commissioner President Brendan Gill with a detailed report of the matter and ongoing monitoring.
    - Response from ECCF: The facility continued to work with the Task Force in providing updates and answers to the TF's inquiries.

February 2021

- A number of complaints and questions were submitted by inmates and ICE detainees.
    - Response from ECCF: All questions were addressed at a tier rep meeting.

March 2021

- The Task Force received an email with grievances from an inmate.
    - Response from ECCF: A county investigation was opened to address grievances.

April 2021

- The Task Force received information regarding a complaint on behalf of an inmate describing the facility's inability to respond to grievances, the inmate's inability to place commissary orders, and being locked in for extended periods of time.

    - Response from ECCF: The facility interviewed the inmate and addressed most of his concerns (some could not be mitigated due to limitations imposed by COVID-19).
- The Task Force received a complaint via email regarding discrimination against veterans and issues with specific officers at the facility.
    - Action(s) Taken: The Task Force forwarded this complaint to Phil Alagia.
    - Response from ECCF: Alagia responded that the facility will answer any questions.
- The Task Force received a complaint about an altercation with a sergeant.
    - Response from ECCF: The inmate was interviewed twice; nothing was substantiated from his initial complaint.
- The Task Force received a complaint about an inmate hit by officers.
    - Response from ECCF: This was investigated by the county's investigation unit and referred to the Essex County Prosecutors Office.
- The Task Force received a complaint about mistreatment from officers.
    - Response from ECCF: Sergeant interviewed this inmate, who said he has no issues.
- The Task Force received a complaint about not being able to leave her cell due to her cellmate being on lockdown.
    - Response from ECCF: Upon interviewing the inmate, it was found that an officer on the unit had opened her cell door several times that day.
- The Task Force received a complaint about being in SHU for longer than anticipated.
    - Response from ECCF: Inmate was no longer eligible to be housed in the unit once off detention. He was released from the facility a couple weeks later.

May 2021

- The Task Force received a complaint about a received charge despite not having done anything.
    - Response from ECCF: The county claimed the individual was placed in pre-detention for throwing bodily fluids on an officer and received 15 days detention after a disciplinary hearing.
- The Task Force received a complaint about an inmate whose medical needs were not being met and who claimed she was incarcerated for no reason.
    - Response from ECCF: The facility conducted an interview with the individual, during which the inmate indicated her needs were being met. Her additional concerns were "outside legal matters," and ECCF made an inquiry on her behalf.
- The Task Force received a complaint from an inmate regarding harassment.
    - Response from ECCF: By the time the inmate was interviewed, he was comfortable in his new housing status.
- The Task Force received a complaint about mistreatment from officers.
    - Action(s) Taken: Followed up with the inmate, who denied ever calling the Task Force.
- The Task Force received a complaint about general cleanliness concerns.
    - Response from ECCF: Could not identify inmate.
- The Task Force received a complaint asking to be contacted

    - Response from ECCF: Could not identify inmate.
-

June 2021

- The Task Force was forwarded an anonymous email regarding lack of transparency and unequal treatment of employees by ECCF leadership.
    - Action(s) Taken: The Task Force reviewed the email.
- The Task Force was notified by ECCF that two ICE detainees have started a hunger strike.
- The Task Force was notified by ECCF that the facility was on lockdown to conduct targeted and facility-wide searches in response to ongoing intelligence information regarding inmate-on-inmate assaults.
- The Task Force received a handwritten letter from an inmate.
    - Response from ECCF: The inmate was attempted to be interviewed but was transferred to Bergen County Jail.

July 2021

- The Task Force was notified by ECCF about the death of an inmate after a prolonged bout with a chronic terminal liver ailment.
    - Action(s) Taken: The Task Force asked ECCF if anything could be done to support the inmate's family.
- The Task Force was forwarded an anonymous email with numerous concerns regarding issues of nepotism, favoritism, and harassment among the correctional officers.
    - Action(s) Taken: The Task Force reviewed the concerns and considered bringing comments directly to Phil Alagia.
- The Task Force received an update from Phil Alagia about four ECCF officers indicted by a federal grand jury for assaulting a federal pretrial detainee.
- The Task Force received a letter from an inmate regarding food.
    - Response from ECCF: The county contacted the vendor immediately; could not confirm nor deny complaint claims after investigation, but it established certain food procedural modifications "in an abundance of caution."

August 2021

- The Task Force received a complaint from an attorney regarding lack of privacy during lawyer visits.
    - Action(s) Taken: The Task Force relayed ECCF's response to this, which lists the different options provided by the facility for private lawyer visits and calls.

September 2021

- The Task Force received a complaint from an attorney on behalf of an inmate regarding insufficient mental health treatment.
    - Action(s) Taken: The Task Force relayed this message to Phil Alagia, attaching a related court order.

- Response from ECCF: The inmate received care, and the attorney was given a complete update on the care of her client. The attorney followed up updated the Task Force on this matter and concluded the facility complied with the judges' orders.

November 2021

- The Task Force received a complaint about alleged sexual harassment.
  - Response from ECCF: A full investigation report was provided; allegations were unfounded.
- The Task Force received four voicemails regarding lockdown and lack of access to showers.
  - Response from ECCF: The Chair reached out to each caller and provided explanations for lockdown due to safety.
- The Task Force received a complaint about money being taken from commissary.
  - Response from ECCF: The inmate was given a commissary reimbursement.
- The Task Force received a complaint about not getting proper meals, as the inmate is diabetic.
  - Response from ECCF: The County followed up with the kitchen and the inmate, who confirmed he is getting the proper diet.
- The Task Force received a complaint from a woman on behalf of her incarcerated husband regarding lack of masks and COVID-19 safety measures.
  - Response from ECCF: No contact information was left on the voicemail, but the county provided Dr. Anicette an explanation of COVID policy.
- The Task Force received a complaint from a woman regarding her incarcerated husband's health.
  - Response from ECCF: The county contacted her via the number she left, but she was ignorant to the phone call. She further stated that she hadn't called the jail in months.
- The Task Force received a complaint regarding poor living conditions.
  - Response from ECCF: The county explained the reasoning behind lockdown and provided explanation of lockdown procedure and application at the time.
- The Task Force received a complaint from a woman about concerns regarding her incarcerated son.
  - Response from ECCF: Each inmate is given a free 15-minute call each day.
- The Task Force received a complaint from a man about concerns involving his incarcerated son.
  - Response from ECCF: The Chair reached out to the caller, and the county investigated and communicated with both the father and son.
- The Task Force received two complaints from women regarding getting in touch with their incarcerated sons.
  - Response from ECCF: The Chair reached out to the callers, and the county connected the callers with their sons.

December 2021

- The Task Force received a call from public defender regarding the violence at ECCF and a situation where inmates are allegedly sleeping on the floor without beds.
    - Action(s) Taken: The Task Force considered scheduling a call to discuss these issues.
- The Task Force was made aware of a death at the facility due to an altercation between inmates.
    - Action(s) Taken: The Task Force discussed what actions could be taken to prevent a situation like this in the future. Dr. Pernell was made aware the county's decision to contract with a private consulting firm regarding this matter; she has also been working on a medical report. The Task Force considered an internal meeting.
- The Task force received a complaint about Code Black lockdowns and lack of access to phones or showers.
    - Response from ECCF: The administration assured it will continue to monitor all housing units to provide showers and phone calls while complying with COVID-19 protocols.
- The Task Force received a complaint about having to use phones to activate the tablets every month.
    - Response from ECCF: ECCF conferenced with the GTL technician to add and update the numbers to the tablet.
- The Task Force received a complaint about being locked out of the law library, inability to exercise, and lack of movement.
    - Response from ECCF: The facility was released from lockdown status due to COVID-19, which should alleviate much of these concerns.
- The Task Force received a complaint from a concerned mother about an inmate with medical conditions who had been assaulted and stabbed by another inmate.
    - Action(s) Taken: The Task Force immediately flagged this complaint and relayed it to ECCF.
    - Response from ECCF: The administration opened an investigation, completed a full medical assessment, and conducted an interview with the inmate, during which the inmate did not substantiate the allegations.
    - Subsequent Action(s) Taken: The Task Force spoke again with the mother, who said she spoke with her son and is still concerned. She confirmed again that he had been stabbed and that he had repeatedly been subject to retaliation from officers. She requested that he be relocated to a different correctional facility.
    - Subsequent Response from ECCF: A doctor and the Director conducted a second wellness check. The inmate admitted he was assaulted but could not provide names. He was able to contact his mother to assure her he is fine; he was placed in protective custody. Efforts are being made to transfer him closer to his family in Brooklyn. Later, another report was conducted when the mother expressed concern again. Inmate was transferred to the infirmary.

Appendix L

Essex County Corrections Covid-19

PROTOCOLS as of 03-11-2022

- Supplies – We still have the additional storage unit that was placed on the premises to hold additional supplies. We continue our 4-6-month inventory of supplies for needed items.

- Due to temporary suspension of family visits; we reinstituted the two daily free, up-to 10 mins, phone calls for all inmates, extended until March 31, 2022.

- Cleaning and disinfection above and beyond normal activity continues. Appropriate disinfection solutions continue to be issued to our cleanup crews and staff for continued disinfection.

- All family visits are temporarily suspended (pending a date from the county health office); all inmates continue to utilize our new tablet system which will allow for phone calls, video visits, games, music, to name a few of the features accessible to them.

- Due to the increase in mail as a result in the increase of COVID cases and limit facility movement, we continue to use the Chemical Detection System Scanner for illegal substance detection.

- We continue to use the Additional sanitizing machine was purchased for our Emergency Response Equipment.

- As of Monday, March 7th, as a recommendation the county health office, all attorney visits will continue with Window visits (no verification of vaccination needed, only masks needed) as well as in house lobby virtually conducted visits. **Please note: We still continue to conduct attorney/client legal calls via our internal transfer line service. Also, prescheduled virtual attorney visits are conducted through our Visits' Sergeant.

- Hand held sanitation devices continue to be utilized for all attorney visit area sanitation, mattresses, vehicles, etc.

- All religious services conducted by volunteers continue to be suspended. When appropriate, inmates will be allowed to conduct a service on their own under staff supervision.

- All Jail outside work crews (the SLAP program) have been limited to only facility ground work.

- GD Corrections, our Food Service provider continues to do the following. They are making sure to have 30 days of meals on hand. They have acquired freezer space in the area and have 14 days of frozen meals available if needed. Extra staff has been transferred to Essex County to work in the jail kitchen. They are sanitizing all areas every hour. All items in the Officers Dining Room continue to be grab and go, NO self-serve items. They have a transportation plan in place in the event public transportation should stop for their employees.

- Inmates continue being educated on the importance of Hand Washing and best practices for prevention of spread.

- Medical Staff continue monitoring all inmate checking for symptoms and signs of illness.

- The Medical Department continues following protocols for handling inmates who may be compromised, (over the age of 45 with underlying Health Conditions). These include additional daily monitoring and a plan to separate them from the population should the need arise.

- The Facility was designed with zero pressure rooms that are available in the Infirmary to house affected individuals.

- Our staff continues to be educated on Corona Virus protocols and best practices.

- All classes conducted by volunteers and or part-time workers have been suspended.

- Our inmate Advocate and Social Service Departments are making daily rounds in the housing units attending to our inmate concerns and issues.

- Vaccination and Testing continues for both inmates and staff

- The inmate vaccination incentive program continues. When an inmate completes both vaccinations shots, he/she will receive a $10 credit in his/her inmate account.

- The County Health Department authorized recreational activity within the housing area as long as area is sanitized after each use. i.e. basketball.

Appendix M

COUNTY OF ESSEX

DEPARTMENT OF CORRECTIONS
ESSEX COUNTY CORRECTIONAL FACILITY
354 Doremus Avenue – Newark, New Jersey 07105
973-274-7800 --- 973-274-6193 (Fax)

Joseph N. DiVincenzo, Jr.
Essex County Executive

Alfaro Ortiz, Jr.
Director

TO: Essex County Civilian Task Force

FROM: Alfaro Ortiz, Director

DATE: October 30, 2020

RE: Answers to Medical Questions from Dr. C. Pernell

Please note that these responses are a compilation of answers from our staff including Dr. Anicette, Medical Director; Madeline Bell, Health Services Administrator; and Heidi Reifenberg, Coordinator of Monitoring and Evaluation.

1. **Questions regarding inspections**
   It was presented that the ACA, NCCHC, NJDOC, ICE/PBNDS, and the federal Office of Detention Oversight assess the facility on some regular basis. May you provide what the schedule/frequency is and the process of review including the specific criteria that each agency uses to evaluate the facility as well as the most recent performance on any assessments/evaluations that ECC may have undergone? How does the most recent performance compare to past trends? On Slide 4 in the Medical Monitoring Presentation this was alluded to but no specifics were provided.

Accreditation Agencies	**Frequency of Audits**	**Most recent dates audited**	**Upcoming dates scheduled**	**Describe the process of review, including specific criteria used to evaluate**	**Provide the most recent performance on assessments/evaluations**	**Compare the most recent performance to past trends**
ACA	***Every 3 years***	***June, 2019***	*Approx. 9/2022*	ACA Medical Stds	Passed w/ full accreditation	Same as past inspections
NCCHC	***Every 3 years***	***April, 2017***	***Nov/Dec 2020 undetermined due to Covid***	NCCHC.ORG	Passed w/full compliance	Same as past inspections

NJDOC	***Every year***	*2019*	*2020/2021 Undetermined due to Covid*	NJDOC JAIL STDS	Passed w/full compliance	Same as past inspections
ICE/PBNDS	***Yearly and ongoing***	Office of Detention Over-site (ODO) 6/2020 Nakamoto 9/2020	***To be determined by ICE***	ICE PBNDS	Meets Standards	Same as past inspections

2. Medical area description

a. "It is my understanding that each building has its own medical unit with a provider for that particular building, in addition to 2 medical stations in central processing and a 42-bed infirmary in building 5. Is this accurate?"

RESPONSE: ***Yes***

b. "Please be specific on which provider types/titles are in each building and hours of access. And, do inmates and detainees receive medical care by the same staff though inmates may be housed separately from the non-detainee population?"

RESPONSE: ***Medical providers include Physicians, Nurse Practitioners and Physician's Assistants. They treat both inmates and detainees. There are 8 physicians/NPs/PAs (providers) in the facility on the weekday daytime shift; 2 providers on the weekday evening shift; and 1 provider on the weekday night shift. On weekends, there are 2 providers on the day shift; 2 providers on the evening shift and 1 provider on the night shift.***

An administrator, physician, RN, psychiatrist and a dentist on-call 24 hours per day, seven days per week.

3. Population

a. Breakdown

	Population	Male	Female	% English not first language
Detainee	256	256	None	Unknown
Non-detainee	1993	1896	97	Unknown
Totals	2249	2152	97	

Age	Total
18-23	362
24-30	604
31-40	703
41-50	368
51-60	182

>60	30

Race/Ethnicity	Total
Asian Pacific	12
Black	1512
Hispanic	335
Am Indian/Alaska	1
Unknown	2
White	380
Other	7

b. Gender identity
   i. Are inmates/detainees able to identify as non-binary?

   RESPONSE: ***Yes***

   ii. Does the facility currently house transgendered persons or has in the past?

   RESPONSE: ***Yes***

c. Languages
   i. Are medical services provided in the preferred language?

   RESPONSE: ***Yes***

   ii. Is there access to interpretation/translation services as needed?

   RESPONSE: ***Yes***

   iii. How often are translation/interpretation services used?

   RESPONSE: ***Translation/interpretation services are used whenever needed.***

   iv. How many individual languages does the language line include? What is the percentage of inmates who speak a language other than English?

   RESPONSE: ***60 languages are available and other languages can be accessed as needed. Approximately 10-15% of patients speak a language other than English.***

4. Medical delivery of care

Medical intake screenings

a. It is my understanding that every inmate/detainee must complete an intake screen performed by a nurse, including a questionnaire and mandatory TB, RPR and COVID Antibody testing. Please advise if this is complete and accurate.

RESPONSE: ***Yes (RPR is done within 30 days)***

b. Provide copy of nursing intake form

RESPONSE: ***Please see Attachment A.***

c. Do all female inmates/detainees undergo pregnancy testing during their initial intake? What gynecological/women health care services are offered at the facility?

RESPONSE: ***Yes, an Ob/Gyn is on staff and sees patients three days/week.***

d. Who performs the History and Physical <within 24 hours>?

RESPONSE: ***Physician, Nurse Practitioner or Physician's Assistant***

e. Why on Slide 5 in the Medical Monitoring Presentation are nurse screens reported to be about 1460/month and physical assessments are about 815/month. Based on the avg census on total population stats provided in the Safety and Security Protocols presentation, there is a discrepancy. Please advise.

RESPONSE: ***Numbers were taken from January-March. The numbers differ because many inmates are released before they can have their History and Physical.***

5. Other medical stats (Medical Monitoring Presentation)

a. Do those numbers represent unique visits or are they inclusive of persons who may have had multiple encounters?

RESPONSE: ***The numbers are inclusive of persons who may have had multiple encounters.***

b. Can you provide a report that summarizes the numbers with a breakdown by inmates vs. detainees?

RESPONSE: ***We do not break down this data according to inmate type.***

c. Top 5 medical diagnoses

RESPONSE: ***Diabetes, Hypertension, COPD, HIV, Substance Abuse***

d. Top 3 mental health diagnoses

RESPONSE: ***Depression, Anxiety Disorder, Adjustment Disorder***

e. What are the top 5 prevalent medical conditions, inclusive of mental/behavioral health diagnoses?

RESPONSE: ***Hypertension, COPD, Depression/Anxiety, Substance Abuse, Diabetes***

It was reported that approx 1200-1400 have chronic conditions hence the prior question. It was also reported that 20-30% of the population has mental health conditions.

f. It was presented that the medical vendor is required to supply monthly statistical reports. What data is contained in the report and may we receive regular updates?

RESPONSE: ***Please see Attachment B (Monthly Statistical Report)***

Is this report distinct from the monthly CQI report?

RESPONSE: ***Yes***

If they are separate documents, then what data is contained in the monthly CQI report and again, may we have access to this report on a regular basis?

RESPONSE: ***Please see Attachment C for a sample agenda from a monthly meeting.***

6. **Continuous Quality Improvement (CQI)**
It was mentioned that studies are done on various key performance indicators such as timeliness of sick calls, physical assessments and chronic conditions which are under control/uncontrolled. Are there standard KPIs that are run with some regular frequency or is the data that is pulled more episodic in nature?

RESPONSE: ***Studies are performed regularly and presented at monthly CQI meetings. There are studies performed with regular frequency and others performed episodically. Studies performed in the last year include:***

Nurse Sick call
Expiring psychotropic medications renewed
E-sign electronic consent and refusals
EMR orders for suicide watches
Intake process
Withdrawal protocol
Emergency room transfers
Timeliness of MH referrals and visits
HTN chronic clinic
Medical record accuracy

7. **Sick calls**

Sick call requests	Average per day	Average per month	Average per quarter	Average per Year
	46	*1,338*	*4,015*	*16,000*

a. How many sick visits occur in one month, on average?

RESPONSE: ***2,200***

b. What demographic information is captured about the person submitting the sick call request? Stratifying the data would be useful by REAL data at least (Race/Ethnicity, Age and Language) as well as Sex. (I'm assuming SOGI data isn't collected, i.e., sex, orientation and gender identity.)

RESPONSE: ***Demographic information is imported into the electronic medical record from custody data including Age, Race, Gender ID, and Language spoken.***

c. Can you trend the most common complaints/reasons for sick calls?

RESPONSE: ***Generalized pain, headaches, dental complaints, medication requests***

d. What other trend data is available about the sick calls?

RESPONSE: ***Areas within sick calls which are looked at include timeliness of sick calls; referrals to higher level provider; treatment provided as prescribed.***

e. Which buildings or units do the majority of the calls come from?

RESPONSE: ***Generally speaking, Buildings 2 and 3.***

f. How do these numbers break down by demographic data? Via inmates vs. detainees?

RESPONSE: ***We don't collect this type of information.***

g. The standard is that the concern should be triaged within 8 hours and evaluated by a nurse who can refer to a mid-level provider or MD within 24 hours unless the concern is deemed urgent/emergent. Is this accurate?

RESPONSE: **Yes,** ***Sick call requests are triaged on all three shifts.***

h. Who triages the sick calls and determines what is urgent or emergent?

RESPONSE: ***Registered nurses triage sick calls and determine what is urgent or emergent based upon nurse sick-call protocols..***

i. What percentage of calls are urgent/emergent?

RESPONSE: ***Approx. less than 3% based upon random sampling.***

j. How often is the standard of 8 hrs and 24 hours met? When it is not met, has the facility done a root-cause analysis to understand the contributing factors to the delay?

RESPONSE: ***Studies and audits are performed regularly on the timeliness of sick call visits. Daily root-cause analysis is done to determine contributing factors and work to correct them.***

k. How many sick calls are generated by the individual via the tablet vs. by contact with a nurse or officer?

RESPONSE: ***Approx. 90% are via Tablet.***

l. Is the electronic device equipped in the preferred language of the person using it?

RESPONSE: ***Yes***

8. Chronic care services

Please provide a copy of the evidence-based medical screening guide developed by the Medical Department which outlines guidelines for determining "controlled" versus "uncontrolled" diagnoses of incarcerated individuals.

RESPONSE: ***Please see attachment D.***

9. Medical staffing

a. FTEs broken down by type

RESPONSE: ***Please see Attachment E.***

b. Comments were made that the staffing was changed to reflect gaps in care. What is the context for those statements? We don't have access to those reports/performance-based outcomes that may have prompted a different staffing model.)

RESPONSE: ***Staffing can be changed, based on results of repeated CQI studies. For example, if sick calls are high over a period of time, sick call nurses may be added.***

c. Who is available in the facility (exact site) and across which hours?

RESPONSE: ***Please see Attachment F.***

Who is available on a 24hr basis (exact site/location)?

RESPONSE: ***An administrator, physician, RNs, psychiatrist and a dentist on-call 24 hours per day, seven days per week. There are always at least 1 provider and2 nurses in Main Medical and the Infirmary at all times.***

Also, please summarize/confirm how many hours per week the specialists are on duty.

RESPONSE:

OB/GYN	***12 hours/week***
Orthopedist	***12 hours/week***
Oral Surgeon	***4 hours/week***
Podiatry	***4-8 hours/mo***
Optometry	***4 hours/mo***
Nephrologist	***On-call***

10. Access to care

Please provide data on how frequently (# of visits) inmates/detainees are referred to outside facilities for medical care, including to local hospitals and state forensic hospitals.

RESPONSE:
ER visits - about 22/month
ER/MH crisis - about 2/month
Admissions - about 6/month
Outpatient services - about 23/month

11. Medications

It was reported that approximately 1600/2000 inmates are on meds. Is this accurate?

RESPONSE: ***This is accurate and is reflective of response to COVID-19, including vitamins prescribed to all inmates/detainees. The ECCF has a robust preventative health program, which includes a detox program and MAT program. Additionally, vitamins and supplements are provided to all inmates as a response to COVID-19.***

How many meds is each inmate on average?

RESPONSE: ***About 2***

12. COVID-19 response

a. Please provide the list of criteria for determining which ICE detainees are most vulnerable to contracting COVID-19 and should be recommended for expedited release.

RESPONSE: ***Please see Attachment G.***

b. COVID-19 testing protocols
   i. Please confirm the criteria that leads to the performance of a PCR test since the testing strategy that is largely used is the serological testing of all inmates/detainees.

RESPONSE: ***COVID-19 response plan is based on CDC guidelines. PCR testing has been indicated for pre-ops, transfers, forensic placements, deportations, inmate worker clearances. Also PCR test may be given on a case-by-case basis.***

ii. Please confirm infection prevention protocols in place to ensure a safe environment for all inmates/detainees and staff. For instance, please confirm whether staff undergo temperature screening at the start of each shift and if the temperature is elevated, are these persons queried for other symptoms?

RESPONSE: ***All persons entering the facility are temperature screened. There is medical follow up for anyone with an elevated temp who is employed here. Others are refused entry into the facility.***

13. Immigration detainee-specific

a. How often are ICE medical determinations appealed by the facility?

RESPONSE: ***ICE doesn't allow us to release this information***

b. Please provide records of use of translation services for ICE detainees encountering mental health services.

RESPONSE: ***ICE doesn't allow us to release this information***

c. Please provide brief report on the ICE detainee death that occurred under facility incarceration, including the year, month, and cause of death.

RESPONSE: ***ICE doesn't allow us to release this information***

14. Transitions of Care

What processes (i.e. handoff measures) are in place to ensure safe and effective transitions of care whenever an inmate/detainee moves from one care setting to another, especially upon reentry to community, as well as transitions from the facility to an outside facility?

RESPONSE: The transfer form captures the necessary data to maintain a continuum of care when needed. We have an MAT discharge planner, ACA Discharge Coordinator, ICE liaison and re-entry discharge planning.

15. Staff Training

How often do medical staff and all facility staff complete cultural competency training? How soon will medical staff and all staff undergo implicit bias training? I understand this may just be in the planning/exploration phases.

RESPONSE: ***Cultural competency training is done on an annual basis. ECCF is preparing to implement implicit bias training which will be incorporated into current training curriculum.***

16. Grievances

a. Please provide a breakdown of daily/monthly/weekly averages, common types, and submission demographics.

RESPONSE: ***About 140 medical grievances/sick-calls are received per month. Common reasons include clerical issues (ie., accounts i.e., co-pays), dental complaints, medication requests.***

b. If a person files a grievance related to the care they received or a sick call that was issued, typically how long is the grievance process and what are the KPIs to measure performance?

RESPONSE: ***Grievances are answered within 5 days. Nurses check the grievance database everyday to make sure sick calls are not inadvertently submitted as grievances. If grievances are found to be sick calls, they are addressed as such.***
"KPIs to measure performance?" Performance would generally be measured based on timeliness of visit and if the complaint was addressed.

17. Social Services

Please provide the following data from social services classes:

a. Capacity of classes versus overall interest

RESPONSE: ***6-12 students depending on location of group***

b. Funding status

RESPONSE: ***County and state funding***

c. Demographics of participates (i.e. inmate being resentenced)

RESPONSE: ***Unknown; not being tracked***

d. Waiting list existence or capacity

RESPONSE: ***We maintain a waiting list when needed. However, there is no one on a waiting list at this time.***

18. Custodial Questions

ll it being mentioned that only half of a unit's population is permitted outside of their cells at one time. Roughly how many people is that?

RESPONSE: 32 due to social distancing requirements.

ATTACHMENT B

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
On-site Inmate Health Services Utilization																	
MONTHLY CENSUS																	
Total Number of Admissions																	
Average Daily Population																	
County Inmates																	
State Inmate																	
Federal Inmates																	
ICE Detainees/NJ & NY																	
Nursing Services																	
To ER Prior to Jail																	
Refused At Jail For Clearance																	
Cleared for Jail																	
Admitted to Hospital																	
Nurse Sick Call																	
Intake Screens																	
Segregation Rounds																	
Detox - CIWA Screenings																	
Halfway House Clearance																	
Total Nursing																	
Physician/Mid-Level Services																	
Sick Calls																	
Intake Physicals																	
Annual Physicals																	
Chronic Care Visit																	
Food Service/Worker Clearance																	
Infirmary Rounds																	
Total Physician																	
Urgent/Emergent Encounters																	
Visitors																	
Staff																	
Chronic Care Encounters																	
Cardiac																	
Pulmonary																	
Endocrine																	

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Infectious Disease																	
Neurology																	
Total C.C. Encounter																	
On-site Consults & Diagnostic Services																	
Specialists																	
Infection Disease																	
OB/GYN																	
Podiatrist																	
Orthopedist																	
Optometrist																	
Other																	
Special Services																	
Radiology																	
EKG																	
Physical Therapy																	
Ultrasound																	
# of Blood Draws (patients)																	
# of Lab Tests																	
Off-site Specialty Consultations and Diagnostic Services																	
ENT																	
Cardiology																	
Dermatology																	
Dialysis																	
Gastroenterology																	
General Surgery																	
Infectious Disease																	
MRI																	
CT Scan																	
Audiology																	
Neurology																	
Nephrology																	
Oncology																	
OP Surgery																	
Ophthalmology																	
Oral Surgery																	
Orthopedic																	

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Physical Therapy																	
Podiatrist																	
Pulmonary																	
Surgery (Specialty)																	
Urology																	
Trauma																	
Wound Care																	
Other																	
Total																	
Delaney Hall/Logan Clinic Trips Offsite																	
Radiology																	
Pulmonary																	
ENT																	
Orthopedics																	
Cat Scan/MRI																	
Surgery/Outpatient Surgery																	
Urology																	
Mammography																	
Gastroenterology																	
Therapy																	
Oral Surgeon																	
Ophthalmology																	
Podiatry																	
Ultrasound																	
Cardiology																	
Neurology																	
Oncology																	
Other																	
Monthly Totals																	
Delaney Hall/Logan Clinic Trips Offsite																	
Outpatient Utilization																	
ER Utilization																	
Hospitalizations																	
Woman's Health																	
GYN Visits																	

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
# of Paps																	
# of Pregnant Females																	
# of OB Visits On-site																	
# of OB Visits Off-site																	
# of Pregnant Females on Methadone																	
# of Doses of Methadone Administered																	
# of Deliveries																	
# of Mammogram																	
# of Fetal Ultrasound																	
Infection Control																	
TB Surveillance																	
Refused to be tested																	
Implanted on intake																	
PPD'd read-within 72 hours.																	
Released Prior																	
New Positive PPD's																	
Past Positive PPD's																	
st X-rays for New & past pos PPD, Refusals																	
Abnormal Chest X-rays																	
CT scans to r/o TB																	
Inmates on 4-drug TB therapy																	
Inmates on INH/B6 Prophylactic Treatment																	
HIV Services																	
Number of Tested HIV +																	
New Positive Results																	
Number on Rx																	
Active Cases																	
Previously Dx Hepatitis C																	
Newly Dx Hepatitis C																	
# of Hepatitus C Patients on Medication																	
Number Tested for RPR																	
New Positive RPR																	
Past Positive RPR																	
# of Inmates Treated RPR																	
Trichomonas positive results																	
Chlamydia positive results																	
GC positive results																	

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Chicken Pox																	
Ectoparasite																	
Lice																	
MRSA Data Collection - BOILS																	
Entering facility with boils																	
Sick Call slips submitted for alleged boils																	
Assessment found not to be boils																	
Treatment symptomology for boils																	
Boils by Location																	
Abdomen																	
Arm																	
Hand																	
Axilla																	
Back / Shoulder																	
Buttock																	
Breast / Chest																	
Facial / Nostril																	
Head / Neck / Ear																	
Foot																	
Knee / Calf / Leg																	
Scrotal / Female Genitalia / Groin																	
Thigh / Hip																	
Boils Cultured																	
Boils Cultured Positive for MRSA																	
Treatment - Wound Care																	
Vaccines																	
Influenza																	
Hepatitis / Twinrex																	
Pneumovax																	
Tetanus																	
Other																	
Inmate Deaths																	
In Facility																	
Out of Facility																	
Dental Services																	
Number of Sick Call Slips																	
Number of Patients Treated																	
Extractions																	

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Restorations																	
Pulpectomy																	
Prophy																	
Scaling																	
Broken Jaw																	
X-Ray																	
RX																	
Wires Removed																	
Annual Screens																	
Proplaxis																	
Oral Surgery																	
Consults																	
Seen																	
Extractions (# patients)																	
Mental Health Services																	
Intake Referrals																	
Psychiatrist Encounters																	
Psychiatrist Encounters																	
Psych APN Encounters																	
Psychologist Encounter																	
Mental Health Clinician Encounters																	
Mental Health Clinician Encounters																	
Mental Health Evals (AKFC, TPH)																	
Crisis Transfer (NBI)																	
# of Patients on Suicide Watches																	
# of Days on Suicide Watch Constant																	
# of Patients on Suicide Watch Constant																	
#of Days Suicide Watch Close																	
# of Patients on Suicide Watch Close																	
Days Patients on Watch																	
Face to Face contacts with Watches																	
Suicide Attempts																	
Completed Suicide																	
Forensic Watches																	
Days Patients on Forensics																	
Face to Face contact with Forensic																	
Outside Agency Referrals																	
Court Order Evaluations																	

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Intakes Cosigned by MH Director																	
Counselor / SW Services																	
Counseled																	
Intakes																	
Group Visits																	
Outside Agency Referrals																	
Total Inmates																	
Prescription Services																	
Number of Prescribed Medications																	
Number inmates on Medication																	
Number of HIV Medications																	
Number of Psych Medications																	
ER/Outpatient/Hospital Utilization																	
# Emergency Room Visits - Medical																	
County																	
Federal Inmates																	
State Inmates																	
ICE Detainees																	
Hospital- UMDNJ																	
Hospital- Newark Beth Israel																	
Hospital- St. Michaels																	
Hospital-																	
Hospital-																	
Total # of Emergency Room Visits- Medical																	
# Emergency Room Visits - Mental Health/Crisis																	
County																	
Federal Inmates																	
ICE Detainees																	
Hospital- UMDNJ																	
Hospital- Trenton																	
Hospital- Ann Klein																	
Hospital- Newar Beth Israel																	
Hospital-																	
Total # of ER Visits- Mental Health/Crisis																	
# Outpatient Visits																	
County																	

Health Service Report

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
Federal Inmates																	
State Inmates																	
ICE Detainees																	
# Hospital Admissions																	
County																	
Federal Inmates																	
State Inmates																	
ICE Detainees																	
Hospital- UMDNJ																	
Hospital- Trenton																	
Hospital- Ann Klein																	
Hospital- Newark Beth Israel																	
Hospital- Saint Barnabus																	
Total # of Hospital Admissions																	
# Infirmary/Medical Housing Days																	
Admitted to Infirmary - Medical																	
Admitted to Infirmary - Mental Health																	
Housed in Infirmary																	
Total Number of Infirmary Days																	
Total Number of Observation Days																	
Inmate Medical Co-pays																	
Number of Doctor Visits																	
Number of Dental Visits																	
Number of Rx Handling																	
Grievances																	
Number Received																	
Number Answered																	
Number Appealed																	
Number Pending																	
# ICE Grievances																	
# State Grievnances																	
# Federal Grievances																	
# County Grievances																	
Covid 19																	
# of Employee Temp done																	
# of Temps done in Quarantine																	

COUNTY CORRECTIONAL CENTER

	JAN 2020	FEB 2020	MAR 2020	1st Q 2020	APR 2020	MAY 2020	JUN 2020	2nd Q 2020	JUL 2020	AUG 2020	SEP 2020	3rd Q 2020	OCT 2020	NOV 2020	DEC 2020	4th Q 2020	TOTAL 2020
# of Pre Screens at Intake																	
# of Rapid Testing Done																	

ATTACHMENT C

CFG Health Systems, LLC.

Essex County Correctional Facility

Client Services Meeting

September 23, 2020

A G E N D A

I.	Review of Meeting Minutes	Committee
II.	Review of Statistical Report	Committee
III.	Infection Control	S. Grant, RN, DON
IV.	Staffing Report	M. Bell
V.	Deaths/Patient Safety	Dr. Anicette
VI.	Policy and Procedures	M. Bell
VII.	Grievances	M. Bell
	a. Breakdown b. Trends	
VIII.	Access to Care	M. Bell, S. Grant
	a. Sick Call	
IX.	Mental Health	Dr. Sandrock
X.	Hospital and Outpatient Services	Dr. Anicette
	a. Outpatient Scheduling b. Status c. Backlog d. Telemedicine	
XI.	MAT	

CFG Health Systems, LLC

Essex County Correctional Facility

Continuous Quality Improvement

September 23, 2020

A G E N D A

I. Risk Management Report — Committee

a. Review of Clinical Incidents Reports
b. Review of Staff Incident Reports
c. Review of Staff Injury Reports

II. Infection Control Report — S. Grant, RN DON

a. Statistics
b. Practices

III. Review Of CQI Projects/Audits — Committee

IV. Sentinel Events — Committee

V. Mortality and Morbidity — Dr. Anicette

VI. Patient Safety — Committee

VII. Improvements Plans — Committee

VIII. Man Down Drills/Responses — S. Grant, RN DON Dr. Anicette

XI. Physician Feedback

Next Meeting: tba

ATTACHMENT D

2020 Clinical Care Guidelines

[redacted]

[redacted]

[redacted]

Table of Contents

INTRODUCTION

The clinical guidelines discussed herein are presented with the intention of ensuring the delivery of appropriate, consistent healthcare for inmate patients housed in correctional facilities. This manual has been created by licensed and credentialed CFG practitioners with ample experience in correctional healthcare, who are also certified in basic life support (BLS) and are intimately familiar with community-based standards of care. As conditions of their employment, these professionals are also subject to on-going education and training.

CFG clinicians review the material contained herein on an annual basis, making amendments and/or revisions as needed or stipulated by Federal, State and accrediting bodies. This manual shall also be reviewed quarterly by the Corporate Medical Director and at least annually by each facility's individual Medical Director. Written attestations of compliance are kept on file with each facility's Health Services Administrator (HSA).

This manual has been reviewed by corporate medical administration and the Medical Directors at:

- Albany County Correctional Facility
- Atlantic County Justice Facility
- Burlington County Correctional Facilities
- Camden County Correctional Facility
- Camden Youth Detention Center
- Cape May County Corrections Center
- Cumberland County Department of Corrections
- Essex County Correctional Facility
- Mercer County Correction Center
- Monmouth County Corrections Institution
- Ocean County Department of Corrections
- Schenectady County Correctional Facility
- Somerset County Jail
- Union County Jail (the Ralph Oriscello Correctional Facility)
- Warren County Correctional Center

PURPOSE

This manual has been created for the express purpose of:

- Developing and promulgating standards of care designed to ensure the uniform delivery of healthcare services across all contracted correctional facilities
- Ensuring that inmates with chronic diseases are promptly identified and appropriately managed
- Delineating procedures for the documentation of all service rendered
- Establishing clinical norms of care

These guidelines are **NOT** intended to restrict the delivery of appropriate care by licensed clinicians to individual inmates.

An individual practitioner's failure to achieve the standards of care advocated by these guidelines may result in focused peer review and professional critical analysis by the Medical Director.

All healthcare staff members must sign an attestation form upon receiving a copy of the Clinical Guidelines Manual.

The Medical Director at each facility shall develop an annual curriculum for educational in-services for all staff members involved in providing healthcare services to inmates. This curriculum shall include review of the Clinical Care Guidelines Manual.

PRACTICE PRINCIPLES

DOCUMENTATION

The Health Record memorializes the full scope of clinical interaction between the provider and the patient. Through consistent documentation methodology quality performance measures codify all facets of the health program, including timely diagnostics, appropriate clinical decision making, continuity, effectiveness, efficiency and safety.

Health Records systems, both paper and electronic, are similarly formatted to allow for the documentation of each clinical encounter. CFG subscribes to this standard.

CONTENT

The record should not be populated with automatic checks or responses when there is no clinical correlation. Normal should not be selected to respond to an inquiry if the question is not asked or the examination is not completed.

LEGIBILITY OF MEDICAL RECORD

The medical record serves as official documentation of all patient interaction with health professionals; as such, it represents a legal document that must be able to withstand scrutiny. The medical record also serves as the care plan, enabling the health team to provide treatments both timely and appropriate according to directives entered therein. If the medical record cannot be easily read or understood, it becomes a liability; as such, CFG policies B-08 and A-08 (in conjunction with NCCHC guidelines/standards) address this concern and the issue of patient safety. Risks associated with illegible entries include:

- Treatment errors
- Medication errors
- Duplications

(The use of Electronic Medical Records mitigates problems related to legibility)

ENDORSEMENTS

A clinical entry is not considered complete until the note has been endorsed by the author. Endorsement includes recording the date and time of notation and the signature of the notation's author. After signing their name, the practitioner needs to stamp the chart. Documentation of actual date and time of entry are critical to notation and are of immeasurable value when conducting retrospective chart reviews.

Facilities with electronic medical records must also comply with standard operating practices and procedures. Completed entries must be closed and endorsed by the actual provider. Providers are **NOT** permitted to post-date entries.

The fundamental principles of documentation listed below represent benchmarks of care for CFG Health Systems' healthcare providers:

- proper content
- proper format

- legibility
- endorsement
- diagnostics

PEER REVIEW/CLINICAL PERFORMANCE ENHANCEMENT

The Medical Director serves as the principle professional authority, monitoring and assuring the quality and the appropriateness of health services afforded all patients. The National Commission on Correctional Health Care (NCCHC)suggests maintenance of quality carebe achieved through the implementation of concurrent objective reviews of the clinical skills of each practitioner. These reviews are conducted by the Medical Director or a designee with at least equal training in the same general discipline as the practitioner being reviewed. Subject to this process are all licensed practitioners that provide care within a facility, including medical physicians, psychiatrists, dentists, mid-level practitioners (nurse practitioners and physician assistants) and PhD–level psychologists.

All clinical performance reviews are kept confidential and are filed by the Health Services Administrator (HSA) in employees' individual personnel files. Each review conducted shall include the following:

- the name of the individual being reviewed
- the date of the review
- the name and credentials of the reviewer
- confirmation that the review has been shared with the clinician
- a summary of findings
- corrective actions, if necessary

CFG's peer review program focuses on evaluating clinicians' delivery systems - such as chronic care evaluations, infirmary care plans and discharge planning. At the time of review, the Medical Director will determine the number of chartsneeded (selected through random sampling) in order to ascertain a reasonable and accurate picture of a provider's practices. Sample audit tools to be used by the Director (or his/her designee)are included in the Forms section of this manual.

MANAGEMENT OF PHARMACEUTICALS

A precipitous rise in pharmaceutical costs has fomented the need for conscientious monitoring by the CFG clinician. Historically, though medications new to the marketplace were always more costly, cheaper alternatives were usually available using similar older or generic drugs. However, with recent changes in manufacturing, most notably sole-source designation/contracts, the cost of older drugs has also risen significantly. Of greatest concern is the fact that, in many cases, drugs subject to incredible increases in cost are recognized as the standard and are sometimes the only treatment available. For instance, isoniazid (INH) has historically been a component of primary treatment protocols for mycobacterium tuberculosis and is the standard of care for the management of latent tuberculosis infection (LTBI). Colchicine is used to blunt the acute immunologic cascade seen in gouty arthritis and is also used in patients who present with unilateral joint inflammation, both diagnostic and therapeutic. These two widely utilized medications have been subject to steep increases in cost in recent years, taking them from less than fifty cents to more than six dollars per pill.

As at least 1/3 of the incarcerated population is on medication at any given time, it is crucial that healthcare providers remain vigilant in monitoring medication orders for each of their patients, ensuring treatment regimens are clearly defined and appropriate, and that unnecessary medications are discontinued promptly.

DRUG FORMULARY

As a means of managing pharmaceutical costs, CFG and other healthcare providers have created drug formularies. On an annual basis, CFG's Site Medical Directors are expected to jointly prepare and approve a list of all primary medications to be included on the formulary. The drugs listed within should represent the majority of pharmaceutical classes commonly used in CFG's correctional healthcare services programs, at the best value. In addition to listing available drugs, the formulary must also include the formulations available and recommended dosages.

Once a formulary is approved, it is then distributed among all providers to be used as a guide for ordering medications. In most cases, providers may prescribe from the formulary, with the order filled directly using on-site stock; however, in some instances a medication must be ordered "patient-specific"(see further below).

The drug formulary provides clinicians with a listing of all preferred drugs from each pharmacologic classification, in an effort to manage care in the most cost-effective manner. To fully accomplish this, CFG's Site Medical Directors, in conjunction with CFG's pharmacy provider, must review monthly pharmacy utilization reports, changes in pricing, new product launch materials, drug efficacy and safety claims, and CFG policy on regular bases. On a monthly basis,Site and Corporate Medical Directors receive advisories of drugs that have been reclassified, along with information on alternative medications with similar clinical outcomes are available for substitution. With the increasing number of sole-source medications flooding the marketplace, it is of vital importance that the formulary be consistently reviewed and updated.

Medical Directors must routinely monitor treatment practices of their individual site teams, encouraging the use of medications listed on the formulary.

PATIENT-SPECIFIC DRUG ORDERS

Certain medications included in the formulary must be closely monitored and; therefore, ordered as "patient-specific." In general, these are drugs that have been approved for the formulary, but that are not routinely kept in stock in large quantities for a variety of reasons (for instance, all of the HAART medications used in the treatment of HIV infection are examples of drugs that fall into this group). Each facility's Site Medical Director is responsible for closely monitoring patients taking these drugs. It is incumbent upon the Medical Director to ensure the full compliance of patients taking these medications – regularly evaluating patient use, drug efficacy and patient safety.

All vaccines must be ordered "patient-specific" to avoid maintaining a costly stock supply of vaccines on-site, especially since vaccines kept on-site typically expire before actually being needed.In addition, there are few clinical indications for an immunization to be given immediately, meaning there is little risk associated with waiting for an immunization to be delivered.

Protocol for ordering patient-specific medications can be found in the Forms Appendix at the back of this manual.

NON-FORMULARY DRUGS

Medical Directors must work with their teams to encourage the use of medications listed on the formulary. The use of therapeutic substitutions with comparable drugs should be encouraged when there is no perceived impact to drug efficacy or patient safety. However, as the scope of clinical conditions managed in correctional facilities encompasses a wide and vast array, there will be patients who require specific medications, as ordered, that are not a part of the drug formulary. In these circumstances, protocols concerning the use and request of non-formulary drugs must be strictly adhered to and properly documented, as delineated further below.

The ordering of drugs not listed on the formulary is subject to a review process, with requests sent to the Medical Director for approval. As part of the review process, **the Non-Formulary Medical Request form** must be completed in its entirety by appropriate staff – inclusive of proper verification and justification for use - before being submitted to the Corporate Medical Director/Corporate Director of Psychiatry for review. Corporate Medical Directors, in making the final decision to allow or deny the ordering of a non-formulary drug, must consider a drug's efficacy, safety and appropriateness, as well as the availability of alternative supplies (e.g., - the use of the patient's own prescriptions from home, the availability of drug funding through FQCHs and grants, etc.). In this way, medical staff is able to exercise control over the healthcare program and ensure the delivery of appropriate care, while mitigating costs, when possible.

When presented with patient medications of exorbitant cost or that are on the formulary, but not readily available, the Medical Directors must determine whether the patient can be treated with recommended alternatives/substitutions. Each case must be evaluated independently in consultation with the Corporate Medical Director or the Chief Medical Officer, to ensure patient safety and to determine drug efficacy.

NON-FORMULARY REQUEST FORM

(Please see the Forms Appendix for a sample copy of this document.)

The non-formulary request form should, ideally, be completed by the provider at the time an order is written. This allows for pertinent information, such as "Formulary Medications Used Previously," to be noted on the form.

The provider should make sure the Non-Formulary Medication Request form being completed bears the correct facility name.

Critical to form disposition is the designation of the request as either a **"New Order"** or a **"Pre-Incarceration Order."It is of vital importance that the "Pre-Existing Order Approval" section of each request marked as a "Pre-Incarceration Order" be completed.**Failure to complete this section of the form results in delays in order processing. This information, usually obtained by nursing staff, involves contacting the dispensing pharmacy to confirm the prescription and to determine patient compliance. Other means of confirming medications include direct conversation with the provider who prescribed the medication prior to patient incarceration or inclusion of a printed report, such as a hospital discharge summary or a transfer summary, as received from state institutions/municipalities. The completed Non-Formulary Request form must be endorsed, and both date and time-stamped.

Non-Formulary Medication Request forms marked as a "Pre-Existing Order," but absent of patient compliance confirmation should precipitate a provider's re-evaluation of a patient prior to starting treatment.

Patients found to be non-complaint with pre-existing prescriptions/treatment regimens also need to be re-evaluated prior to restarting treatment to prevent the emergence of issues involving drug tolerance,drug resistance and drugsafety related to lapses in medication.

Non-Formulary Request forms for psychotropic medications must be evaluated by the Chief Medical Officer or this person's designee. The Corporate Medical Director evaluates requests for all other non-formulary medications. Forms approved by the Chief Medical Officer or Corporate Medical Director must be endorsed before being faxed to both the pharmacy and the facility housing the patient.

When a request for non-formulary medication is denied, Corporate Directors may list an alternative order on the bottom of the form before endorsing and returning it to the facility.

Please note, non-formulary medications are always patient-specific.

NON-FORMULARY REQUEST PROCEDURES

1. Medication Verification and Confirmation	Nursing staff is responsible for verifying and confirming a patient's medication(s) with the dispensing pharmacy and/or the prescribing practitioner. The Medication Verification Form must be completed by Nursing staff at the time of intake. All requests for non-formulary drugs require completion of a Non-Formulary Request form, as indicated. **(Both of these forms can be found in the Forms Appendix.)**
2. Documentation of Patient Compliance	Nursing staff is responsible for obtaining a record of patient compliance with drug orders by verifying such with the dispensing pharmacy and the prescribing practitioner.
3. Justification for Use	The Medical Director and prescribing clinician must consider the patient's diagnosis, any contraindications for use, and any risky/compromising behavior demonstrated by the patient (e.g., - active substance abuse).
4. Completion of the Non-Formulary Request Form	Both the Medical Director and Nursing staff are responsible for completing this form accurately and in its entirety, as indicated, EACH TIME a non-formulary drug is ordered.
5. Internal Consultation	As needed, the Medical Director and prescribing clinician should consult available sub-specialists.
6. Other Available Sources	Both the Medical Director and Nursing staff are responsible for researching other available sources for a non-formulary medication – e.g., - Does the patient already have a supply of the drug at home (existing prescriptions)? Was the patient being seen at a FQCH (Federally-Qualified Health Center)? Was the prescribing physician obtaining the medication for the patient through a grant or other similar program?
7. Off-Site Treatment	The Medical Director and facility administration need to determine if the patient can continue to be seen outside the facility by the prescribing physician for continued treatment.
8. Classification Review	The Medical Director and jail administration must determine if a patient is eligible to participate in an at-home incarceration program, is eligible for early release, or is going to be transferred to another facility.
9. Ordering Buprenorphines	Confirm which clinician has the DEA waiver
10. Ordering Naltrexone	A licensed clinician
11. Ordering Methadone	Clinician from the prescribing Methadone clinic

It is the responsibility of all members of the facility management team (the Medical Director, the Director of Nursing, and the Health Services Administrator) to ensure that each of the components listed above are completed for any patient requiringa non-formulary medication.

It is important to note that a Non-Formulary Request form needs to be completed EACH TIME an order is placed. For instance, a patient receiving Factor VIII infusions for the treatment of hemophilia must have a new form completed EACH TIME the prescription is ordered.

The patient chart must reflect consistency and must document all times when a facility team is able to procure medication from alternative sources, such as from the patient's home or through a hospital grant.

Regional Managers must work with facility HSAs to monitor and track patients taking non-formulary medications over time. The common goal for all is ensuring the delivery of care that is both appropriate *and* cost-effective.

NON-FORMULARY APPROVALS

A non-formulary approval is valid for one year or the duration of the current incarceration period, whichever occurs first. Clinicians should write the order to include refills and then new non-formulary requests will not have to be endorsed. Should the patient be discharged and return as a recidivist, a new non-formulary request would need to be endorsed and submitted to the pharmacy.

CONTINUITY OF CARE AND ALTERNATE DRUG FUNDING

In an effort to ensure continuity of care while a patient is incarcerated and beyond release, CFG has begun to partner with community-based Federally Qualified Health Centers (FQHCs) throughout New Jersey. These community-based clinics provide much of the comprehensive healthcare afforded incarcerated Medicaid enrollees outside of the emergency room, including perinatal care and mental health support. Most FQHCs are also involved with 340B drug pricing programs that enable healthcare organizations caring for underserved populations to purchase drugs at discounted prices.

In addition, current corrections policy identifies detainees eligible for house arrest. Patients on Medicaid under house arrest are able to retain their Medicaid benefits (whereas, incarcerated individuals lose all Medicaid benefits with the exception of reimbursement for inpatient hospitalization). As such, CFG works collaboratively with custody staff to identify detainees eligible for house arrest and also works with FQHCs to ensure care is available and accessible for this cohort of offenders.

COST CONTAINMENT

All Medical Directors receive monthly invoice reports for their particular facility that provide cost analysis from a variety of perspectives **(Please see the Forms Appendix at the back of this manual for sample reports)**. Medical Directors are responsible for reviewing these reports on a monthly basis to closely monitor prescription drug use and attendant costs. Goals include finding means to reduce expenditures and discerning any discrepancies and/or areas of concern. Please note, to accurately determine a facility's true total

population, Medical Directors should use the following formula versus merely looking at average daily population (ADP) quotes.

Formula for Calculating Population Census: Inmate Census on Day One of the Month + Total Admissions for the Month = The Total # of Individuals Potentially Served.

In reviewing these reports, Medical Directors should:

1. Check the total charge for the month and compare it to previous months.
2. Check the total costs for non-formulary medications (Medical Directors should be knowledgeable of those patients requiring non-formulary medications).
3. Review the number of patients being treated each month using the formula provided above, NOT the ADP (average daily population).
4. Closely review the column marked "RX's PER I/M" (the # of prescriptions per inmate – the average percentage of inmates on medication is usually 30% – percentages exceeding this number require further investigation).
5. Review charges by category (for instance, one patient on treatment for HCV [hepatitis C] can skew monthly totals for overall cost).
6. Closely review the column marked "CREDITS."
7. Review the report with the Health Services Administrator and the Director of Nursing to address outliers, cost variances, and pending credits.
8. Complete Non-Formulary Tracking reports for all costly medications ordered (see further below).
9. Schedule a monthly Pharmacy Review with clinical staff to review all findings.

Costly Medication Tracking Procedures

Detainees are prescribed a full range of medications, including immune modulators, biogenetically engineered products, and semisynthetic analogs, among others. Many of these medications are sole-sourced by a specific manufacturer and are, therefore, extremely expensive. Access to these medications oftentimes requires an order from an authorized clinician prescriber.

When faced with prescribing costly non-formulary medications, CFG's Medical Directors and clinical staff need to adhere to the following protocol:

1. Confirm the existence of an active prescription order. NOTE: The DON may assist in locating sources for medications supplied by non-traditional pharmacies.
2. Complete a Non-Formulary Request form.
3. Establish all available resources for such medications.
4. Confer with Custody staff to obtain clearance for delivery of such medications to the jail. NOTE: The DON must facilitate and document receipt of such medication by nursing staff, while nursing staff must prepare MAR records and tracking inventory forms, as determined by the DON and the HSA.
5. The HSA must report all information mentioned above to the Correctional Health Administrative Assistant for inclusion in a system-wide, annualized report of all non-formulary costs. This report is given to corporate administration for the purpose of preparing accurate annual budgets.

MEDICATION RECONCILIATION PROCEDURES

All medications prescribed for a detainee during the period of incarceration must be transcribed on the Medication Reconciliation Form (MRF) kept within the medical record (please see the Forms Appendix for a copy of this form). Medications must be documented as ordered by the provider and must also be endorsed by either the Chief Medical Officer (for psychotropic medications) or the Corporate Medical Director (for all other meds). **It is imperative that each adjustment to a medication order be reflected upon the MRF.** Upon a detainee's release, these drugs must be provided to the detainee in quantities as specified by the facility/contract.

MEDICATION RECONCILIATION FORM

This document is a master physician's order form, which identifies those medical and mental health drugs which will be made available to the patient at the time of discharge from the facility. Each drug order will reflect the most current prescription for administration to the patient. As such, medications which are under qualitative or quantitative dose titration should not be included on the form. Over the counter medications will not be included on the reconciliation form. All medications listed on the reconciliation form will be approved by a responsible clinician.

Upon release from the facility, nursing staff will transmit the reconciliation form to the back-up pharmacy for medication pick up by the patient. Patients who receive discharge medications packaged by the primary pharmacy will not receive additional medication via the reconciliation process.

The patient will be instructed at Receiving Screening by nursing on how to obtain medications upon release.

AT THE TIME OF RELEASE

Upon notification of release from a facility, Nursing staff are responsible for faxing the MRF to the designated 24-hour community pharmacy for processing. The designated pharmacy is responsible for filling all orders with the contracted allotment of discharge medications. Substitutions and refills are not permitted. The dispensing pharmacy is required to provide detainees with all packaging and patient education materials, along with the medications given.

Upon release, detainees have forty-eight (48) hours from the time an order is faxed to retrieve meds from the dispensing pharmacy before the order will expire. Detainees are informed of medication reconciliation procedures during Receiving Screening. No monetary fees are assessed detainees for medications dispensed at the time of release.

Recidivist detainees on medication who return to the facility must be reprocessed as outlined herein.

INITIAL HEALTH ASSESSMENT (HISTORICAL FINDINGS)

REVIEW OF RECEIVING SCREENING DOCUMENTATION

Initiation of the Initial Health Assessment begins with thorough clinician review of Receiving Screening documents completed by nursing staff during Intake. Clinicians must make note of all reported health

conditions – both medical and mental – as well as all medications prescribed, past hospitalizations, documentation of concurrent chronic diseaseand reports of substance abuse (including tobacco).

HIGHLIGHTS OF IN-DEPTH INQUIRY INTO PATIENT MEDICAL HISTORY

Clinicians are expected to make further inquiry regarding the following issues and conditions:

- **Recent Injuries(with emergency room clearance)** – For any recent injuries, the clinician must ask about any diagnostic tests completed – including laboratory testing, x-rays and scans/imaging. Based on findings, the clinician must determine whether any follow-up intervention is necessary.
- **Substance Abuse History**– The clinician must challenge and delve deeper into information provided, probing the patient for additional detail. For instance:
    - As pharmacologic accommodation often occurs with chronic opioid use, the clinician must inquire about additional substances a patient might use in order to sustain the desired euphoric effects. With further questioning, chronic opioid users will often admit to taking oral benzodiazepines (known as "blues," "rods," "sticks," or "street Xanax"), too.
    - Patients who report only drinking occasionally should be questioned regarding the time of day the patient "occasionally" drinks, the type of alcohol consumed, and the quantity.
    - Clinicians should also ask detainees if they understand what "withdrawal" means or looks like. It is often only when using this line of questioning that a patient might report having had seizures or black-outs in the past, experiencing tremors, or relating that theydrink continuously in an effort to forestall the onset of these symptoms.
    - Are detainees enrolled in substance abuse treatment programs and are these Medication Assisted Therapy facilities.
- **Tobacco Use** – As numerous health conditions are negatively impacted by the use of tobacco and nicotine products – especially cigarette smoking – clinicians must document patient use in terms of the amount of product used daily/weekly over xx number of years –for instance: "Mr. Smith reports smoking one pack of cigarettes per day for the past 17 years" or "Mr. Jones reports smoking E-cigarettes approximately 12 times per day for the past year and a half" or "Mr. Johnson reports using a can of dipping tobacco per day for the past five years".
- Inquiry into all prior **Surgeries and Hospitalizations**noted
- **Review of Systems and Chronic Diseases** –
    - **Asthma** – The clinician must remember that wheezing may be caused by a number of different conditions – not just asthma.Inquiry should be made regarding any asthma-induced ER visits, type of medication(s) taken, frequency of use, environmental triggers (e.g. – exercise, cold weather, dust, pet dander), history of cigarette smoking, and the inhalation of abused substances (such as marijuana and heroin). This information, coupled with physical exam findings, serve to confirm diagnosis, determine condition classification (mild, moderate, moderately severe or severe), and inform treatment planning **(please see "Asthma" under"Initial Health Assessment of Chronic Conditions" and also the section labeled "Asthma" under "Pulmonary" for additional information).**

- **Depression and Anxiety** – The clinician will need to record any patient report of depression or anxiety in the progress notes, along with any evidence of on-going follow-up for such within the community, and<u>issue a referral to Mental Health</u>.
  NOTE: Official mental health diagnoses, as reported in the Master Problem List, can only be entered by Mental Health professionals.
  Detainees reporting use of medications associated with the treatment of mental health disorders must be referred to Mental Health for further evaluation and appropriate management. Of particular note are detainees requesting or reporting use of medications such as Sinequan (doxepin), Seroquel (quetiapine) or Neurontin (gabapentin), as these medications have a strong potential for abuse among detainees.
- **Diabetes** – Upon completion of the examination, the clinician will need to classify the condition on the Problem List as Type 1 or Type 2, insulin dependent. The clinician will also need to target specific "end-organs" to determine the extent of involvement. These "end-organs" include the eyes, heart, kidneys, peripheral nerves, reproductive system, integumentary system, and musculoskeletal system. The clinician must also ascertain the detainee's understanding of the disease in terms of compliance with diet, exercise and medication regimens. Questions posed during the taking of the patient's medical history in reference to these issues will inform the care plan.
- **Hypertension** – Clinicians should make further inquiry regarding current and prior cigarette smoking, family history, prior hospitalizations and concurrent chronic conditions. In conjunction with examination, inclusive of assessment of "end-organs" (eyes, heart and kidneys), the clinician can use historical information reviewed to classify the condition as essential or secondary on the Master Problem List.
- **Seizures** - The clinician will need to ask several questions to ascertain if a patient was placed on anti-seizure medication secondary to withdrawal or in response to an early diagnosis of epilepsy. As part of medical history, the clinician must find out the name of the prescriber, the frequency of follow-up visits, and what diagnostic testing has been conducted. This information, coupled with examination findings, will determine classification of the condition on the Master Problem List asepilepsy, related to substance abuse or secondary to trauma.
- **Sexually Transmitted Diseases (STDs (**– Clinicians must obtain a sexual history from each detainee, prior to visual examination, asking about and recording a wide range of clinical information that includes:
  - Patient report of STDs (both past and present - note severity and chronicity)
  - Known infections of sexual partners
  - The number of sexual partners
  - Instances of unprotected intercourse
  - Presence of genital discharge - note odor, color, consistency and the presence or absence of pain or blood
  - Information regarding menses (abnormal pain, change in flow)
  - Past and present episodes of pediculosis pubis

- Presence of lesions, sores or growths
- Suspected or previously diagnosed hernias
- Hydrocele testis (fluid accumulation around the testicles)
- Cystocele (bladder herniation into the vagina in women; bladder prolapse in men)
- Genital injury/trauma (past and present)
- Phimosis (inability of the foreskin or clitoral hood to fully retract)
- Past treatment (ask what treatment was recommended and whether it was provided by a clinician, in a clinic, in an ER, using over-the-counter medications or using medications given to the patient by a friend or acquaintance)
- Presence or absence of ornamental hardware (note patient reports of pain and/or discharge at piercing sites and any patient reports of restricted urine flow)

Clinicians must question detainees in a professional, non-threatening and non-judgmental manner. Detainees should be made to understand that some findings might require referral to a sub-specialist for definitive diagnosis and treatment. The thoroughness of the clinician's questions can serve todecrease patient embarrassment and stress associated with subsequent visual examination of the genitalia.

NOTE: Clinicians who are unable to perform visual inspection of a detainee's genitalia must inform the Medical Director prior to housing assignment. Clinicians must also mark patient progress notes with either of these two notations:

- **Genital Examination Deferred** – examination to be conducted at a different location or by a different physician within fourteen (14) days
- **Genital Examination Refused** – examination was declined by the patient

- **Chest Pain and Cardiac Disease** – Clinicians often hear patient reports of chest pain.Non-cardiac chest pain (e.g. - chest pains associated with respiration or chest wall tenderness upon palpation) may often be determined via the taking of a thorough patient history. As part of questioning, clinicians must identify an individual's**Cardiac Risk Factors(see the section marked Cardiovascular for a breakdown of these factors)**and must also ask the following questions:
  - Does the patient now or has the patient ever smoked? If so, how often and for how long?
  - Does the patient have a history positive for diabetes or hypertension?
  - Does the detainee note lipid abnormalities, such as hypercholesterolemia?
  - Has the detainee ever had an electrocardiogram performed?
  - Has the detainee ever been given nitroglycerin sublingually?
  - Has the detainee been told to monitor his/her diet or to restrict sodium intake?
  - Has the patient ever been diagnosed with a heart murmur?
  - Does chest pain resolve with over-the-counter medication?
  - Is there a history of substance abuse? Were any of the drugs used taken intravenously?
  - Has the patient ever been hospitalized for chest pain?
  - Has the patient ever been treated for endocarditis?
  - Was the patient compliant with treatment regimens?

- **Renal Disease** – As clinical history aids greatly in determining the care plan, the clinician should ascertain the following:
  - Is the patient on dialysis? If yes, note the history of treatment compliance(**NOTE: dialysis patients presenting with complaints of respiratory insufficiency, pleuritic chest pains and non-descript illness should be transferred to a hospital immediately for dialysis treatment).**
  - Evidence of concomitant substance abuse
  - Existence of any co-morbid conditions and/or chronic infections
  - Vascular competency
  - Medications taken

REVIEW HEALTH ASSESSMENT (PHYSICAL EXAMINATION FINDINGS)

VISUAL INSPECTION

Inspect the patient with every contact/visit. Observe the skin to see if it is dry and/or flaky or if there are blisters or wounds with drainage. Look at the patient's face and eyes. Are the conjunctivas moist? Is there a discharge? Are the pupils sunken? Is there exophthalmos (bulging of the eye)? Are the sclera pale? Is the patient's hair dry or brittle? During the oral exam (which can even be done during an interview) do you notice a dry, whitish film on the tongue (leukoplakia)? Do the gums appear healthy and luminous?Does the patient hold his/her head erect while seated? Is there a visible goiter? Is the trachea along the midline? Is chest wall splinting noted upon respiration? Are there ecchymotic lesions to the trunk? Is the abdomen protuberant? Areperiumbilical venous dilatation or blanching spider hemorrhages detected? Are the genitalia intact? Have the testicles descended? Are hydroceles, hernias, lesions or visible signs of apediculosis pubis infestation noted? Is there asymmetry or aberrancy to the patient's gait or to the musculoskeletal system? In addition to physical characteristics, note the patient's demeanor – is he or she tense, anxious, unfocused, drowsy, obtunded, stressed, relaxed?

PHYSICAL EXAMINATION

A basic physical examination should be performed for all newly arriving detainees, even those who lack a significant clinical history and who appear without injury upon visual inspection.

The clinician must maintain a professional demeanor throughout the entire examination process. Prior to beginning the physical exam, the clinician must inform the detainee of the examination's scope and purpose. The detainee must understand that the examination is done to identify any health conditions requiring immediate attention, intervention and treatment. The detainee must understand that clinical staff will address urgent and/or emergent conditions, while assessing the status of chronic diseases. However, elective and or cosmetic interventions requested by the detainee will not be addressed. Finally, the clinician must seek approval from the detainee to begin the physical examination before actually doing so.Detainees that refuse the physical examination may be isolated/segregated according to facility policy and procedures.

Vital Signs

Obtaining vital signs is fundamental for acquiring critical diagnostic information. Clinicians should assess not just the values themselves, but the character of the vitals. For instance, is the pulse weak or thready versus

bounding and strong? Is there an orthostatic change in blood pressure? Is jugular venous distension noted or are neck veins absent? Are there peripheral pulses? Is the skin warm, cool, dry, ashen, scaly ...? Are skin changes chronic (stasis dermatitis)?

During the examination, the clinician should note the following (those detainees with chronic conditions may require additional screening and/or evaluations during the initial health assessment):

- CRANIUM –Note symmetry, lesions, visible vascularization, hair texture, signs of pediculosis.
- EYE –Using a penlight, observe the sclera and conjunctiva. Evaluate the third cranial nerve (the oculomotor nerve), the fourth cranial nerve (the trochlear nerve) and the sixth cranial nerve (the abducens nerve). While performing an assessment of the eyes,evaluate the size and shape of the pupils (are they equal and round?), the pupils' reaction to light, and their ability to accommodate. If all findings are normal, use the acronym "PERRLA"to indicate such in the medical record.
- NECK – Note range of motion, ease of motion (supple, spastic), jugular venous distention, goiters, a palpable thyroid, bruits, and adenopathy.
- CHEST – Note symmetry, splinting, retraction, flailing. Upon auscultation, assess for wheezes, rales and rhonchi.
- CARDIAC – Palpate for a cardiac "lift" or "thrill." Upon auscultation, assess for heart sounds (S1, S2 with +/- S3 or S4) and hemodynamic sounds or murmurs.
- ABDOMEN– Note abdominal girth. Provide additional commentary regarding a protuberant abdomen (Is the protuberance associated with shifting dullness and a fluid wave [ascites] or a ridged, firm abdomen with bounding percussive sounds and/or rebound pain?). Feel for palpable masses and auscultate for bowel sounds in at least four quarters of the abdomen.
- GENITALIA – **NOTE: This examination is done by initially asking the detainee about specific problems or conditions. Male detainees should be asked if they are circumcised, have any lesions or discharges. Female detainees must be asked about lesions or discharges. Female detainees must have a comprehensive birth history, including the number of times pregnant, the number of children, any miscarriages or abortions. If the interview identifies problems warranting examination, the clinician must organize the examination in the presence of a chaperone. This part of the physical examination entails visual inspection of the patient's genitalia under conditions that must ensure the patient's personal privacy. Before initiation of this portion of the exam,patients must be advised of the scope and intent of the examination. The detainee's permission must be obtained again in order to continue. Should the detainee decline this portion of the examination, the clinician must ascertain the patient's rationale for doing so. If this portion of the examination is NOT performed, the Medical Director must be immediately located and the clinician must notate the medical record using one of the following delineations:**
  - **DEFFERRED** – Note "deferred" in the genitalia examination results field for those detainees requesting a same sex clinician or whenever the location where the physical is being performed is not conducive to ensuring a patient's privacy. The clinician must make a notation in the progress note offering justification for the deferment and must also issue an order toreschedulethis portion of the initial health evaluation within mandated timeframes.

- **REFUSED**– Note "refused" in the genitalia examination results field for those detainees who decline visual examination of the genitalia for any other reason.
  Examination of patient genitalia must include comment on the observation ofphimosis, lesions, hydrocele, cystocele, hernia, sores, discharge andpediculosis.

All visual and physical examinations of urogenitalia must be with an appropriate chaperone. It is recommended that all female detainees at facilities with on-site Gynecology staff be referred at intake for a comprehensive examination, as indicated by age and comorbidity.

- MUSCULOSKELETAL – Witness the patient's gait. Does the patient limp? Can the patient ambulate without assistance? Is there symmetry or is there evidence of muscle wasting? Does the patient have a prosthetic or use support braces? Observe the patient's musculature and report on anyfasciculation observed.
- PULSES –Note the absence or presence of peripheral pulses.

Detainees who present with signs or symptoms of active infection or infestation must have the issue(s) addressed expeditiously and in a manner that provides personal treatment, while ensuring environmental containment. The clinician must contact the Charge Nurse to retrieve any specimens collected, to put the patient in isolation and to initiate treatment. The setting of the initial health evaluation and the number of detainees to be seen will influence management strategy.

Dehydration

Though specific findings are stressed in each diagnostic section of this manual, in relation to dehydration, physicians should look for dependent bruises (indicative of early muscle injury) in patients presenting with acute intoxication that are unable to provide a reliable history. In patients with clubbing of the nails and a quiet auscultatory examination, clinicians should consider the possibility of pulmonary disease underlying dehydration.

Tests Associated with Dehydration

Clinicians are responsible for ordering and interpreting any testing deemed necessary following examination; however, **at a minimum, the following tests should be done when a patient is dehydrated:**

- Urinalysis – check:
  - Osmolality
  - Glucose levels
  - The presence of ketones (indicative of starvation)
  - The presence of lactic acid (indicative of hypoperfusion)
  - The presence of sediment (granular casts)
- Electrolytes – BUN: creatinine ratio in dehydration > 20:1.
- Is there an increase in the anion gap?

Treatment Initiation for Dehydration

The underlying state of hydration is a fundamental aspect of basic care. As such, the treatment interventions initiated by clinical staff must take into accountfactors that contribute to dehydration, such as hyperglycemia, hyperthermia, hemorrhage, tachypnea and trauma.Nursing staff members who assess new detainees for signs and symptoms of substance abuse must consider the multiple causes of volume contraction and begin immediate replacement therapy as an initial treatment intervention **(please see the subsection of "Substance Abuse Withdrawal" entitled "Treatment Protocols for Withdrawing Inmates with Elevated Blood Pressure" for additional information).**

The Hydration Therapy Table on the following pageserves as a model for clinicians to follow.

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS (1 liter = 33.81 oz. or 1000 cc/mL)	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

IV Fluids – Normal saline (0.9 NS) will treat shock, but physicians should note that the use of normal saline will push a fragile patient with underlying cardiac deficiency into congestive heart failure. Physicians must make careful considerations regarding when to use normal saline versus half-normal saline (0.45 NS). Remember to give the vitamins thiamine, folate and magnesium orally as hydration progresses and the patient begins to take in nutrition.

Oral Hydration – Electrolyte replacement fluids are available at CFG contracted-facilities. These fluids may be used, but should be balanced with water. Clinicians should consider the glucose content of electrolyte replacement fluids and remember to order thiamine, folate and magnesium, dosing at the earliest opportunity. **See the Physicians' Orders and Withdrawal Monitoring Form in the Forms Section of this Manual.**

MANAGEMENT OF GENDER NON-CONFORMING DETAINEES

This section has been created to inform and assist health professionals in caring for gender non-conforming detaineeswithin the correctional environment. Gender non-conformingindividuals may not identify with or present as the gender assigned to them at birth, though the extent to which a person's gender identity, role or

expression differs from cultural norms associated with a particular sex can represent a broad range of phenotypes.

Stigma associated with gender non-conformity can often lead to targeted prejudice and discrimination, giving rise to the potential for mental health problems, such as anxiety and depression, in transgender individuals. Gender dysphoria (discomfort or distress caused by a discrepancy between the gender a person self-identifies with and that person's sex as assigned at birth) can, in large part, be alleviated through treatment – both mental and medical (via medication and/or surgery); however, care plans must be individualized to meet each patient's express clinical needs.

To protect the right to privacy afforded all patients and to uphold the inviolability of the doctor-patient relationship, health providers must ensure care is rendered in a private and confidential area. Clinicians must also maintain a professional demeanor, withholding personal judgment.

CONSENT TO TREAT

The New Jersey Department of Education directs licensed prescribing clinicians caring for transgender patients already on exogenous hormone regimens at the time of presentation to maintain hormone treatment therapy. Exogenous hormonal therapy, given in pharmacologic dosages sufficient to blunt the effects of intrinsic gonadal production, is used to alter a person's external appearance. Estrogens given to males lead to changes in the hair line, reduction in laryngeal prominence, changes to the timber of the voice, development of pendulous mammary glands, widening of the hips, and softening of the skin. Likewise, exogenous testosterone given to females may alter the hair line and cause an increase in facial and body hair, changes in body hair distribution, changes to the voice, and cessation of the menstrual cycle. These phenotypic changes may sometimes be associated with dysplasia of the gonads in both sexes, manifesting as breakthrough menses, hemangiomas of the liver, and malignancies of the male and female reproductive tracts.In addition to increased incidence of hemangiomas, pharmacologic ingestion of estrogens in males can lead to other vascular malformations. Dysplastic changes to the morphology of the epithelial cells of the cervix and other tissues, resulting in abnormal PAP smears, may be noted in females taking testosterone.

The Consent Form for Hormone Therapy **(please see the Forms Appendix)** must be reviewed in detail with patients requesting continuation of exogenous hormone therapy. Review of this form should be conducted by nursing staff during Receiving Screening. Upon completion of the Consent Form for Hormone Therapy, Nursing staff must complete the Medication Verification process **(see Management of Pharmaceuticals for further detail)**.

ALTERNATIVE PHARMACEUTICAL SUPPLY SOURCES

Detainees undergoing gender reassignment often acquire hormones from non-traditional sources, such as internet drug store mail order suppliers, or illicitly within the community. In these circumstances, the prescribed medication verification process cannot be completed bynursing staff.As such, the clinician performing the Initial Health Assessment must make a determination as to whether exogenous hormone therapy will be continued. This decision must be based upon:

- Patient reported history of treatment and the duration of therapy
- Phenotypic presentation of the patient

- Documented history of prior mental and medical intervention

Detainees exhibiting outward signs of prolonged exogenous hormone therapy, such as males with pendulous breast tissue or females with facial hair and deep voices, will be prescribed hormone replacement as reported during intake.

Detainees lacking visible changes to appearance, but for whom pre-incarceration treatment plans can be confirmed with either a treatment center or valid provider will also be maintained on hormone therapy.

Treatment will **not** be continued or initiated for detainees lacking phenotypic changes and for who no consistent or credible past history of treatment can be confirmed.

Mental Health Evaluation

Gender dysphoric patients with active care plans require on-going support from mental health specialists. Throughout the process of gender reassignment, counseling should parallel the stages of transition. All detainees requesting exogenous hormone therapy will be referred to Mental Health for an initial evaluation and care plan, as needed. In addition, special needs treatment plans must be developed that encompass input from Mental Health, medical consultants, and the on-site healthcare team.

Patients who have undergone gender reassignment surgery prior to incarceration may need to continue to be seen for follow-up by surgical and mental health specialists outside the correctional facility. Post-op patients may also require support pertaining to prosthetic devices.

Special Garments, Prosthetic Devices and Housing

Sports bras will be provided to detainees, as needed and approved.

The Medical Director must confer with the surgeon or specialist of record regarding any prescriptions for post-op prosthetic devices. The Medical Team will then develop a plan of care considerate of prescribed usage, security issues and the cleaning of said prosthetics. At case conferences and patient safety meetings (as allowed under NCCHC standard J-B-08) convened with the Warden, key designees and the Medical and Mental Health teams, management protocols will be reviewed and submitted for approval, as will recommendations regarding appropriate housing and patient access to prosthetic devices. In consideration of therapy plans, health staff must seek to identify the most appropriate setting for detainee use of approved devices, ensuring patient privacy, while meeting all custody directives pertaining to safety issues and contraband.

Special Needs housing may be recommended as part of a care plan; however, gender non-conformingdetainees should have access to the general population (in order to partake of recreation services, use telephones andtelevisions, and enjoy outside visits).

Annual Health Evaluations

It should be noted that females transitioning to males (FTMs)who are on testosterone therapy will still need to undergo regular gynecologic examinations and PAP smears. These detainees must also be advised to promptly report any instances of excessive pelvic cramping or pain and any abnormal menses or bleeding to clinical staff. Likewise, males on estrogen therapy must be told to report any instances of urogenital pain or changes in the stream of urine to the clinician (changes in the urine stream may be related to prostatic hyperplasia). In

addition, the testicles of males transitioning to females (MTFs) must be monitored for any growths or deformities. Detainees on exogenous hormone replacement therapy – both those who have and those who have not undergone gender reassignment surgery – may require additional monitoring by sub-specialists.

SMOKING CESSATION PROGRAM

Cigarette smoking is the most common type of nicotine addiction. During incarceration, inmates are forced to undergo abrupt nicotine withdrawal. All clinical staffmembers are required to provide ***firm*** and ***focused*** counseling for inmates, inclusive of the benefits to be gained with smoking cessation, outlined below.

Smoking cessation leads to:

- A reduction in the progression of coronary artery disease within one (1) year
- A reduction in hypertension levels
- A reduction in myocardial infarction rates
- A reduction in symptomatology related to peripheral vascular disease
- A reduction in cardiovascular complications in those persons with underlying diabetes
- A reduction in cases of COPD and improved pulmonary function in those persons with reversible airways disease
- A reduction in the risk of thromboembolic events related to hormone replacement therapy
- A reduction in perinatal morbidity and mortality
- A reduction in rates of macular degeneration and the new onset of cataracts

Medications are not routinely prescribed as part of a smoking cessation program;however, medical staff will assist those inmates interested in smoking cessation via patient education, behavioral modification techniques, and if needed, non-prescription nicotine suppression lozenges.

Medical staff shall **NOT** prescribe:

- Polacrilex gum
- Nicotrol inhalers
- Varenicline (Chantix) (Chantix has been associated with increased risk of depression, suicidal ideation and suicide attempts)

Literature on smoking cessation is available in all medical clinics as part of nursing and medical education.

INITIAL HEALTH ASSESSMENT OF CHRONIC CONDITIONS

Patients with specific long-term healthcare conditions must be identified and enrolled in a chronic disease management clinic. Employing the healthcare models implemented in community-based ambulatory clinics in New Jersey, the CFG healthcare team will develop interdisciplinary physician, mid-level and nursing care teams for each subspecialty. Key subspecialty clinics are addressed individually farther below and include:

- Asthma
- Cardiovascular Disorders
- Diabetes
- Dyslipidemias, Hyperlipidemias
- HIV/AIDS
- Hypertension
- Seizure Disorders (including relation to Withdrawal Syndrome)
- Major Mental Illness

The patient will be identified as "Chronic Care" in the progress notes. Nursing staff will maintain concurrent Chronic Care Rosters for patients at each facility. The Problem List is to be used to identify the Chronic Care condition(s). The Medical Director will establish the frequency of medical follow-up based on clinical and laboratory information available at the time of enrollment. Patients requiring special housing accommodations will be identified to custody staff. Nursing staff are to provide pertinent educational materials for the patients.

ASTHMA

(Also, please see the section devoted to Asthma under Pulmonary)

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - History of asthma diagnosis
    - Last emergency room visit for the treatment of asthma
    - Last hospitalization for the treatment of asthma
    - Current medications for the treatment of asthma and frequency of use
    - Current primary medical provider for the treatment of asthma
    - Presence or absence of auscultatory findings, such as wheezes, rhonchi, etc.
    - History of smoking
    - History of inhaled substance abuse and its relationship to asthmatic exacerbation
    - Environmental triggers (e.g. – exercise, cold weather, dust, pet dander, etc.)
2. The Problem List must be completed and the diagnosis of asthma must be characterized as Mild, Moderate, Moderately Severe or Severe (see Asthma section).
3. The written clinician's orders are to include:
    - Enrollment in chronic care
    - Smoking cessation education
    - Documentation of peak flow at baseline and at every nursing sick-call visit for assessment of respiratory problems

- Documentation of pulse oximeter at baseline and at every nursing sick-call visit for assessment of respiratory problems
- The RN is to auscultate the lungs and make notation in the medical record prior to each nebulizer treatment.

4. Asthmatic patients are offered the annual influenza vaccine.

CARDIOVASCULAR DISORDERS

(Also, please see the Cardiovascular section under System Disorders and Specific Conditions)

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - Review of medical history, including primary care
   - Jugular venous distension
   - Neck bruits
   - Lung field
   - Auscultation for gallops, murmurs
   - Akinesis
   - Mitral valve prolapse
   - Abdominal bruits
   - Hepatojugular reflux
   - Dependent edema
   - Pulse
   - Concurrently occurring conditions (i.e., - diabetes, kidney disease, etc.)
   - Electrocardiogram (ECG/EKG)
   - Echocardiogram with ejection fraction (EF)

2. The Problem List must be completed with the diagnosis, cardiac risk factors and functional level documented.
3. The written clinician's orders are to include:
   - Nursing Care Plan
   - Diagnostic testing
   - Sub-specialty support and cardiac work-up
   - Level of monitoring required through:
     - Chronic Care
     - Infirmary Care
   - Identification of treatment goals
   - Initiation of smoking cessation program (as necessary)
4. The information obtained in items 1 - 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

DIABETES

(Also, please see the section devoted to Diabetes under Endocrinology)

Clinicians will determine at the Initial Health Assessment whether the patient is insulin deficient (Type 1) or insulin resistant (Type 2). Patients thought to have Metabolic Syndrome (Syndrome X) will be noted.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Level of control of diabetes
    - Past hospitalizations or emergency room evaluations for diabetes management
    - Methods of home monitoring of blood sugar levels and home treatment regimens
    - Discussion with the current primary medical provider regarding management of the patient's diabetes
    - Last electrocardiogram
    - Last chest x-ray
    - Last eye examination (Optometry or Ophthalmology) - NOTE: The Snellen Eye Test is performed by nursing staff
    - Knowledge of comorbid conditions, such as hyperlipidemia, hypertension, gout
    - Physical examination of critical "end-organs" with notation of pertinent negative findings (for example - "No neovascularizations seen on funduscopic exam"):
        - Eye
        - Lungs (check for rales, rhonchi, wheezes)
        - Cardiac (check for gallops or murmurs)
        - Abdominal bruits
        - Renal (BUN, creatinine, urine microalbuminuria [dipstick], urinalysis [dipstick])
        - Pulses
        - Peripheral nerves
        - Integumentary system (check for stasis dermatitis, hair loss, dependent edema)
        - Reproductive system
        - Musculoskeletal system
2. The Problem List must be completed with Insulin deficiency (Type 1), Insulin resistance (Type 2) or Metabolic Syndrome noted.
3. The initial written clinician's orders should include:
    - Enrollment in Chronic Care Clinic
    - Smoking cessation education
    - ADA diet – specifying daily caloric intake
    - Sodium restrictions for Insulin resistant and Metabolic Syndrome patients
    - Urinalysis/Urine dipstick testing for ketones, leucocyte esterase, RBCs, sediment
    - Assessment of urine chemistry, osmolality and specific gravity
    - Daily FBS (fasting blood sugar) and pre-prandial blood glucose determinations for insulin deficient (Type 1) patients
    - Determination of glycosylated hemoglobin (HbA1c) at intake to determine the level of control needed and the frequency of clinic visits
    - Baseline weight

- Baseline abdominal girth (should be <40inches for males and <35inches for females – abdominal girth greater than the numbers indicated is indicative of Metabolic Syndrome)**NOTE:** This test may be deferred until the initial chronic care visit
- Urinalysis for microalbuminuria
- Microfilament testing of the feet - NOTE: This test may be deferred until the initial chronic care visit
- Baseline Snellen Test

4. Clinicians are to make notation of identified Cardiac Risk Factors
5. The information obtained in items 1 - 4 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

   NOTE: Diabetic patients found to have significant microalbuminuria are at increased risk for cardiovascular sequelae and vascular compromise. Early introduction of angiotensin converting enzyme inhibitor therapy [ACE] or Angiotensin receptor blockers [ARB] for those with intolerance will clinically slow the progression and delay the onset of vascular compromise.

DYSLIPIDEMIA, HYPERLIPIDEMIA

(Also, please see the section of this manual entitled Hypercholesterolemia)

The clinician must determine if the lipid dyscrasia is part of a clinical syndrome (i.e., - Metabolic Syndrome characterized by diabetes, hypertension, lipid dyscrasia, truncal obesity) or is a finding associated with a particular illness (such as Hypertriglyceridemia in diabetic ketoacidosis [DKA]). In the latter circumstance the treatment is targeted at correcting the DKA.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - Past medical history pertaining to dyslipidemia or hyperlipidemia
   - Where was the diagnosis made?....pre-admission, ER visit, emergency response in the jail?
   - Did the patient fast prior to having a blood sample taken?
   - Are there any comorbid conditions, such as diabetes, renal disease, cardiac disease?
   - Who is the primary care clinician?
   - Look for signs of lipid overload, such as xanthomas
   - Is the cardiac examination within normal limits – are there gallops, murmurs, etc., present?
2. The Problem List must be completed to include hyperlipidemia and/or other information, as provided.
3. The written clinician's orders should include:
   - A request for old records
   - Pharmacy verification of medications
   - Fasting lipid profile specimen. NOTE: Call the laboratory for special handling requirements.
   - Dietary recommendations (the ADA [American Diabetic Association] diet is most appropriate)
   - ECG/EKG (electrocardiogram)
4. Clinician must make note of identified **Cardiac Risk Factors**.
5. The information obtained in items 1 – 4 above will be reviewed by the clinician and be used to support the development of a patient-specific treatment plan.

HIV/AIDS

(Also, please see HIV/AIDS under the Infectious Diseases section of this manual)

Additional information is provided in the Infection Control Manual regarding the management of HIV.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Requests for old records
    - Identification of primary medical provider for treatment of HIV
    - Pharmacy verification of medications
    - Information on current laboratory values from the clinic, physician or order including:
        - CD4
        - viral load
        - CBC with differential
        - CMP (comprehensive metabolic panel)
        - urinalysis
2. The Problem List must be completed and include HIV, AIDS
3. The initial written clinician orders should include:
    - Enroll in chronic care clinic – Infectious Diseases
    - Requests for existing laboratory and testing data
    - Orders for CD4 and viral load titers to be drawn after Week Three, with results available for the initial chronic care visit after 30 days (unless recent counts have already been provided)
    - Primary prevention review for current immunizations, including:
        - Influenza vaccine
        - Pneumovax (should be within eight[8] yrs.)
        - Hepatitis immunity (A and B), plus screening for HCV+
        - PPD
        - Females with +STDs will have HPV testing completed through community health clinics
    - Referral to gynecology for PAP smear (females)
    - Medication verification report – **NOTE**: Patients compliant with pre-incarceration medication regimens inclusive of HAART will have all associated drugs initiated upon admission
    - Dietary orders, including the ordering of supplementation for asthenic and cachectic patients
4. The information obtained in items 1 –3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

HIV EVALUATIONS IN FEMALES

- Annual PAP smear evaluations is not recommended for general female population.
- Annual PAP smear evaluations are recommended for HIV+ patients.

HYPERTENSION

(Also, please see the section devoted to Hypertension)

During the Initial Health Assessment, the clinician must determine whether the hypertension is acute or chronic; essential or secondary; controlled, uncontrolled, accelerated or malignant. Patients who present with acute or new onset hypertension must be assessed for signs or symptoms of volume contraction.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Contact information for the patient's primary medical provider
    - Clinical events related to hypertension, including emergency room visits and prior hospitalizations
    - History of tobacco use
    - Family history
    - Concurrent chronic conditions
    - The physical examination must document all pertinent negative findings (such as: "no jugular venous distention," "no rales or rhonchi," "no cardiac heaves, gallops or murmurs," "no abdominal bruits," "no dependent edema," etc.)
    - Critical "end-organs" need to be assessed to determine the extent of damage to the:
        - Eyes (funduscopic assessment)
        - Heart
        - Kidneys
    - The results of diagnostic testing completed in the past, including:
        - CXR
        - ECG/EKG
        - echocardiogram
        - urinalysis
        - stress test
    - Review of all current and prior medications
2. The Problem List must be completed and must characterize the type of hypertension:
    - Essential – must indicate controlled, uncontrolled, benign, accelerated or malignant (See the Hypertension Section of this manual)
    - Secondary (causes include anxiety and dehydration, which should be "resolved")
    - **Comorbid conditions and cardiac risk factors must be delineated**.
3. The initial written clinician orders should include:
    - A written diet order (recommendation for a low sodium diet is most common)
    - CMP (comprehensive metabolic panel) must be obtained and should include:
        - BUN
        - creatinine
        - urinalysis
        - glucose
        - calcium

- An ECG must be obtained within two(2) weeks of the inmate's arrival, sooner if there are cardiac complaints or a cardiac history
- A chest x-ray should be obtained within thirty(30) days for patients with ECG evidence of ventricular hypertrophy or for those with rales, gallops, murmurs or dependent edema
- Smoking cessation education (if applicable)
- Enrollment in Chronic Care Clinic

4. The information obtained in items 1 – 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

SEIZURE DISORDER

(Also, please see Seizures located under the Neurology section of this manual)

Review of clinical practice outcomes over several years has provided justification and support for early classification of reported seizures among inmates. The clinician must determine if the seizures are associated with substance abuse/substance withdrawal. Seizures occurring after significant head trauma represent a different cohort. Patients with new onset, unprovoked seizure activity represent a clinical emergency and must be sent for immediate CT scan or MRI.Patients with a history of epilepsy or an underlying seizure disorder of several years' duration represent yet another cohort.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - History of seizures, nature of seizures and last hospitalization for seizures
   - Possible relationship between substance abuse withdrawal and onset of seizures
   - Emergency room management of seizures (especially as related to substance abuse)
   - Age at onset
   - History of significant head trauma
   - Comorbid conditions, such as diabetes, ischemic heart disease, chronic renal failure
   - Documentation of all medications (especially insulin, levothyroxine, Keppra, and phenobarbital and other anti-seizure medications)
   - HIV/AIDS status
   - Malignancies
   - Clinician will note pertinent negatives on examination including: "no carotid bruits," "no cardiac ectopy, gallops, murmurs"
2. The Problem List must be completed and must characterize the seizure type as one of the following:
   - Related to substance abuse withdrawal
   - Epilepsy
   - Secondary to trauma
   - New onset
3. Clinician's written orders should include:
   - Review of old records
   - Seizure precautions
   - CMP, CBC with differential, urinalysis
   - ECG

- CXR

4. The information obtained in items 1 – 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

MAJOR MENTAL ILLNESS

The nursing staff will make referrals for all patients diagnosed with mental illness at the time of Receiving Screening (NCCHC standard E-02). The clinicians must review mental health assessments, when available, during the Initial Health Assessment (NCCHC standard E-04), and amend treatment plans accordingly.

The clinician will evaluate all substance abuse withdrawal patients during the Initial Health Assessment for associated Axis I and Axis II diagnoses. These **M**entally-**I**ll **C**hemically **A**ddicted (**MICA**) patients must be carefully monitored throughout the periods of withdrawal and adjustment to living within a correctional facility. Special procedures for caring for these patients are delineated under the Substance Abuse Withdrawal section of this manual.

LABORATORY STUDIES AND DIAGNOSTIC TESTING

Laboratory forms are available to practitioners. Diagnostic profiles (groupings of laboratory tests) afford the clinician needed information in the most cost-effective manner. The Medical Director will collaborate with practitioners to ensure that only appropriate tests are ordered. **NOTE**: Single tests usually require special assays and are generally more costly.

ASSESSMENTS

- **Lifestyle modifications (see chart)**
- **Standardized diagnostic tests (facility-initiated)**
  - Ultrasound
  - X-ray
  - EKG/ECG
  - Spirometry
  - Echocardiogram
  - CT scans/MRI
- **Standardized diagnostic tests (consultant-initiated)**
  - Bronchoscopy
  - Cardiac catheterization
  - Paracentesis
  - ERCP (endoscopic retrograde cholangiopancreatography)
  - Biopsy
    - Diagnostic
    - Therapeutic

- Ultrasound
  - Transesophageal echocardiography
  - Transrectal
- D&C (dilation and curettage)

- **Diagnostic Testing**
  - On-Site
    - Urinalysis
    - Microalbumin 2-1Combo Strips
    - Electrocardiogram (ECG/EKG)
    - Immunizations
    - X-ray
    - Ultrasound
  - Off-Site
    - CT scan
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiography)
    - Ambulatory electrocardiogram/Holter monitoring
    - Cardiac stress test

CONSULTATIONS AND THE USE OF SUB-SPECIALISTS

1. Establish a working diagnosis or a tentative care plan.
2. Record in progress notes what diagnostic tests, consultants or sub-specialty services are required and what information you expect to obtain. Please see the following examples:
   - Ultrasound of kidneys for hematuria – R/O nephrolithiasis, renal cysts, mass lesion
   - Echocardiogram with ejection fraction for dyspnea and orthopnea – Ejection fraction <35% versus >60%
   - Thyroid ultrasound for goiter – cystic or solid lesion
3. Issue a written order using the Physicians' Order Sheet.
4. Staff clinicians **MUST** submit all requests for diagnostic testing, consultations and sub-specialty services to the Medical Director for approval.
5. The Medical Director reserves the right to not concur with the proposed operating differential diagnosis, to not support the current clinical care plan and to deny any requests. In these instances, an alternative plan must be entered in the progress notes. Consult requests are filed in the medical record and not forwarded to the Corporate Medical Director.
6. Diagnostic testing, consultation and sub-specialty service requests approved by the Medical Director are forwarded to the Corporate Medical Director for review and final approval (this process is usually

completed within 24 hours). The Medical Director may circumvent standard procedures in the event of urgent or emergency requests by calling the Corporate Medical Director directly to discuss a case.

7. The Corporate Medical Director reserves the right to not concur with the proposed operating differential diagnosis, to not support the current clinical care plan or to deny a request. In these instances, an alternative plan must be outlined on the Consultation Request form. This form must be placed in the medical record and the clinician must complete a new progress note.
8. Upon completion of diagnostic testing, consultation or sub-specialty services, the official report must be reviewed and endorsed. Endorsement must include the clinician's name/initials, name stamp and date. A corresponding note must also be included in the progress notes. See examples below:
    - CXR reveals infiltrate with a 20mm PPD skin test. Plan: Order CT scan of chest.
    - Endoscopy completed by Gastroenterology. Polyps removed from colon. Patient informed will follow-up with pathology report.

See Forms for:

- Consultation Request Form
- Consultation Response Form
- Consult Return Review

INFORMATIVE DOCUMENTS

PAIN MANAGEMENT PRINCIPLES

NOCICEPTIVE PAIN			
	CAUSE	**CHARACTER**	**TREATMENT**
SOMATIC	**Musculoskeletal:** – Skin – Muscle – Joints – Ligaments	– Sharp – Localized – Reproducible – Positional	– NSAIDs – Injectable NSAIDs – Ketorolac (Toradol)
VISCERAL	**Internal Organs:** **Thorax** – Heart – Lung **Abdomen** – Liver – Kidney – Spleen – Bowel **Pelvis** – Bladder – Uterus – Ovaries	– Ache (dull, deep) – Stretching – Heaviness – May refer (e.g., backache)	***Opioids:** – Mild – Codeine – Strong – Morphine Ultram (Tramadol)

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.

- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off of the opioid, as appropriate.
- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

NON-NOCICEPTIVE PAIN			
	CAUSE	**CHARACTER**	**TREATMENT**
NEUROPATHIC	**Primary Neurologic:** – CVA (cerebral vascular accident) – Multiple sclerosis – Disc herniation – Compression fracture	– Hypesthesias – Highly variable – Variable temperature (hot/cold) – Localized or referred – Treat the primary cause	**Anticonvulsants** – Gabapentin (Neurontin) – Pregabalin (Lyrica) **Antidepressants** – Amitriptyline (Elavil) **Ultram**(Tramadol) **Lidocaine** – Patches – Creams
SYMPATHETIC	– Acute fracture or soft tissue injury – CRPS (complex regional pain syndrome)	– Severe pain – Disuse secondary to pain – Diaphoresis – Swelling – Sudden and debilitating	– Anti-convulsants – Anti-anxiety – Anti-depressants – Anti-inflammatory – Surgery

LIFESTYLE MODIFICATIONS

Lifestyle Modifications

This information is provided with the intention of assisting the practitioner in the development of care plans for:-

- Hypertension
- Diabetes
- Dyslipidemia/Hyperlipidemia
- Smoking cessation

MODIFICATION	RECOMMENDATION	SYSTOLIC BP REDUCTION
WEIGHT REDUCTION	Body Mass Index = 18.5 to 24.9 kg/M2	5 to 20 mmHg for each 10 kg of weight loss
DIET MODIFICATION	Increased fruits and vegetables, low saturated fats, low-fat dairy	8 to 14 mmHg
SODIUM REDUCTION	<100 mmol per day 2.4 Na+ or 6 gm NaCl	2 to 8 mmHg
PHYSICAL ACTIVITY PLAN	Aerobic exercise for 30 minutes per day, most days	4 to 9 mmHg
ALCOHOL CONSUMPTION MODERATION	<2 drinks (1 oz. ethanol) – e.g., - 24 oz. of beer or 10 oz. of wine or 3 oz. 80 proof per day	2 to 4 mmHg

PHYSICIAN ORDER SHEET for DIABETIC PATIENTS

1. Admit to Chronic Care Clinic
2. Prescribe 1800 calorie diet recommended by the ADA (American Diabetes Association)
3. Instruct Nursing to provide educational materials on Healthy Lifestyle Management
4. No added salt

DEHYDRATION PRINCIPLES AND STANDARDS OF CARE

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

Dehydration is one of the most common clinical conditions encountered within correctional facilities, and yet it is frequently unaddressed, leading to protracted morbidity and negative outcomes.

- **underdiagnosed**
- **partially-treated**
- **often recurrent**

There are numerous clinical causes associated with dehydration. Some are subtle in presentation and require intensive observation and thorough examination. Increased insensible water loss can be due to tachypnea (as part of upper respiratory conditions like influenza and pneumonia), increased core temperature (as with fever and malignant hyperthermia) and extensive dermatologic pathology (like exfoliations and blisters). Some clinical causes of dehydration are dramatic and acute, such as hemorrhage and shock. In all of these instances stabilizing treatment initiatives discontinued prematurely can lead to dehydration recurrence and relapse.

All clinicians who interact with patients must be able to recognize and effectively treat dehydration. Care plans must be multidisciplinary in approach and iterative in scope of management. Prognosis is oftentimes directly related to:

- **PROMPT INITIATION** of
- **APPROPRIATE CARE** for
- **THE RIGHT DURATION**

Throughout this manual, treatment for dehydration factors into treatment regimens. Outcomes often correlate with the correction of volume deficit. For instance, diabetics who present in ketoacidosis require hydration to correct hyperglycemia, but proper hydration will also counter poor perfusion and ketoneogenesis. Pneumonia patients receiving appropriate antibiotics may not initially respond to treatment if hypovolemic and on physical examination the lungs may sound clear to auscultation; however, once the patient is adequately hydrated, rales and rhonchi may suddenly become audible upon auscultatory examination.

Withdrawing patients will remain confused or obtunded, with hyper- or hypotension, if there is underlying volume contraction due to diaphoresis and/or diarrhea, even though therapeutic doses of Chlordiazepoxide have been administered. Patients seen on admission with CPK elevations in the thousands and prerenal azotemia will progress to rhabdomyolysis and obstructive uropathy if fluid repletion is not aggressive and intensive. Patients with bronchial asthma will remain refractive to respiratory treatment if not euvolemic and if underlying pneumonitis goes undiagnosed. **With each section in this manual, the clinician is asked to assess the volume status of the patient and to implement necessary volume replacement therapy in support of the care plan.**

ANNUAL HEALTH EXAMINATIONS

An annual health examination will be conducted for all inmates housed in the facility for 364 days or more. This applies to all inmates who have been sentenced, as well as those awaiting trial or disposition.

The annual health examination is conducted in two phases. **Phase One** includes the clinician's comprehensive review of the patient's health record to identify any chronic diseases, as well as prior conditions that have already resolved. All significant laboratory tests, diagnostic procedures and consultation reports are evaluated. Medications for chronic conditions are identified. Lastly, the patient level of compliance is determined following review of the objective information obtained. The Problem List is continually reviewed and periodically updated to include new clinical events and outcomes, as well as scheduled interventions, such as the "Annual Physical Examination" (with the date). **Phase Two** is an objective, hands-on evaluation of the inmate-patient. It involves the inspection, palpation, auscultation and percussion of the patient's body to determine the presence or absence of physical signs of disease. The clinician documents all clinically significant findings stemming from the physical examination, along with all "pertinent negative findings" in the medical record.

NCCHC has shifted its position regarding the annual physical examination to recommend that said services be defined by the facility.

The Centers for Medicare & Medicaid Services (**CMS**), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid,

Affordable Care Act (ACA) has a provision that private insurance plans cover preventive services without any patient cost-sharing. This requirement stems from evidence-based research yielding two pivotal outcomes:

- Impact mortality [save lives]
- Impact morbidity [improve heath]

These outcomes are achieved by:

- Early identification of illnesses
- Effective management strategies
- Effective and definitive treatment interventions prior to complications and/or debilitating illnesses

Full achievement of these stated goals are prevented to some individuals due to cost.

e.g. Colon cancer screening with colonoscopy with mean cost of $1000.00 for the procedure alone, ancillary fees [conscious sedation, medications, professional fees, post op medications] significantly higher.

Yearly "Wellness" visit - The compromise

This plan is designed to help prevent disease and disability based on:

- Current health
- Clinical risk factors.

The visit is based on the completion of a questionnaire, called a "Health Risk Assessment," which stratifies clinical information needed to develop a personalized health maintenance plan:

- A review of your medical and family history.
- Developing or updating a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options.
- A screening schedule (like a checklist) for appropriate preventive services
    - Vaccines
    - PAP smears
    - PSA determinations
- Advance care planning

COMPONENTS OF THE ANNUAL HEALTH EXAMINATION

NURSING DOCUMENTATION

Intake Screening

- Review of inmate patient history
    - Obtain SIGNED Release of Information form
    - Medication review
    - Confirmation of Medications – FAXED TO ORDERING PHYSICIAN/DISPENSING PHARMACY
- Determination of current level of disease control through review of inmate history
- Ascertain any special needs requirements
- Complete and include all necessary medical documentation in the medical record

COMPONENTS OF THE ANNUAL HEALTH EXAMINATION

Age	Sex	Examination	Factoids
All	M/F	Comprehensive "hands-on" examination	CBE(Clinical Breast Exam)
All	M/F	CBC with differential, CMP, PPD	Systems review for LTBI
All	M/F	Disease-specific testing (such as HA1c, CD4, viral load)	
All	M/F	Primary Prevention Review and Update	All annual vaccines will be documented, along with other immunizations[1] and clinically appropriate screening tests.[2]
All	M/F	Comprehensive dental examination	X-ray studies, as indicated
All	M/F	Disease-specific Diagnostic Testing[3]	See Chronic Disease Management – Clinical Guidelines Manual
50+	M/F	Secondary Prevention [Screening]	
All	M	PSA testing over 50	This test is under review; therefore, recommendations are subject to change.
Adult	F	Pelvic examination and PAP smear	Emancipated juvenile defendants, as well as those with a history of STDs will be included.
All HIV+	M/F	CB4, viral load and CXR	
All	M/F	Ophthalmology	
All	M/F	Podiatry and Microalbuminuria	
HIV+	F	PAP	

EMERGENCY CARE MANAGEMENT

ACUTE CARE MANAGEMENT

[1] Refer to the Infection Control Manual and the Clinical Guidelines Manual for a listing of recommended tests.
[2] HIV screening is offered at intake in some facilities. Private grants operate HIV Testing-on-Demand programs.
[3] Examples of tests include - ECG for hypertensive patients, diabetics, cardiac patients; echocardiogram with ejection fraction for patients in congestive heart failure or renal failure.

Patients presenting to the nursing staff with certain urgent or emergent conditions that DO NOT require immediate transfer to a tertiary care emergency facility shall require management by the clinician on-duty or on-call. Standardization of these orders assures compliance with established treatment guidelines and supports favorable clinical outcomes.

EMERGENCY CONDITION	**TREATMENT ORDERS**
Abdominal Pain	DO NOT GIVE ANALGESICS UNTIL ETIOLOGY IS CONFIRMED Flat plate abdominal x-ray or ultrasound – to discern pancreatic calcifications, gas Ultrasound – for determining cholelithiasis, choledocholithiasis, nephrolithiasis
Acute Asthma [reversible airway disease]	0.083% Albuterol 2.5mg in 3cc of normal saline administered via nebulizer
Allergy – Pruritus [Mild to Moderate]	Benadryl 50mg IM
Allergy – Pruritus [Severe]	Solu-Medrol 125mg IM
Chest Pains	Electrocardiogram Cardiac – nitroglycerin SL Costochondritis – indomethacin [Indocin] – high dose NSAIDs
Dehydration	Urine specific gravity test IV – normal saline or 0.45 normal saline [avoid glucose on first liter until thiamine and folate supplementation have been provided]
Dental Pain	Motrin 800mg BID Monitor vital signs [if fever present, rule out infection] Antibiotics [if necessary]
Diabetic Ketoacidosis	Urine testing - specific gravity, ketone levels Electrocardiogram [to determine silent AMI or ischemia] IV – normal saline or 0.45 normal saline [avoid glucose on first liter until thiamine and folate supplementation have been provided] Regular insulin on sliding scale **[Glucose levels decline rapidly with hydration]**
Falls, sprains, non-displaced fractures	Ice Elevation Immobilization NSAIDS, including Ultram or Toradol
Hematuria with **severe** pain	Ketorolac [Toradol] 60mg IM Abdominal ultrasound **ASAP**
Seizure	Known etiology – Epilepsy or withdrawal Ativan 2mg IM with continual monitoring up to 4mg in 30 minutes **DO NOT MASK NEW ONSET SEIZURES; SEIZURES SECONDARY TO HEAD TRAUMA OR FALLS; OR FEBRILE SEIZURES – REFER PT. TO ER**

System Disorders and Specific Conditions

CARDIOVASCULAR

CARDIOVASCULAR PROTOCOL

Review of Intake Screening/Clinical History (Nursing Documentation)

Enroll in Chronic Care (all necessary documentation must be included in the medical record)

Initial Health Assessment (Physical Examination Findings)

- Review of past medical history, including primary care
- Jugular venous distension
- Neck bruits
- Lung field
- Auscultation for gallops, murmurs
- Akinesis
- Mitral valve prolapse
- Abdominal bruits
- Hepatojugular reflux
- Dependent edema
- Pulse
- Concurrently occurring conditions (i.e., - diabetes, kidney disease, etc.)
- Electrocardiogram (ECG/EKG)
- Echocardiogram with ejection fraction (EF)

CHRONIC CARE FOR CARDIOVASCULAR PATIENTS

- Review inmate's cardiac history and indicate diagnosis using appropriate ICD code(s) – i.e., ischemic heart disease, restrictive cardiac disease, obstructive cardiac disease
- Risk Factors (identify in medical intake notes [baseline] and initial chronic care visit [clinic])

CARDIAC RISK FACTORS
o **Male**
o **Diabetic**
o **Hypertension**
o **Smoker**
o **Dyslipidemia/hypercholesterolemia**
o **History of ischemic heart disease**
o **Diet high in saturated fats and sodium**
o **Angina**
o **Metabolic Syndrome**
o **Neck circumference >20 inches**
o **Waist circumference >40 inches**
o **Gallops and murmurs**

CHRONIC CARE DIAGNOSTIC TESTS

- Electrocardiogram (ECG/EKG)
- Echocardiogram with ejection fraction (EF)
- Ambulatory electrocardiogram/Holter monitoring

MEDICATIONS

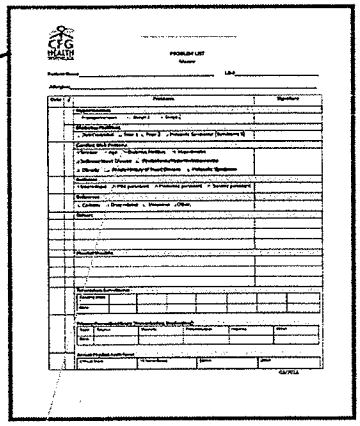
- Beta blocker
- ACE/ARB
- Amiodarone (for ejection fraction <35%; persistent cardiac ectopy)
- ASA (acetylsalicylic acid/aspirin)
  - Low dose (81 mg) - cardioprotective
  - Full dose (325 mg) - antithrombotic for females
  - ASA + dipyridamole (vs. clopidogrel)
- Diuretics (thiazides, loop)
- Aldosterone Antagonist
- Vasodilator Therapy (Hydralazine)
- Digitalis (decreases rates of heart failure hospitalizations)
- LCZ- 696 (Entresto, Ivabradine)
- NTG

Did You Check For?	Did You Do?

Risk factors (assessed at baseline and clinic evaluations)
 	
CARDIAC RISK FACTORS
 	
Male
Diabetic
Hypertension
Smoker
Dyslipidemia/Hypercholesterolemia
History of ischemic heart disease
Diet high in saturated fats and sodium
Angina
Metabolic syndrome
Neck circumference >20 inches
Waist circumference >40 inches
Gallops and murmurs
 	
• Insulin control
• Vegetation
• Mitral valve prolapse
• Akinesis
	• Comprehensive physical exam
	• Chronic Care enrollment
	• Patient education
	  o Comment on cardiac risk factors:
	  o Initiate smoking cessation program (if necessary)
	  o Encourage aerobic exercise (walking)
	• Cardiac work-up (via consultation) to include:
	  o Stress test
	  o Catheterization
	  o MUGA scan (multi gated acquisition scan)
	• Electrocardiogram (ECG/EKG)
	• Echocardiogram with ejection fraction (EF)
	  o 58% - Normal
	  o 45 - 55% - Moderate failure (controlled with medication)
	  o < 35% - Low (administer amiodarone; use defibrillator, if necessary)
	• Write Orders
	  o Nursing Care Plan
	  o Diagnostic testing
	  o Sub-specialty support
	  o Establish level of monitoring through:
	  ▪ Chronic Care
	  ▪ Infirmary Care
	• Identify Treatment Goals
	• Stabilize and improve cardiac reserve by:
	  o Increasing cardiac output (via inotropic medications, afterload reduction, antiarrhythmic drugs)
	• Eliminate pain and discomfort through the use of:
	  o Beta blockers
	  o Nitrates
	• Contain or eliminate hypoxia and/or cardiac ectopy through the use of:
	  o Amiodarone
	  o Oxygen

CARDIOVASCULAR DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Characterize cardiac disease and comment on risk factors (see chart next page)** • **Include ICD code** • **Provide documentation of functional level (e.g., -** *severe congestive cardiomyopathy with EF 34% with defibrillator*)
Orders and Care Plan
Nursing Education
Discharge Planning • **Review all medications and studies** • **Clinic referral**



Cardiac Risk Factors:

□Smoker □Age □Diabetes Mellitus □Hypertension

□Ischemic Heart Disease □Dyslipidemia/Hypercholesterolemia

□Obesity □Family History of Heart Disease □Metabolic Syndrome

HYPERTENSION

HYPERTENSION PROTOCOL

(Treatment of hypertension as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Review of Intake Screening/Clinical History (Nursing Documentation)

- Inmate history of hypertension (obtained from nurse screening)
- Results of prior diagnostic testing including:
  - prior electrocardiograms (ECGs/EKGs) and laboratory studies
- Ascertain any special needs requirements and comorbid conditions (i.e., diabetes, kidney failure, cardiac insufficiency, end organ deficits, etc.)

Initial Health Assessment (Physical/Examination Findings)

- Review of hypertension history with inmate, including medications
- Focused physical examination, with particular emphasis on end organ impact, to include:
  - Cardiovascular examination:
    - presence of heaves, thrills, gallops, murmurs, rubs
    - uncontrolled blood pressure
  - Eye examination:
    - Proptosis
  - Neck examination:

        - jugular venous distension (JVD)
        - bruits
    - Peripheral pulses
    - Renal vascular evaluation
- Temperature
- **IT IS IMPERATIVE THAT THE CLINICIAN MAKE NOTATION OF CRITICAL NEGATIVE FINDINGS (PERTINENT NEGATIVES).**

Diagnostic Tests

- Snellen eye test
- electrocardiogram (ECG/EKG)
- echocardiogram with ejection fraction (EF), as indicated
- Doppler study
- 24-hour urinary free cortisol
- urinalysis, noting:
    - osmolality
    - presence of ketones
    - chem
    - sediment
    - presence of vanillylmandelic acid (VMA)
    - presence of metanephrine
    - evidence of hyponatremia
    - evidence of hematuria
    - increased catecholamines

Referrals

- Cardiology
- Nephrology

TREATMENT STRATEGIES FOR HYPERTENSION

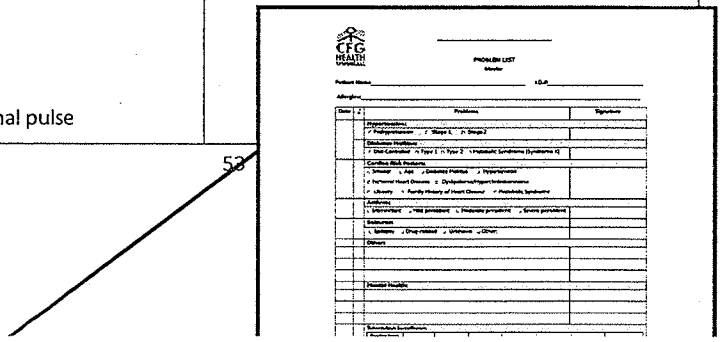
BLOOD PRESSURE	SYSTOLIC mmHg	DIASTOLIC mmHg	LIFESTYLE MODIFICATION	INITIAL CLINICAL INTERVENTION ESSENTIAL HYPERTENSION	INITIAL CLINICAL INTERVENTION HT+DM or CRF
NORMAL	<120	<80	Support		
PRE-HYPERTENSION	120-139	80-89	Yes	No Rx	Start Rx
STAGE 1 HYPERTENSION	140-159	90-99	Yes	Thiazide, then assess and prescribe additional medications (as indicated)	Many Rxs available
STAGE2 HYPERTENSION	>160	>100	Yes	Two Rx combination + diuretic	Many Rxs available

Lifestyle Modifications

This information is provided with the intention of assisting the practitioner in the development of care plans for hypertensive patients.

MODIFICATION	RECOMMENDATION	SYSTOLIC BP REDUCTION
WEIGHT REDUCTION	Body Mass Index = 18.5 to 24.9 kg/M2	5 to 20 mmHg for each 10 kg of weight loss
DIET MODIFICATION	Increased fruits and vegetables, low saturated fats, low-fat dairy	8 to 14 mmHg
SODIUM REDUCTION	<100 mmol per day 2.4 Na+ or 6 gm NaCl	2 to 8 mmHg
PHYSICAL ACTIVITY PLAN	Aerobic exercise for 30 minutes per day, most days	4 to 9 mmHg
MODERATION OF ALCOHOL CONSUMPTION	<2 drinks (1 oz. ethanol) – e.g., - 24 oz. of beer or 10 oz. of wine or 3 oz. 80 proof per day	2 to 4 mmHg

Did You Check For?	Did You Do?
Abnormal pupil reaction	Electrocardiogram (ECG/EKG)
Abnormal heart function	Funduscopic examination
Abnormal kidney function	Electrolyte panel
Peripheral pulses	Urinalysis
Jugular venous distension	Optometry/Ophthalmology referral
Carotid bruit	Doppler study
Gallop rhythms S3 and S4	Echo with ejection fraction (EF)
Murmurs	Lab studies
Heaves	Increase BP with ACE inhibitor for *Renal Art Stenosis*
Hematuria	Special studies
BUN:Creatinine (Cr) ratio of >20:1	Arrange consultations
Abdominal bruits	
Diminished pulse	
Bounding pulse	
Distal pulse lower than proximal pulse	



Hyperkalemia Hypokalemia Metabolic alkalosis	

HYPERTENSION DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Classification via ICD coding** • **Etiology (*e.g. – essential, renal, etc.*)**
Orders and Care Plan • **Note level of control** • **Enroll in Chronic Care**
Nursing Education
Discharge Planning • **Medication review** • **Compliance issues and impotence in males** • **Review of laboratory results and consultations**

Hypertension:

□ Prehypertension □ Stage 1 □ Stage 2

CONGESTIVE CARDIOMYOPATHY

CONGESTIVE HEART FAILURE

BNP (B-type Natriuretic Peptide) is a substance secreted from the ventricles or lower chambers of the heart in response to changes in pressure that occur when heart failure develops and/or worsens. The level of BNP in the blood will increase when heart failure symptoms worsen and will decrease when the heart failure

condition is stable. The BNP level in a person with heart failure is ***always***higher than in a person with normal heart function.

The B-type Natriuretic Peptide laboratory test is used when heart failure is suspected to evaluate and manage problems associated with the ventricles of the heart. The B-type Natriuretic Peptide test is particularly useful for the following clinical situations:

- Differentiating CHF (congestive heart failure) from pulmonary disease
- Screening for CHF in high risk patients
- Determining severity of CHF
- Risk stratification after acute myocardial infarction
- Assessing left ventricular hypertrophy in dialysis patients
- Assessing cardiotoxicity related to chemotherapy

NOTE: The BNP titer increases with age. Basal levels of BNP are consistently higher in females.

MEAN BNP CONCENTRATION BY AGE:

AGE	MALE	FEMALE
45 – 54	14.3	25.2
55 – 64	19.2	33.6
65 – 74	23.3	37.7
75+	46.1	76.5

Measured in pg/mL

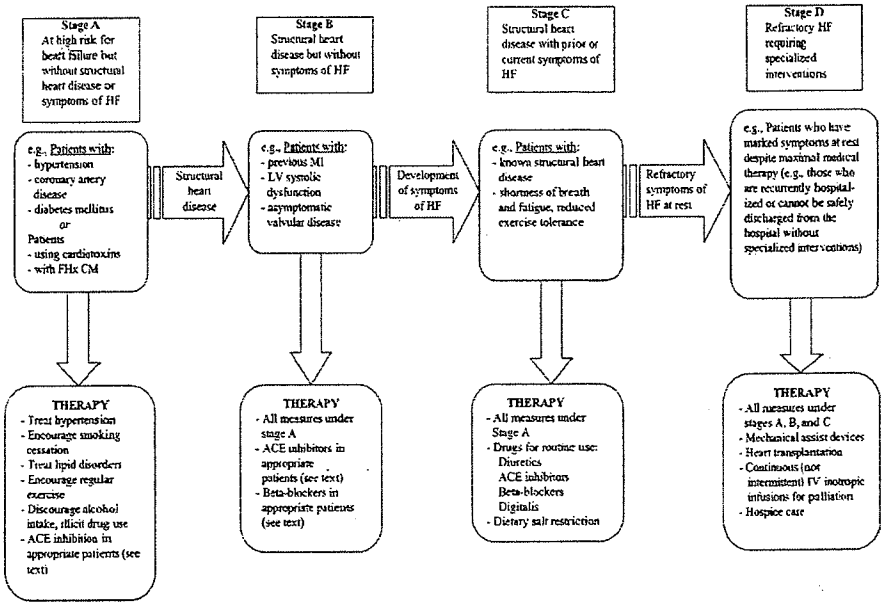
CLASSIFICATION OF HEART FAILURE SEVERITY

NYHA Class I (mild)	**Normal**	**No Symptoms** **Normal Exercise Test** **Normal LV Function**	**71**
NYHA Class II (mild)	**Asymptomatic LV (some dysfunction)**	**No Symptoms** **No Problems Exercising** **Abnormal LV Function**	**204**
NYHA Class III (moderate)	**Compensated CHF**	**Symptoms on Exercise** **Abnormal LV Function**	**349**
NYHA Class	**Refractory CHF**	**Symptoms Present at Rest**	**1022**

IV (severe) **Not Controlled with Treatment**

Measured in pg/mL
LV=left ventricle

HEART FAILURE TREATMENT GUIDE AND RECOMMENDED THERAPY BY STAGE



ACC/AHA Practice Guidelines TableClinical Applications:

1. Patient presents with dyspnea at rest. BNP is < 100 pg/mL. Is the dyspnea cardiac in origin? Should the next diagnostic test performed be a chest CT scan or echocardiogram with ejection fraction?

Answer: Dyspnea is non-cardiac in origin; next test should be a chest CT

2. Breast cancer patient on Adriamycin therapy. Initial BNP is 25 pg/mL when therapy begins, but is now 375 pg/mL. What is the appropriate diagnostic test? What is the anticipated clinical scenario?

Answer: Echocardiogram with ejection fraction; dyspnea on exertion (NYHA III)

3. 38 yo with cocaine cardiomyopathy, chest pains at rest, hypotension and dyspnea is transferred to the ER. Troponins are 3 and the BNP is 900 pg/mL. Patient has audible pulmonary wheezing. Cardiac or asthma?

Answer: Cardiac

Heart Failure with Preserved Ejection Fraction

- Left ventricular ejection fraction is > 50%
- Also known as "Diastolic Heart Failure
- Elderly females
- Diabetes mellitus
- Essential hypertension

Diagnosis is based on left ventricular ejection fraction, preferably with two-dimensional echocardiography.

Treatment

- Tight blood pressure control
- Weight reduction
- Beta blockers
- Anti-arrhythmia medications
- Management of ischemic heart disease

Hypertrophic and Restrictive Cardiomyopathy

Echocardiogram demonstrates the pathology.

Range of presentations from sudden syncopal episodes to chronic debilitating dyspnea and fatigue. Refer to Cardiology for care and treatment.

Acute Coronary Syndromes Unstable Angina, Non-ST Segment Elevation Myocardial Infarction

- Clinical spectrum based on severity of symptoms with a similar underlying pathogenesis
- Risk for death at one year is considerable
- Patients usually with comorbid conditions
- Females have a worse short-term and long-term outcomes and more complications
- Symptoms may occur at rest
- Angina may be prolonged – may have atypical presentation such as jaw pain
- Risk for recurrent events

Check hemodynamic status immediately. Provide oxygen supplementation.

ECG may be normal or Q in lead III only

Transport to tertiary center

ST-Segment Elevation Myocardial Infarction

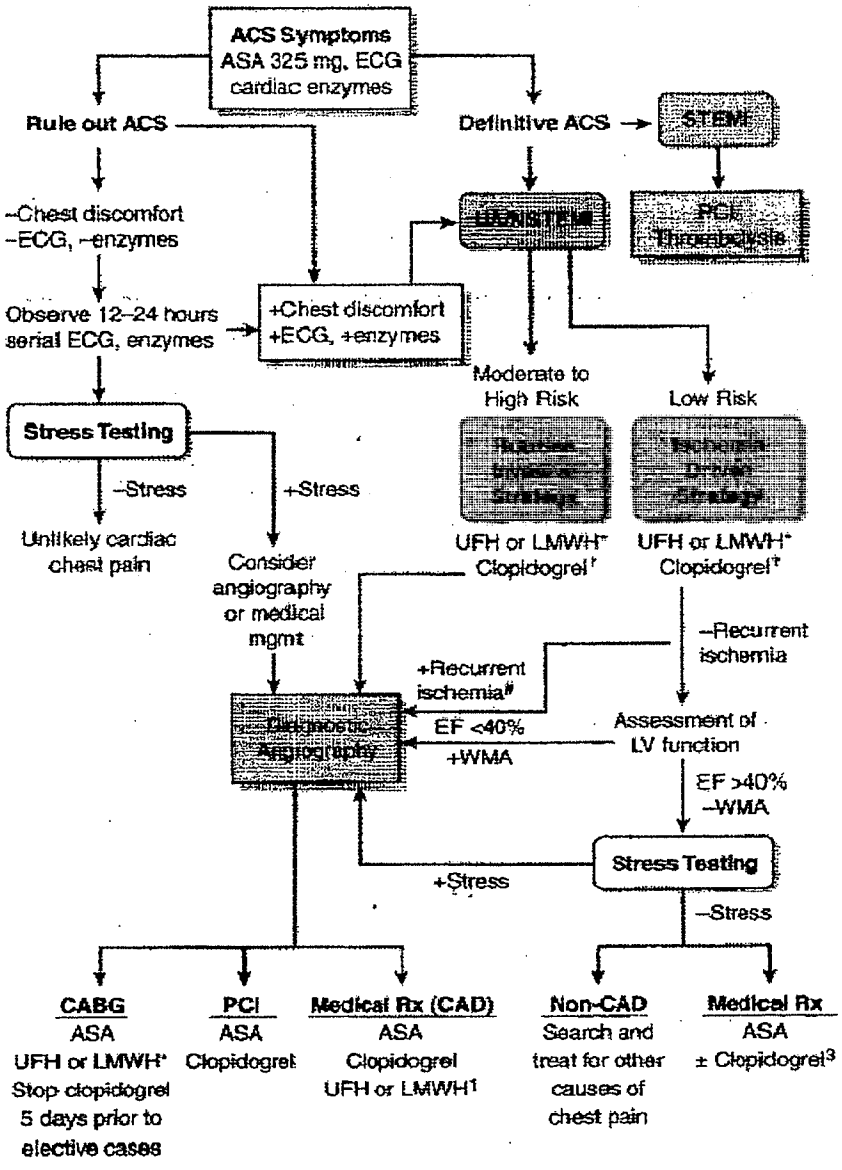
- Persistent ECG ST elevations

- Total occlusion of epicardial coronary artery, most often due to atherosclerotic plaque rupture or erosion and subsequent thrombus formation.
- Severe symptoms lasting for a longer duration
- Diabetics may present with sudden dyspnea with little chest pain
- Hemodynamic compromise is sudden onset, with range from dyspnea to shock
- Assess risk factors for treatment with thrombolytic therapy
- Rule out cocaine-abuse disorder

Check hemodynamic status immediately. Provide oxygen supplementation.

ECG with ST-elevations and Q waves

Transport to tertiary center


ACS Symptoms
ASA 325 mg, ECG
cardiac enzymes
Rule out ACS
Definitive ACS
STEMI
–Chest discomfort
–ECG, –enzymes
PCI
Thrombolysis
Observe 12–24 hours
serial ECG, enzymes
+Chest discomfort
+ECG, +enzymes
Moderate to
High Risk
Low Risk
Stress Testing
–Stress
+Stress
Unlikely cardiac
chest pain
Consider
angiography
or medical
mgmt
UFH or LMWH*
Clopidogrel†
UFH or LMWH*
Clopidogrel†
–Recurrent
ischemia
+Recurrent
ischemia#
EF <40%
+WMA
Assessment of
LV function
EF >40%
–WMA
Stress Testing
+Stress
–Stress
CABG
ASA
UFH or LMWH*
Stop clopidogrel
5 days prior to
elective cases
PCI
ASA
Clopidogrel
Medical Rx (CAD)
ASA
Clopidogrel
UFH or LMWH†
Non-CAD
Search and
treat for other
causes of
chest pain
Medical Rx
ASA
± Clopidogrel‡

HYPERCHOLESTEROLEMIA

HYPERCHOLESTEROLEMIA PROTOCOL

(Treatment of hypercholesterolemia as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Review of Intake Screening/Clinical History (Nursing Documentation)

Initial Health Assessment (Physical/Examination Findings)

- Ascertain and document any comorbid conditions, including, but not limited to:
  - Diabetes
  - Hepatitis
  - Pancreatitis
  - Alcoholism
  - Cholelithiasis
  - Choledocholithiasis

DIAGNOSTIC TESTS

- Ultrasound
- Abdomen
  - Liver
  - Laboratory Studies
- Lipid panel:
  - total cholesterol (TC)
  - triglycerides (TG)
  - HDL
  - LDL
- Liver function tests (LFTs)

MEDICATIONS GUIDELINE

Please visit the following link:

http://www.nhlbi.nih.gov/guidelines/cholesterol/atglance.pdf

- Goal of treatment is LDL cholesterol <70

Did You Check For?	Did You Do?
Xanthomas	Retrieve inmate patient's prior medical records
Skin lesions	Physical examination
Hepatomegaly	Abdominal flat plate x-ray
Positive Murphy's sign	Ultrasound of abdomen
Mid-line calcifications	Fasting specimen
Air-fluid levels	Serum glucose
Cholelithiasis	Amylase
Choledocholithiasis	Lipase
Fatty hepatic infiltrate	Liver function tests (LFTs)
Fatty hepatic degeneration (liver has mottled appearance)	Lipid panel
Comorbid conditions including, but not limited to:	
Diabetes	
Pancreatitis	
Dehydration	
Substance abuse	

HYPERCHOLESTEROLEMIA DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **ICD code(s)** • **Primary or secondary prevention** • **Level of control** • **Risk relationships (such as uncontrolled diabetes, alcohol abuse, etc.)**
Orders and Care Plan • **Abdominal ultrasound**
Nursing Education
Discharge Planning • **Discuss treatment targets** o **LDL <70** • **Behavioral modifications** o **Smoking cessation** o **Alcohol abstinence** • **Medications** • **Follow-up care**

HMG- CoA Reductase inhibitors are effective in lowering total cholesterol, LDL-C and raising HDL-C. These drugs, the statins, now have a FDA box warning.

Cytochrome P450- metabolism

- Rhabdomyolysis
- Ketoconazole
- Fibrates
- Cyclosporins

ENDOCRINOLOGY

DIABETES

(Treatment of diabetes as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Diabetes is a chronic condition whose clinical hallmark is elevation of blood glucose levels. Over 20 million people in the United States (7% of the population) have diabetes, and a significant number of these individuals remain undiagnosed. End-organ vascular damage related to diabetes involves:

- the *micro*-vascular system, including the retinal artery and renal capillaries
- the *macro*-vascular system, including the coronary and cerebral arteries

As such, treatment strategies are designed to forestall progressive cardiac, renal, ophthalmologic and neurologic issues and premature death.

Intrinsic insulin levels among these patients help to differentiate the two types of diabetes:

- Type 1 diabetes - characterized by insulin deficiency
- Type 2 diabetes - characterized by hyperinsulinemia and insulin resistance

MANAGEMENT OF TYPE I DIABETES – INSULIN DEFICIENCY

Insulin therapy is paramount to the treatment of patients diagnosed with Type 1 diabetes. Type 2 diabetes is often included in the clinical presentation of Metabolic Syndrome:

- Atherogenic dyslipidemia
- Abdominal obesity
- Elevated blood pressure
- Insulin resistance; +/- glucose intolerance
- Pro-inflammatory state
- Pro-thrombotic state

MANAGEMENT OF TYPE II DIABETES – INSULIN RESISTANCE

The management of Type 2 diabetes is multifactorial and includes the possible need for:

- Insulin, along with other oral blood glucose-lowering medications
- Antihypertensive preparations
- HMG-CoA reductase inhibitors (such as the "statins")

The evaluation parameters differ between the two diseases -- fasting blood glucose levels are measured for Type 1 diabetics versus HA1c, fasting lipids and blood pressure determinations for Type 2.

TREATMENT INITIATION

- Lifestyle Modifications (see chart in Office Practice Assessments)
- General principles applied to all patients with diabetes include:

- Education
- Nutritional management (education, caloric counts, calorie exchanges)
- Daily exercise
- Blood pressure management
- Weight
- Abdominal girth measurements
- BMI

The Diabetes Prevention Program[4] was a 27 clinical center study involving 3,234 participants followed for over three (3) years to assess the impact of lifestyle intervention (i.e. - exercising 150 minutes weekly, reducing fat and caloric intake, weight loss target of 7%) versus Metformin 850mg twice daily versus placebo tablets. The participants were identified as impaired glucose tolerance (IGT) (also called pre-diabetics). The findings were dramatic in terms of demonstrated prevention or delay in the onset of Type 2 diabetes in both of the groups receiving treatment. The Lifestyle Modification group sharply reduced progression from IGT to Type 2 diabetes and more robustly than the group receiving Metformin.

The HEALTHY Study, a primary prevention trial sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases (a division of the National Institutes of Health) looked at early intervention among the middle school level at risk juveniles to assess the impact of lifestyle modification on the development of IGT, pre-diabetesand Type 2 diabetes. The outcomes,published in 2008, were the same as those in the Diabetes Prevention Program.

NON-MEDICATION TREATMENT PLANS IN THE CORRECTIONAL SETTING

All inmates, residents and/or or detainees identified as IGT, pre-diabetic, having Metabolic Syndrome or having Type 2 diabetes will be placed on the calorie-restrictive American Diabetic Association diet (to be provided by the contracted food services providers). The essential role of dietary regulation will be the cornerstone of treatment and education and will be reinforced by the clinicians and nursing staff during chronic care visits and medication passes.

Facility-adjusted exercise regimens will be required for each inmate, resident and/or detainee identified as IGT, pre-diabetic, as having Metabolic Syndrome or as having Type 2 diabetes. For those individuals with access to a gymnasium or outdoor activities, nursing will assist in the development and management of an activity log. For those inmates confined to their housing units or cells only, marching in place and performing arm swings 4 to 5 times daily will be considered sufficient activity.

The patient must understand that at each clinical visit the provider will monitor both their dietary compliance and exercise activity.

Though smoking is not allowed in correctional facilities, all clinical staff must counsel patients against smoking and document this education in the medical record.

MEDICATIONS

[4]Knowler WC, Barrett-Connor E, Knowler SE et al, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or metformin", NEJM, 2002, Feb 07;346(6):393-403.

Type 1 diabetics require adequate insulin supplementation.

Type 2 diabetics who do NOT have renal insufficiency should receive Metformin, up to the maximum daily dosage, as part of their regimen.

Type 2 diabetics also require a plan that manages any comorbid conditions concomitantly while treating blood glucose elevations. The treatment regimen must address the control of blood pressure and dyscrasia, in addition to blood glucose elevations. **NOTE**: Blood pressure goals in diabetics are BP < 130/80. ACEI/ARBS are first line therapy. LDL goal is less than seventy(70). Medications should be adjusted accordingly to meet these goals.

CATEGORY/MEDICATION	ACTION	OUTCOMES	SIDE EFFECTS
BIGUANIDES • **Metformin**	• decreases hepatic gluconeogenesis (GNG) • blocks intestinal absorption of glucose • secondary increase in glucose sensitivity	• first line Rx • hypoglycemia rare • HA1c down 1.5 • weight OK (possible gain)	• renal failure • cardiac issues • lactic acidosis (more prevalent among the elderly)
SULFONYLUREAS **First Generation:** • **Acetohexamide** • **Chlorpropamide** • **Tolazamide** • **Tolbutamide** **Second Generation:** • **Glipizide** • **Glyburide** • **Glimepiride**	• pancreatic beta-cell stimulation	• HA1c down 1.5	• weight gain • decreased efficacy with time • problems among the elderly
MEGLITINIDES • **Repaglinide** • **Nateglinide**	• pancreatic beta-cell stimulation	• HA1c down 1.5 • must be taken with food	
AMYLIN ANALOG • **Pramlintide**	• injectable Amylin • slows gastric emptying • decreases gluconeogenesis • increased feeling of satiety		• gastroparesis
THIAZOLIDINEDIONES • **Rosiglitazone** • **Pioglitazone**	• increases sensitivity to insulin • increases uptake of glucose into adipose,	• **only works when insulin is present** • HA1c down	• fluid retention • weight gain • secondary

CATEGORY/MEDICATION	ACTION	OUTCOMES	SIDE EFFECTS
	muscle and hepatic cells	1.0	congestive heart failure • bladder cancer (with Pioglitazone)
DIPIPIDYL PEPTIDASE-4 (DPP-4) INHIBITORS • **Sitagliptin**	• enzymatic degradation of incretin hormones: 1. glucagon-like peptide-1 (GLP-1) 2. glucose-dependent insulinotropic polypeptide (GIP)	• HA1c down 0.5 • blocks inhibition of the enzymes	
ALPHA-GLUCOSIDASE INHIBITORS • **Acarbose** • **Miglitol**	• delays digestion of fat, proteins and carbohydrates	• minimal HA1c impact	• gas, diarrhea, cramping
SODIUM-GLUCOSE COTRANSPORTER-2 INHIBITORS •	•	•	•
[illegible]	•	•	•
[illegible]	•	•	•

INSULIN THERAPY

Insulin Coverage – Sliding Scales

Use the total daily coverage figures to determine an appropriate dose of long-acting insulin to prescribe. The goal is to blunt cyclic variations in blood glucose while lowering basal glucose levels to within normal range.

LANTUS INSULIN

LANTUS offers stable basal control of blood glucose levels in both Type1 and Type 2 patients. As control over dyscrasia, blood pressure and excessive caloric intake begin to blunt hyperglycemia in Type 2 diabetics, LANTUS insulin may be tapered and/or discontinued.

FASTING BLOOD GLUCOSE DETERMINATIONS

Fasting blood glucose (FBS) determinations, along with evening preprandial (4:00 PM) or nighttime (8:00 PM or 12:00 AM) glucose monitoring (via finger sticks) are important data points for defining insulin requirements. Blood glucose should be determined prior to each dose of insulin. In patients diagnosed as IGT, pre-diabetic or as having Type 2 diabetes, a single blood glucose level will be helpful in establishing a care plan. FBS and 4:00 PM blood glucose determinations are not indicated in the absence of insulin therapy.

HEMOGLOBIN A1C LEVELS

Glycosylated hemoglobin levels are more appropriate determinants of glucose control in Type 2 diabetics and should be taken to establish a baseline, within thirty(30) days after a medication change or with the addition of LANTUS coverage. Individual therapeutic targets should be developed with each patient. It should be noted that across all correctional facilities CFG serves within New Jersey, the goal is to achieve an average HA1c titer of < 7.0.

ANCILLARY MANAGEMENT OF DIABETES

As part of the Initial Health Assessment (Physical/Examination Findings), the following should be conducted:

OPHTHALMOLOGIC ASSESSMENT:

A baseline Snellen score must be obtained within thirty (30) days of an inmate's arrival at the facility. Annual ophthalmology appointments shall be conducted for all patients designated IGT, pre-diabetic, diabetic or diagnosed with Metabolic Syndrome. The practitioner must request tonometry, visualfields, fundoscopic examination with macular evaluation and vascular review. Laser treatment for neovascularization is considered a community standard of care.

CARDIAC ASSESSMENT:

The clinician must complete a cardiac examination within thirty(30) days of an inmate's admission and must comment on all auscultatory findings. For those individuals with concomitant hypertension or hyperlipidemia, a cardiogram must be performed. Symptomatic patients should be referred for on-site echocardiogram with ejection fraction determination requested. Patients with evidence of "third-spacing" or dependent edema should also have a chest x-ray done.

RENAL ASSESSMENT:

All patients designated as IGT, pre-diabetic, diabetic or as having Metabolic Syndrome must undergo urinalysis and have a urine microalbumin test done within thirty(30) days of admission. Diabetic patients and/or those with evidence of proteinuria must be placed on an ACE-inhibitor. Those patients who cannot tolerate this class of medication and/or in whom measurable proteinuria has been identified will be referred for sub-specialty evaluation and care.

Clinicians must monitor the urine for leucocyte esterase, along with WBCs and sediment. Glycosuria is often associated with colonization that must be differentiated from urinary tract infections. **NOTE:Pregnant**

patients with urinary tract infections, with or without diabetes, must be referred for prompt evaluation and treatment.

GASTROINTESTINAL ASSESSMENT:

Clinicians must inquire about a patient's bowel habits and any perceived bowel issues. As nocturnal diarrhea may be seen in diabetics, clinicians should question patients about frequency and urges. Early satiety with eating, excessive flatus and/or bloating may be indicative of gastroparesis and may need special attention in the jail.

INTEGUMENTARY ASSESSMENT:

Within thirty (30) days of inmate admission an evaluation of the skin, including a podiatry examination, must be completed. Clinicians must assess the pedal pulses and look for pressure ulcers or lesions.

NEUROLOGY ASSESSMENT:

Microfilament units are available on-site to test for gross peripheral neuropathy. Patients with paresthesias may require medication to blunt symptoms. It is reported that control of glucose and lipids will abate symptomatology.

DIABETES PROTOCOL

Review of Intake Screening/Clinical History

LABORATORY STUDIES

- Random glucose testing (finger stick)
- Urinalysis
- Order medications
- Order HA1c test (glycosylated hemoglobin A1 c test) for chronic diabetics every three(3) months unless well controlled and then every six(6) months.
- Enroll in Chronic Care (complete and include all necessary documentation in the inmate's medical record)

DIAGNOSTIC TESTS

- Cardiovascular:
  - examination
  - electrocardiogram (ECG/EKG)
  - echocardiogram with ejection fraction (EF) – as indicated

CARDIAC RISK FACTORS
o **Male**
o **Diabetic**
o **Hypertension**
o **Smoker**
o **dyslipidemia/hypercholesterolemia**
o **history of ischemic heart disease**
o **diet high in saturated fats and sodium**
o **angina**
o **metabolic syndrome**
o **neck circumference >20 inches**
o **waist circumference >40 inches**
o **gallops and murmurs**

CHRONIC CARE:

- HA1c test
  - Eyes:
    - Snellen eye test
    - fundoscopic eye examination
    - optometry/ophthalmology referral
  - Kidney:
    - urinalysis for albuminuria, leukocyte esterase and white blood cell count (WBC)
  - Skin:
    - examination for/of pressure ulcers, stasis dermatitis and other chronic changes
    - microfilament examination

Did You Check For?	Did You Do?
Adequate hydration	Hydration therapy
Orthostatic blood pressure	Medication ordering, including:
Skin turgor	Oral medications
Mucus membranes	Insulin
Urinalysis	ACE/ARB inhibitors (NOTE: All diabetics shall be placed on ACE inhibitors [ARBs]. Patients intolerant of ACE inhibitors due to intractable cough, rashes, etc., should be offered a trial of ARBs.)
Osmolality	
Ketones	
BUN: creatinine (> 20:1)	Beta blockers (for treatment of ischemic heart disease)
Acidosis	
Tachypneaic	Diagnostic testing
Urinalysis	Referrals for consultation
pH	Intake and output measuring
Ketones	Review of nursing orders
Nidus of infection	IV for saline hydration; add glucose if blood sugar is <250mg/dL
Skin – check for abscesses and sores	Administration of insulin using sliding scale
Lungs – cough or rhonchi	Routine urinalysis using:
Urine	DiaScreen 10
WBC – leukocyte esterase	Microalbumin 2-1 Combo Strip
High or low orthostatic blood pressure	Echocardiogram with ejection fraction (EF), when applicable
BUN: Creatinine (Cr) ratio of >20:1	Abdominal ultrasound of liver for NASH
C02 content	Chest x-ray (CXR)
Abnormal respiratory rate	
Ketone breath	
Urinalysis for albuminuria,	
Rhonchus/cough	
Skin changes	
Abnormal lipid profile	
Abnormal liver function tests (LFTs)	
Non-alcoholic steatohepatitis (NASH)	
Abnormal ECG/EKG	

CARDIAC RISK FACTORS

Male

Diabetic

Hypertension

Smoker

dyslipidemia/hypercholesterolemia

history of ischemic heart disease

diet high in saturated fats and sodium

angina

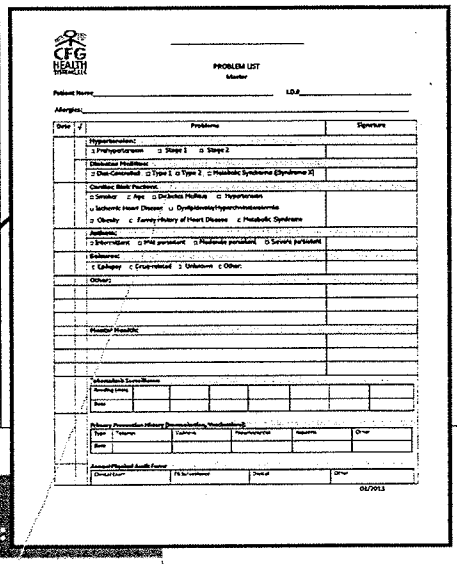
metabolic syndrome

neck circumference >20 inches

waist circumference >40 inches

gallops and murmurs

Need for smoking cessation program



PROBLEM LIST

DIABETES DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **Identify inmate as:**
  - **insulin dependent**
  - **taking oral hypoglycemic**
  - **mixed**
- **ICD codes**

Diabetes Mellitus:

□Diet-Controlled □Type 1 □Type 2 □Metabolic Syndrome [Syndrome X]

Orders and Care Plan

- **Enroll in Clinic**
- **Statement of level of control (necessary documentation for the medical record)**

Nursing Education

- **Dispense at intake**

Discharge Planning (site specific)

- **Educational materials**
- **Diagnostic test results**

METABOLIC SYNDROME

Twenty-five percent (25%) of all general, non-obese, non-diabetic people have significant insulin resistance, as seen in Type 2 diabetes.

Indicators associated with Metabolic Syndrome include the following:

- Normal or slightly elevated BMI (Body Mass Index)
- Normal 2-hour postprandial glucose levels
- Abdominal girth >40 inches (for males); >35 inches (for females)
- Neck girth >20 inches (for males only)

Those individuals diagnosed with Metabolic Syndrome are at increased risk for developing:

- Type 2 diabetes
- Hypercholesterolemia (high LDL-C)
- Pro-inflammatory states
- Hyperuricemia

In some populations, there exists underlying insulin resistance or hyperinsulinemic states.

THYROID DISORDERS

DIAGNOSTIC TESTING

- Ultrasound of thyroid
  - Cystic?
  - Solid?
- Thyroid scan and uptake

LABORATORY STUDIES

- Rule out any comorbid conditions, such as diabetes

THYROID ABLATION THERAPY

- Patients with Grave's Disease are often treated with ablation therapy utilizing I^{131}. The facility may not be able to provide post-therapy isolation. The Medical Director will confer with the Warden prior to the initiation of I^{131} to inform them of procedures on segregation.

MEDICATIONS

NOTE: Please refer to Endocrinology Clinic for the initiation of thyroid medication.

DIABETES INSIPIDUS (DI), SYNDROME OF INAPPROPRIATE ANTIDURETIC HORMONE (SIADH) AND PSYCHOGENIC WATER DRINKING (PWP)

Initial Health Assessment (Physical/Examination Findings)

- SIADH (Syndrome of Inappropriate Antidiuretic Syndrome) indicators:
  - Hyponatremia
  - Hyposmolality (<280 mosm/kg)
  - Urinary sodium elevation (>20 mEq/L)
- Psychogenic water drinking
  - Review mental health history
  - Implement water restriction

Laboratory Studies

- Serum electrolytes
- Serum creatinine
- Serum osmolality
- Urinary sodium

PULMONARY

Asthma/COPD

(Treatment of asthma as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Asthma is characterized by reversible airflow obstruction, indicated by FEV I measurements greater than 12% from baseline or an increase of FEV I greater than 10% of predicted results after use of a bronchodilator. Patients often report dyspnea, cough, nocturnal wheezing, difficulty breathing and a feeling of tightness in the chest. Hyperinflation of the lungs is observed during acute episodes and is generally accompanied by diminished breath sounds, high-pitched wheezing and the use of accessory muscles. The condition is usually exacerbated by exercise, viral infections, inhalation of allergens, exposure to irritants, changes in weather, strong emotion, stress and menstruation.

For asymptomatic, non-compliant patients, discontinue medication and complete a Non-Compliance form. Reassess the level of disease in these patients when they have not been exposed to allergens and known irritants, such as cigarette smoke.

Asthma Protocol

Review of Intake Screening/Clinical History

- Management History

Initial Health Assessment (Physical/Examination Findings)

- Vital signs
- Auscultation of lung fields
- Assess peak expiratory flow (PEF)

- Spirometry Assessment

- Make clinical diagnosis

  "All Wheezing is **NOT** Asthma"

  - Primary:
    - Mild
    - Moderate
    - Moderately Severe
    - Severe
  - Secondary:
    - Essential
    - Cardiac
    - Smoking
    - Other
- Assess severity and establish control
  - Self-medication techniques
  - Health plan and community support
  - Enroll in Chronic Care

MEDICATIONS

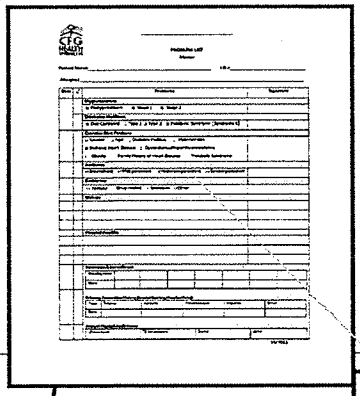
Please visit the following links:

http://www.health.ny.gov/diseases/asthma/pdf/2009_asthma_guidelines.pdf

http://img.medscape.com/fullsize/migrated/editorial/journalcme/2008/17618/fromer.fig2.gif.

- Nebulizer Treatments, PRN
- Steroids
- Selective Beta-agonists
- Leukotriene blockers

Did You Check For?	Did You Do?
Resolution of symptoms Primary prevention (immunizations) Patient compliance with medication	Reduce impairment via control of environmental/external contributing factors (i.e., cleaning, extermination, smoking cessation, etc.) Provide long-term chronic symptom control (proscribed medication) Maintain normal pulmonary function tests (PFTs) Enable the patient to engage in normal activity Stabilize condition through steroid use, reducing short-acting Beta-2 agonist (SABA) use Work toward preventing recurrent ER interventions Optimize medications, minimizing long-term side effects



Asthma:

□Intermittent □Mild persistent □Moderate persistent □Severe persistent

ASTHMA DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Establish primary and secondary diagnoses (i.e. – Primary: moderate-severe; Secondary: exercise-induced** • **ICD codes**
Orders and Care Plan • **Pulse oximeter** • **Peak expiratory flow**
Equipment • **Oxygen Concentrators- provide low flow oxygen therapy in the medical housing unit or infirmary**
Nursing Education • **Printed patient materials**
Discharge Planning

EMBOLISM

DVT (DEEP VEIN THROMBOSIS)

PROBABILITY SCORING

RISK FACTORS OF DEEP VEIN THROMBOSIS (DVT)

DVT can occur in almost anyone. Only about half of all patients with DVT exhibit any symptoms; however, certain individuals may be at increased risk for developing a DVT. Risk factors include, but are not limited to, the following:

- Surgery
- Restricted mobility
- Congestive heart failure
- Cancer
- Respiratory failure
- Infectious disease
- Age >40
- Overweight/obese
- Smoker
- Prior VTE (venous thromboembolism)
- Family history of VTE (venous thromboembolism)
  - Ex: Factor V Leiden Prothrombin gene 620210A, Deficiency Protein C, Protein S and AT
- Homocystinuria
- Acquired Autoantibodies

On the heels of a widely-adopted set of clinical criteria for pulmonary embolism, in 2006 Scarvelis and Wells overviewed a set of clinical prediction rules for DVT (deep vein thrombosis).

Wells Score Criteria

1) Active cancer (treatment within last 6 months or palliative care)	1 point
2) Calf swelling >3 cm compared to other calf (measured 10 cm below tibial tuberosity)	1 point
3) Collateral superficial veins (non-varicose)	1 point
4) Pitting edema (confined to symptomatic leg)	1 point
5) Swelling of entire leg	1 point
6) Localized pain along distribution of deep venous system	1 point
7) Paralysis, paresis or recent cast immobilization of lower extremities	1 point
8) Recently bedridden >3 days or major surgery requiring regional or general anesthetic in past 4 weeks	1 point
9) Alternative diagnosis at least as likely	1 point

- ❖ Plus heart rate ≥ 100 bpm

Interpretation of results:

1) Score of 2 or higher – deep vein thrombosis is likely. Consider imaging the leg or veins.
2) Score of less than 2 – deep vein thrombosis is unlikely. Consider blood testing, such as the D-dimer test to further rule out deep vein thrombosis. If D-dimer is negative, it is highly unlikely the patient has a DVT.

Review of Intake Screening

Initial Health Assessment (Physical Examination Findings)

- Measure the circumference of both limbs (affected and non-affected)

<u>DIAGNOSTIC TESTING</u>

- Doppler study
- CT Scan

Activate emergency transfer to tertiary care center

HOSPITAL TREATMENT

- TPA

ANTICOAGULANT MEDICATIONS
Rivaroxaban
Xarelto
Warfarin
Apixaban
Edoxaban
Dabigatran
Dalteparin
Enoxaparin
Fondaparinux
Tinzaparin
Unfractionated Heparin

TREATMENT INITIATION

- Elevation of affected limb
- Apply warm compresses
- **NOTE:** If aspirin is given, this must be documented in the order form
- Refer to Emergency Room for anticoagulation. **DO NOT INITIATE WARFARIN OR LOVENOX ON-SITE.**

INFECTIOUS DISEASES

(Clinicians must refer to the Infection Control Manual)

INFECTIOUS DISEASE PROTOCOL

Receiving Screening

- Review nursing statements
- History of fever or rash or cough
- Other people affected or sick
- Travel history
- Treatments already taken such as an antibiotic
- Obtain vaccine-specific consents
- Confirm pregnancy

Initial Health Assessment (Physical/Examination Findings)

- Complete the Immunization History
- Obtain vaccine-specific consents
- Confirm pregnancy

If pregnant, **withhold** the following vaccinations:

- MMR
- HPV
- Polio
- H1N1 Mist

Primary preventive vaccines offered:

- Pneumovax
- Influenza
- Tetanus toxoid
- Hepatitis
- Tdap
- Polio
- MMR
- H1N1

CFG does not offer the Varicella vaccine, hyperimmune globulin or the HPV vaccine.

Did You Check For?	**Did You Do?**
Consult Infection Control Manual	Identify any chronic diseases
Disease background information	Identify any comorbid conditions
Additional guidelines	
Care Plans	
Forms for tracking and reporting	

HEPATITIS

BACKGROUND

There are five (5) primary viral hepatitis infections: Hepatitis A (HAV), Hepatitis B (HBV), Hepatitis C (HCV), Hepatitis D (HDV) and Hepatitis E (HEV). These infections vary widely in their:

- communicability
- scope of morbidity
- chronicity

- response to treatment
- long-term consequences and sequelae

Please see the Hepatitis Chart on the following pages for information specific to each type of infection.

Hepatitis Table

	Hepatitis A	**Hepatitis B**	**Hepatitis C**	**Hepatitis D**	**Hepatitis E**
Etiology	RNA virus	DNA virus	Single-strand RNA virus	Sub-viral RNA particle	Single-strand RNA virus
Transmission	Oral-fecal (poor hand-washing)	Blood Mother-to-baby Sexual	Blood Mother-to-baby Tattoos	Found in combination with HBV	Oral-fecal (poor hand-washing) Water contamination
Incubation Period	15 to 50 days (average 30 days)	45 to 160 days (average 120 days)	2 to 25 weeks (3 wks. PCR testing;< 9 wks. HCV-antibody)	2 to 8 weeks (+HBV infection)	2 to 9 weeks (average 40 days)
Symptoms	None Jaundice Dark urine Myalgia Nausea Fatigue	None Flu-like symptoms +/- Jaundice +/- Dark urine Myalgia Nausea Fatigue Fulminant hepatitis	Usually none Co-morbidity with: – Nephrotic syndrome – Thrombocytopenia – Autoimmune disease Cirrhosis Fulminant hepatitis Hepatoma	See HBV	Inflammatory transaminitis outbreak
Diagnostic Examination	– Hepatitis panel – CBC with differential – CMP – Urinalysis – Serial transaminase titers – Albumin, globulin, INR – Abdominal ultrasound (for severe abdominal pain)	– Hepatitis panel – CBC with differential – CMP – Serial transaminase titers – Albumin, globulin, INR – Abdominal ultrasound – Monitor HBeAg, HBeAb, HBcAg, HBcAb and HBsAb	– Hepatitis panel – CBC with differential – CMP – **Abdominal ultrasound (with cirrhosis; hepatoma)**		

	Hepatitis A	Hepatitis B	Hepatitis C	Hepatitis D	Hepatitis E
Treatment	– HBV vaccination – Supportive	– HAV vaccination – Anti-viral medications – Supportive – Enroll in Chronic Care Clinic – Infectious disease consultation for NNRT therapy (as needed)	– HAV, HBV vaccination – Medication, as indicated by established clinical protocols – Anti-viral[5] medications – Enroll in Chronic Care Clinic	– HAV, HBV vaccination – Hospital-based management	Supportive
HIV Surveillance	Primary prevention	Primary prevention	Primary prevention	Primary prevention	
Vaccination	2 dose regimen: – baseline – 6 months	3 dose regimen: – baseline – 1 month – 6 months	Primary prevention (protection from combined A or B + C)	3 dose regimen: – baseline – 1 month – 6 months	

MANAGEMENT AND TREATMENT PROTOCOLS

Hepatitis A (HAV)

Patients, who present with extreme jaundice, diffuse abdominal pains, dark urine and clay-colored feces should be placed in contact isolation until etiology can be determined. A diagnostic hepatitis panel must be ordered to:

1. establish acute diagnosis
2. determine passive immunity to other forms of hepatitis

Patients found to have hepatitis A (HAV) infection with no immunity to hepatitis B are to begin three phase immunization therapy for hepatitis B, with a baseline inoculation administered at the time of diagnosis, a second inoculation given one (1) month later, and a third and final inoculation administered at six (6) months post-testing. As the primary route of infection is fecal/oral, the Infection Control Nurse (ICN) must work closely with Custody staff to determine any possible sources of infection within the jail. Proper hand-washing techniques, plus universal precautions and personal hygiene training should be given to all key staff and especially food service workers. A comprehensive health screening of the facility should be performed under the direction of the ICN to monitor for potential outbreaks. Finally, the Medical Director must monitor the patient's serial transaminase titers (to confirm healing/reduction in titer), as well as albumin, globulin and INR titers (to monitor hepatic reserve). Patients who fail to improve must be referred to a Gastroenterology specialist.

[5] Anti-viral medications blunt the efficacy of anti-HIV protease inhibitors; possible other classifications

HEPATITIS A SYNOPSIS	
Transmission	Oral-fecal
Actions	✓ Contact isolation for patients with diarrhea ✓ ICN surveillance ✓ Supportive care (self-limiting) ✓ Immunization against HBV ✓ Serial transaminase titers to assess injury ✓ Monitor albumin, globulin and INR to assess hepatic function ✓ Abdominal ultrasound for severe abdominal pain

Hepatitis B (HBV)

Hepatitis B is a highly contagious disease and is usually contracted via blood-borne transmission and/or through unprotected sexual activity with an infected partner. As with hepatitis A, a diagnostic hepatitis panel must be ordered to:

1. establish acute diagnosis
2. determine passive immunity to other forms of hepatitis

Patients found lacking in immunity to HAV must begin immunization therapy, with a baseline inoculation administered at the time of diagnosis and a second dose given six (6) months later, in order to confer complete immunity. Medical and jail staff must employ universal precautions. Contact isolation should be used whenever a patient diagnosed with HBV is jaundiced and/or has diarrhea. The Medical Director will monitor serial transaminase titers (to confirm healing/reduction in titer), as well as albumin, globulin and INR titers (to monitor hepatic reserve).

There are several types of chronic hepatitis often associated with HBV infection – chronic, active and persistent. Patients will need to have assays for HBeAg, HBeAb, HBcAg, HBcAb, and HBsAb performed. Patients with progressive hepatitis who fail to improve must be referred to Gastroenterology. An Infectious Disease specialist may be consulted regarding NNRT therapy (this is often the case with patients co-infected with HIV).

HEPATITIS B SYNOPSIS

Transmission	Sexual and blood-borne transmission
Actions	✓ Contact isolation for patients with jaundice and/or diarrhea ✓ Immunization against HAV ✓ Serial transaminase titers to assess injury ✓ Monitor albumin, globulin and INR to assess hepatic function ✓ Monitor HBeAg, HBeAb, HBcAg, HBcAb and HBsAb (persistent "core" or "e" antigenemia) ✓ Abdominal ultrasound for severe abdominal pain ✓ Enroll in Chronic Care Clinic (every 3 to 6 months) ✓ Provide primary prevention immunizations ✓ Screen for HIV ✓ Infectious disease consultation for NNRT therapy

Hepatitis C (HCV)

There are several genotypes of the hepatitis C virus, with type 1 being the most common in the United States. Hepatitis C is usually spread through contact with blood from an infected individual. Increased risk factors for contracting HCV include:

- Having undergone blood transfusion or organ transplant prior to 1992 or receiving blood clotting factor concentrates prior to 1987
- Intravenous drug use
- Being born between 1945-1965
- Long-term hemodialysis
- HIV-infection

CFG policy (based upon NCCHC guidelines) dictates that medical staff only screens patients for HCV infection when clinical conditions or co-morbidities associated with HCV infection exist, as delineated below:

Screening Associated with HCV

1. Patients with acute or uncontrolled HIV infection should be screened for hepatitis A, B and C. Here, the intent is to determine whether immunity exists in the patient and, if not, to implement primary prevention through the administration of vaccines. Since no vaccine exists for HCV, intervention at this stage is to immunize solely against HAV and HBV, as previously indicated.

2. Patients with persistent or increasing hepatic transaminase titers over a ninety (90) day period - with assessment occurring on at least two (2) occasions separated by one (1) month - should undergo hepatitis C screening.

3. Patients who present with moderate to severe anemia, defined as a low MCV and MCHC, and/or those with significant thrombocytopenia (platelet counts less than 25,000) will need to have HCV ruled out.

4. Patients who present with nephrotic syndrome (as determined by massive proteinuria of greater than 3.5 grams per twenty-four [24] hours), or those with kidney biopsy findings of membranous glomerulonephritis should be screened for HCV.

The vast majority of HCV-infected individuals remain asymptomatic, even when chronic disease is present. The literature reports some 25% of those with acute HCV infection (demonstrated by a positive HCV assay and associated elevations of hepatic transaminase titers) will spontaneously clear the virus from the body and will have no long-term sequelae (chronic hepatitis, cirrhosis or hepatic failure). In most cases, progression of HCV is measured in terms of years, with less than one-fifth of HCV infection progressing to cirrhosis; however, one-fifth of those who do develop cirrhosis will develop a hepatoma within 20-30 years post-diagnosis.

A liver biopsy should be performed to determine whether cirrhosis of the liver has developed. In the past, the decision to treat was based on virus genotype and the results of liver biopsy, in conjunction with the presence of co-morbid conditions, such as uncontrolled HIV infection, severe anemia, severe thrombocytopenia and/or nephrotic syndrome. The new nucleotide analog NS5B polymerase inhibitors, which mediate HCV RNA replication, have properties that protect against disease genotypes 1, 2, 3 and 4, with efficacy data in existence for patients with evidence of cirrhosis; however, there is no current firm consensus regarding clinical criteria for beginning such treatment.

Hepatitis C Treatment Paradigm

Detainees with active HCV who will remain in county custody and who present at Receiving Screening already on therapy will be evaluated on an individual basis to determine if hepatitis medication will continue. The Medical Director must confer with the prescribing physician and establish their area of specialty (Hepatologist, Infectious Disease). The Medical Director will contact each treating physician who has prescribed a medication regimen for addressing HCV to arrange for the patient's uninterrupted and continued access to such

medication. Many of these practitioners may make HCV medications available to their patients via treatment grants. CFG shall work in tandem with each of these providers to maintain the patient's medication supply.

NOTE: Detainees who arrive on medication, but for whom no responsible clinician can be identified or who have demonstrated poor compliance with treatment will not have HCV medication regimens continued. Continuity of care is an imperative to minimize risks associated with treatment. Without evidence of proper and consistent follow-up care beyond the treating physician's initial order, HCV medication shall be discontinued.

All patients for whom the initiation of treatment is recommended while incarcerated shall be referred to the Corporate Medical Director, who will work in collaboration with the jail, outside agencies and the Courts to expeditiously relocate the patient to the most appropriate care setting.

Strict adherence to the treatment regimen, along with long-term follow-up, is essential to the care plan. This often presents a problem in county jail settings, where most patients' terms of incarceration are for short periods of time – up to 47% of detainees incarcerated in New Jersey county jails are released within two (2) weeks.

Facility Medical Directors shall not be permitted to initiate medication therapy prior to the receipt of an approved non-formulary request from CFG's Corporate Medical Director. Supportive pharmacies are advised not to ship HCV meds without prior receipt of a CFG Non-Formulary Request form endorsed by the Corporate Medical Director.

Patients who present with symptomatic HCV infection, along with serious co-morbid conditions (as previously reviewed), must be referred to Custody classification for identification of those detainees who will not remain incarcerated for at least eight (8) months (HCV protocol dictates a minimum three [3] months of treatment and two [2] months of follow-up and monitoring). At those facilities where a relationship has been established with a Federally-Qualified Health Centers (FQHCs), CFG shall work to establish a viable care plan for adequate follow-up and treatment. CFG will also work in collaboration with Custody/the Warden to promptly identify detainees who qualify for bracelet monitoring outside the jail. For detainees who will transition to the State penal system, CFG will provide supportive care while the patient remains in county custody, but will let the State provide medication therapy and follow-up care.

HEPATITIS C SYNOPSIS

Transmission

Blood-borne transmission

Symptomatic HCV defined by

- Severe anemia
- Thrombocytopenia
- Nephrotic syndrome
- HCV viral load in the millions

Actions

***Note – CFG will not initiate medication in asymptomatic HCV-infected individuals.**

- ✓ Immunization against HAV and HBV, as indicated
- ✓ Serial transaminase titers to assess injury
- ✓ Abdominal ultrasound
- ✓ Medication therapy – to be ordered only when:
  - clinical documentation exists of patient compliance with treatment as initiated by an external physician
  - case review and endorsement from CFG's Corporate Medical Director has been obtained
- ✓ Anti-viral medications, as needed
- ✓ Enroll in Chronic Care Clinic (every 6 months)

Special Considerations and Actions

CFG will provide supportive care to symptomatic HCV+ patients while appropriate treatment and facilities for long-term management are being identified. Jail administrationmay be informed of symptomatic HCV patients for expedited transfer to the State prison system (as applicable) and when a facility has established a relationship with an FQHC (federally-qualified health center) in order to determine eligibility for release and/or transfer for treatment.

This section shall serve to spotlight key diagnostic and treatment parameters of CFG's clinical pathway for treatment of the Hepatitis C viral infection. Consistent with guidelines from the National Commission on Correctional Health Care (NCCHC), this plan identifies and defines pivotal decision points along the disease continuum for clinical intervention by CFG clinicians.

For Inmates who are HCV+ and on medication at Intake:

1. Nursing must complete a comprehensive initial health assessment, verify all medications and obtain a Release of Information form signed by the patient.
2. The clinician must complete a comprehensive history and physical examination, inclusive of assessment for active infection or intercurrent disease (such as cryoglobulinemia, nephrotic syndrome, anemia, thrombocytopenia, HIV or depression).
3. The clinician shall review all verified medications and contact the primary prescribing clinician in order to obtain a history that includes the following information:
    - Date of diagnosis
    - Clinical presentation at time of diagnosis (i.e., - cryoglobulinemia, renal failure, thrombocytopenia, cirrhosis)
    - Known HCV risk factors and patient's level of compliance in demonstrating restraint
    - Primary prevention intervention via vaccinations
    - Secondary prevention intervention, including prophylaxes such as isonicotinic acid hydrazide INH for latent tuberculosis infection (LTBI)
    - HIV serology
    - Serologic laboratory testing, inclusive of liver function tests (LFTs), blood chemistry, hemograms and platelet counts
    - Hepatitis C viral RNA titers
    - Liver biopsy results and histopathology
    - Specific findings, recommendations and the treatment plan from the patient's last office visit
4. Enroll the patient in Chronic Care Clinic
5. Provide Primary and Secondary prevention, accordingly (or confirm prior treatment)
    - Vaccination for Hepatitis A and B, if no evidence of immunity exists
    - HIV testing (if patient status is unknown or unconfirmed)
    - Monitoring and evaluation of the PPD skin test site, with INH prophylaxis for LTBI
    - Tetanus vaccination
    - Pneumococcus vaccination
6. **Medications:**
    - **Continue with patient's previously prescribed medications if:**
        - Continuation of care with necessary specialist(s) is possible
        - The patient's compliance with medications has been confirmed
        - A positive clinical response to treatment has been confirmed through:
            - Reduction of present HCV RNA titers when compared to baseline
            - Rise in total platelet count
            - Rise in hemoglobin/hematocrit

        - Improved renal function (diminished proteinuria)
- **Discontinue a patient's medications if:**
    - No Gastroenterologist or Infectious Disease Specialist managing care
    - No evidence of follow-up care beyond initial order or evidence of missed appointments with specialist(s)
    - Patient resumption or continuance of risky behaviors
    - Patient has failed to respond to treatment as evidenced by the following (must discuss in collaboration with specialist[s]):
        - Persistent elevation of HCV RNA titer
        - Continued thrombocytopenia
        - Presence of hemolytic, persistent or refractory anemia
        - Diagnosis of nephrotic syndrome
    - Clinical evidence or prior diagnosis of major depression

For patients who are HCV+ and NOT on medications at intake:

1. Nursing must complete a comprehensive initial health assessment, verify all medications and obtain a Release of Information form signed by the patient
2. The clinician must complete a comprehensive history and physical examination inclusive of assessment for signs of active infection and intercurrent disease (i.e., - cryoglobulinemia, nephrotic syndrome, anemia, thrombocytopenia, HIV or depression)
3. Enroll patient in Chronic Care Clinic
4. Provide Primary and Secondary prevention, accordingly (or confirm prior treatment)
    - Vaccination for Hepatitis A and B, if no evidence of immunity exists
    - HIV testing (if patient status is unknown or unconfirmed)
    - Monitoring and evaluation of the PPD skin test site, with INH prophylaxis for LTBI
    - Tetanus vaccination
    - Pneumococcus vaccination
5. **The following laboratory tests should be ordered – baseline LFTs, CBC with differential, blood chemistry - with the applicable steps listed below followed:**
    - If LFTs are abnormal, CBC is normal and there is no evidence of thrombocytopenia, GO TO NUMBER 6 (below)
    - If LFTs are normal and CBC is normal, PROCEED TO NUMBER 6 (below)
    - If LFTs are abnormal, CBC is abnormal and the patient has thrombocytopenia, then order HCV RNA titers:
        - If LFTs are abnormal, CBC is abnormal and HCV RNA titers are elevated, refer the patient for consultation with the specialist
        - If LFTs are abnormal, CBC is abnormal, but HCV RNA titers are normal or only mildly elevated, PROCEED TO NUMBER 6 (below)
        - If LFTs are abnormal, but CBC is normal, PROCEED TO NUMBER 6 (below)
6. Repeat LFTs, CBC with differential and blood chemistry in four (4) months

Hepatitis D (HDV)

Hepatitis D is a co-morbid viral infection only associated with active HBV infection. Patients with hepatitis D will be referred promptly to a tertiary care setting for proper management under a Hepatologist, as significant rates of mortality are associated with fulminant HBV+HDV infection.

HEPATITIS D SYNOPSIS	
Transmission	Incidental finding in clinically-compromised HBV+ patients
Actions	Hospital-based management

Hepatitis E (HEV)

Like HAV, Hepatitis E is transmitted via the fecal-oral route and presents in a similar manner. HEV is extremely rare in United States patient populations, but may nevertheless be seen at jail facilities housing INS detainees. Though this condition is self-limiting and is not associated with chronic disease, universal precautions should be taken and supportive care given when the condition is detected.

HEPATITIS E SYNOPSIS	
Transmission	Oral-fecal
Actions	Supportive (disease is self-limiting)

SEXUALLY TRANSMITTED DISEASES (STDS)

Multiple studies, as reported by the CDC (Centers for Disease Control), indicate correctional facility populations have high rates of STDs (sexually transmitted diseases) – including HIV and viral hepatitis – especially among persons aged 35 and younger. Risk factors for contracting STDs (having unprotected sex; having multiple partners; using drugs and alcohol; and engaging in commercial, survival and/or coerced sex) are also more

prevalent among incarcerated populations. Compounding the problem further, prior to incarceration, many detainees have limited access to medical care, especially community-based clinical prevention services.

In its approach to both detection and treatment of STDs, CFG utilizes recommendations released by the CDC in its Morbidity and Mortality Weekly Report (MMWR) as part of treatment paradigms. The MMWR contains important data on current prevalent infections, including information on susceptibility, resistance patterns and recommendations for treatment. As such, the MMWR represents a clinical mean, helping to establish standards of care for public health providers, with local health departments assisting in the dissemination of MMWR publications throughout the community.

It should be noted that all sexually transmitted diseases (STDs) have subclinical (latent) phases during which time patients appear asymptomatic. Screening for asymptomatic infections allows for identification and early treatment of STDs that might otherwise go undetected; thereby, eliminating potential complications and reducing the prevalence of infection both inside and outside the jail. Please note, patients may also present with several co-occurring infections (or multiple organisms) at the time of screening.

Screening

Patients testing positive for syphilis must be screened for HIV, as syphilis is considered an "AIDS-defining illness." Similarly, patients found to have oral thrush infections of the tongue and oral cavity must also undergo HIV testing. Patients testing positive for gonorrhea should also be screened for chlamydia and ureaplasma. Those patients with a history of substance abuse should be screened for the following:

- Lesions/anomalies of the skin and soft tissue
- Aspiration pneumonias
- Hepatitis A, B and C
- HIV/AIDS
- HPV
- Syphilis
- Endocarditis
- Septic arthritis

Referrals

- Consult a specialist for any of the following:
    - New case of HIV
    - Persistent or relapsing infection
    - Endocarditis
    - Osteomyelitis

Treatment Guidelines for Sexually Transmitted Diseases

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
SYPHILIS		
ADULTS Primary, secondary or early latent (< 1 year)	• Benzathine penicillin G 2.4 million units IM once	**(For penicillin-allergic non-pregnant patients only)** • Doxycycline 100 mg orally 2 times per day for 14 days ***OR*** • Tetracycline 500 mg orally 4 times per day for 14 days
ADULTS Late latent (> 1 year) or latent of unknown duration	• Benzathine penicillin G 2.4 million units IM for 3 doses at 1 week intervals (total 7.2 million units)	**(For penicillin-allergic non-pregnant patients only)** • Doxycycline 100 mg orally 2 times per day for 28 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 28 days
NEUROSYPHILLIS	• Aqueous crystalline penicillinG 18 - 24 million units per day, administered as 3 - 4 million units IV every 4 hours or continuous infusion for 10 - 14 days	❖ Procaine penicillin 2.4 million units IM once daily PLUS Probenecid500 mg orally 4 times per day, both for 10 - 14 days
CONGENITAL SYPHILIS	**See CDC guidelines – www.cdc.gov/std/treatment**	
HIV INFECTION	**Same stage-specific recommendations as for HIV-negative persons.**	
PREGNANT	**Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and treated with penicillin. Treatment is the same as in non-pregnant patients for each stage of syphilis.**	
GONOCOCCAL INFECTIONS		
ADULTS AND ADOLESCENTS (aged 12-19) Urogenital, pharyngeal and rectal	❖ Ceftriaxone 250 mg IM once* PLUS Azithromycin 1 g orally once (preferred) ***OR**** Doxycycline 100 mg orally 2 times per day for 7 days **(doxycycline NOT recommended for pregnant or lactating women)** ***Because data is limited concerning the efficacy of ceftriaxone and azithromycin regimes in HIV-infected persons, these regimens should be used for such patients	***Note*: Use of any alternative regimens for gonorrhea should be followed by a test-of-cure one week after treatment ends. *** **For urogenital or rectal infections ONLY (and ONLY if ceftriaxone is not available):** ❖ Cefixime 400 mg orally, once PLUS Azithromycin 1 g orally once (preferred) ***OR*** Doxycycline 100 mg orally 2 times per day for 7 days **For severe cephalosporin allergy:**

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	only if follow-up care can be ensured.	• Azithromycin 2 g orally in a single dose
ADULTS AND ADOLESCENTS (aged 12-19) Conjunctival	❖ Ceftriaxone 1 g IM once PLUS lavage the infected eye with saline solution once	*Test-of-cure for gonorrhea should be performed with culture or with nucleic acid amplification (NAAT), if culture is not available. If NAAT positive, confirmatory culture is recommended. If treatment failure after recommended regimen use, perform anti-microbial susceptibility testing, then notify and consult with the State Health Department and/or an infectious disease specialist, an STD/HIV Prevention Training Center or the CDC. If treatment failure after alternative regimen use, treat using ceftriaxone 250 mg IM, PLUSazithromycin 2 g orally once and perform test-of-cure one week later.
CHLAMYDIAL INFECTIONS		
ADULTS AND ADOLESCENTS (aged 12-19)	• Azithromycin 1 g orally once *OR* • Doxycycline 100 mg orally 2 times per day for 7 days	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days *OR** • Levofloxacin 500 mg orally once per day for 7 days *OR*** • Ofloxacin 300 mg orally 2 times per day for 7 days** *If the patient cannot tolerate high dose erythromycin schedules, change to a lower dose over a longer period of time (see alternatives for Pregnant patients - below) **Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age. Also contraindicated in pregnant patients.
PREGNANT	• Azithromycin 1 g orally once *OR* • Amoxicillin 500 mg orally 3 times per day for 7 days	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR* • Erythromycin base 250 mg orally 4 times per day for 14 days *OR* • Erythromycin ethylsuccinate 800 mg orally 4 times per day for 7 days *OR* • Erythromycin ethylsuccinate400 mg orally 4 times per day for 14 days
NON-GONOCOCCAL URETHRITIS		
ADULT AND ADOLESCENT MALES (aged 12-19)	• Azithromycin 1 g orally once *OR* • Doxycycline 100 mg orally 2 times per day for 7 days Infections with *M. genitalium* may respond better to azithromycin.	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days *OR** • Levofloxacin 500 mg orally once per day for 7 days *OR*** • Ofloxacin 300 mg orally 2 times per day for 7 days**

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
		*If the patient cannot tolerate high dose erythromycin schedules, change to a lower dose over a longer period of time (see alternatives for Pregnant patients - above) **Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age.
EPIDIDYMITIS		
ADULT AND ADOLESCENT MALES (aged 12-19)	❖ Ceftriaxone 250 mg IM once PLUS Doxycycline 100 mg orally 2 times per day for 10 days The recommended regimen of ceftriaxone and doxycycline is for epididymitis most likely caused by gonococcal and/or chlamydial infection. Given the increase in quinolone-resistant gonorrhea, an alternative regimen of ofloxacin or levofloxacin is recommended only if epididymitis is not found to be caused by gonorrhea or if infection is most likely caused by enteric gram-negative organisms.	• Levofloxacin 500 mg orally once per day for 10 days *OR** • Ofloxacin 300 mg orally 2 times per day for 10 days* *Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age.
PELVIC INFLAMMATORY DISEASE		
ADULT FEMALES	• Ceftriaxone 250 mg IM once *OR* ❖ Cefoxitin 2 g IM once PLUS Probenecid 1 g orally once *OR* ❖ Other third generation cephalosporin PLUS Doxycycline 100 mg orally 2 times per day for 14 days WITH OR WITHOUT Metronidazole 500 mg orally 2 times per day for 14 days	See complete CDC guidelines for alternatives - www.cdc.gov/std/treatment
PREGNANT	**Patients should be hospitalized and treated with the appropriate recommended parenteral IV therapy (see CDC guidelines - www.cdc.gov/std/treatment)**	
CHANCROID		
ADULTS	• Azithromycin 1 g orally once *OR** • Ceftriaxone 250 mg IM once	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	OR* • **Cipfofloxacin** 500 mg orally 2 times per day for 3 days ***OR**** • **Erythromycin base** 500 mg orally 3 times per day for 7 days ***Because data is limited concerning the efficacy of ceftriaxone and azithromycin regimes in HIV-infected persons, these regimens should be used for such patients only if follow-up care can be ensured.** ****Quinolones (such as ciprofloxacin) not recommended for use in patients under 18 years of age. Also contraindicated in pregnant patients.**	
BACTERIAL VAGINOSIS (BV)		
ADULT FEMALES	• **Metroniazole** 500 mg orally 2 times per day for 7 days ***OR**** • **Metronidazole** gel 0.75%, 5 g intra-vaginally once per day for 5 days ***OR*** • **Clindamycin cream** 2%, 5 g intra-vaginally at bedtime for 7 days ***Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole.**	• **Tinidazole** 2 g orally once daily for 3 days ***OR**** • **Tinidazole** 1 g orally once daily for 5 days ***OR**** • **Clindamycin** 300 mg orally 2 times per day for 7 days ***OR*** • **Clindamycin ovules** 100 mg intra-vaginally at bedtime for 3 days ***Tinidazole safety during pregnancy has NOT been established. Interruption of breastfeeding is recommended during treatment and for 3 days following the last dose.**
PREGNANT	**Oral therapy is the preferred treatment for pregnant women with BV due to the possibility of sub-clinical upper genital tract infections.** • **Metronidazole** 500 mg orally 2 times for 7 days ***OR**** • **Metronidazole** 250 mg orally 3 times per day for 7 days ***OR**** • **Clindamycin** 300 mg orally 2 times per day for 7 days ***Multiple studies and meta-analyses have *not* demonstrated an association between**	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole.	
TRICHOMONIASIS		
ADULTS	• Metronidazole 2 g orally once ***OR**** • Tinidazole 2 g orally once** *Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole. **Tinidazole safety during pregnancy has NOT been established. Interruption of breastfeeding is recommended during treatment and for 3 days following the last dose.	• Metronidazole 500 mg orally 2 times per day for 7 days Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole. The 7-day metronidazole regimen may be more effective than single dose metronidazole in women co-infected with trichomoniasis and HIV.
PEDICULOSIS PUBIS		
ALL (pregnant detainees should be treated using the recommended treatments only and *NOT* the alternative treatments listed)	• Permethrin 1% cream rinse applied to the affected area and washed off after 10 minutes ***OR*** • Pyrethrins with piperonylbutoxide applied to the affected area and washed off after 10 minutes	• Malathion 0.5% lotion applied for 8 - 12 hours and washed off ***OR*** • Ivermectin 250 mcg/kg orally once – repeated in 2 weeks* *Ivermectin not recommended for pregnant or lactating women.
SCABIES		
ALL	• Permethrin 5% cream applied to all areas of the body from the neck down and washed off after 24 hours ***OR*** • Ivermectin 200 mcg/kg orally, repeated in 2 weeks* *Ivermectin not recommended for pregnant or lactating women.	• Lindane 1% 1 oz. lotion or 30 g of cream applied thinly to all areas of the body from the neck down and washed off after 8 hours* *Lindane is no longer recommended as the first line of treatment due to its toxicity. Lindane should not be used immediately after a bath, for persons with extensive dermatitis or for women who are pregnant or lactating.
GENITAL HERPES SIMPLEX		

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
ADULTS AND ADOLESCENTS (aged 12-19) First clinical episode	• Acyclovir 400 mg orally 3 times per day for 7 - 10 days ***OR*** • Acyclovir 200 mg orally 5 times per day for 7 - 10 days ***OR*** • Famciclovir 250 mg orally 3 times per day for 7 - 10 days ***OR**** • Valacyclovir 1 g orally 2 times per day for 7 - 10 days ***The efficacy and safety of famciclovir has not been established for patients younger than 18.**	
ADULTS AND ADOLESCENTS (aged 12-19) Episodic therapy for recurrence	• Acyclovir 800 mg orally 2 times per day for 5 days ***OR*** • Acyclovir 400 mg orally 3 times per day for 5 days ***OR*** • Acyclovir 800 mg orally 3 times per day for 2 days ***OR*** • Famciclovir 125 mg orally 2 times per day for 5 days ***OR**** • Famciclovir 1000 mg orally 2 times per day for 1 day ***OR**** • Famciclovir 500 mg orally once, followed by 250 mg orally 2 times per day for 2 days ***OR**** • Valacyclovir 500 mg orally 2 times per day for 3 days ***OR*** • Valacyclovir 1 g orally once per day for 5 days ***The efficacy and safety of famciclovir has not been established for patients younger than 18.**	
ADULTS AND ADOLESCENTS (aged 12-19) Suppressive therapy for recurrence	• Acyclovir 400 mg orally 2 times per day for 1 day ***OR*** • Famciclovir 250 mg orally 2 times per day for 1 day ***OR**** • Valacyclovir 500 mg orally once ***OR*** • Valacyclovir 1 g orally once	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	*The efficacy and safety of famciclovir has not been established for patients younger than 18.	
HIV INFECTION	Higher dosages for longer periods of time are recommended. See the CDC's complete guidelines - www.cdc.gov/std/treatment	
PREGNANT	See the CDC's complete guidelines for the management of herpes in pregnant women - www.cdc.gov/std/treatment	

GENITAL WARTS

ALL	RECOMMENDED TREATMENT			
	External or Perianal	Urethral Meatus	Vaginal	Anal
	• Cryotherapy using liquid nitrogen or cryoprobe. Repeat applications every 1 – 2 weeks, if necessary ***OR*** • Podophyllin resin 10% – 25% in a compound tincture of benzoin. Limit application to < 10 cm^2 and< 0.5 ml. Do not apply to open wounds or lesions. Allow to air dry. Wash off 1 - 4 hours after application. Repeat weekly, if necessary ***OR****	• Cryotherapy using liquid nitrogen***OR*** • Podophyllin 10% - 25% in a compound tincture of benzoin. The treatment area must be dry before allowing contact with normal mucosa. Repeat weekly, if necessary* *Podophyllin, podofilox, imiquimod andsinecatechins should not be used on pregnant patients.	• Cryotherapy using liquid nitrogen.Cryoprobe not recommended due to risk of perforation and fistula formation ***OR*** • TCA or BCA 80% - 90%. Apply a small amount to warts only. Allow to dry. If an excessive amount is inadvertently applied, cover with baby powder, talc, baking soda or liquid soap. Repeat weekly, if necessary.	• Cryotherapy with liquid nitrogen***OR*** • TCA or BCA 80% - 90%. Apply a small amount to warts only. If an excessive amount is inadvertently applied, cover with baby powder, talk, baking soda or liquid soap. Repeat weekly, if necessary ***OR*** • Surgical removal Many people with anal warts may also have them in the rectal mucosa. Inspect rectal mucosa via digital examination or anoscopy. Warts on the rectal mucosa should be managed in consultation with a specialist.

- **Trichloroacetic acid (TCA) or bichloroacetic acid (BCA)** 80% - 90%. Apply a small amount to warts only. Allow to dry. If an excessive amount is inadvertently applied, cover with baby powder, talc, baking soda or liquid soap. Repeat weekly, if necessary ***OR***
- **Surgical removal**

***Podophyllin, podofilox, imiquimod and sinecatechins should not be used on pregnant patients.**

MRSA [Methicillin-Resistant Staphylococcus Aureus]

Methicillin-Resistant Staphylococcus Aureus (MRSA) is an infection caused by a strain of staphylococcus bacteria that has become resistant to antibiotics commonly used in the treatment of ordinary staph infections.

Colonies of staphylococcus can be found in the nostrils of 25-35% of all healthy, asymptomatic individuals. Other common infection sites within asymptomatic individuals include the axillae (armpits) and groin.

The Infection Control Nurse (ICN) works in collaboration with the clinician in the management of cases of MRSA. Information on the source of the staph bacteria (i.e., pre-existing wound or animal bite vs. perirectal boil) are to be obtained and documented by the ICN. Open or weeping lesions need to be cultured prior to the initiation of any antibiotic therapy.

Nursing staff are to begin symptomatic treatment, including the application of warm compresses and irrigation with wet-to-dry dressings (or mechanical wound debridement). Clinicians are not encouraged to routinely forcibly or surgically culture lesions.

Treatment Initiation

- Oral, single-antibiotic therapy is NOT encouraged in this cohort population.

- Bactrim DS and Clindamycin are an effective drug therapy regimen.

Referrals

- Patients requiring intravenous therapy must be seen by the specialist.

Skin, Soft Tissue, and Bone Infections

- Community-associated methicillin-resistant Staphylococcus aureus [CA-MRSA]
- Toxic Shock Syndrome [TSS] caused by exotoxin superantigens from Staphylococcus aureus or group A Beta-hemolytic Streptococcus [GABHS]

Toxic Shock Syndrome

Clinical Risk Settings:

- Surgical wounds
- Burns
- Vaginitis
- Tampon use in younger females
- Nasal packing for epitaxies

The clinical presentation is dramatic with fever, hypotension, macular desquamating erythroderma of the palms and soles. There may be generalized symptoms of emesis, diarrhea, severe myalgia's, weakness, dyspnea and altered mental status.

This is a medical emergency and the patient must be moved to a tertiary care setting for immediate diagnosis and treatment.

Purulent Skin and Soft Tissue Infections [Furuncles, Carbuncles, and Abscesses]

- Nursing protocols activated of warm compresses
- Avoid forcibly expressing the wound
- Incision and drainage [I&D] under control conditions in the clinic should be scheduled
- Send wound cultures for C&S studies
- Schedule nursing daily wound care and dressing changes
- Empiric antibiotics, especially if there is evidence of surrounding cellulitis 5 to 7 days
    - Clindamycin 150mg BID
    - Bactrim DS po BID

Non-purulent Skin and Soft Tissue Infections [Erysipelas and Cellulitis]

- Sharply demarcated lesions
- Superficial
- Painful
- Blanching
- Treatment options include:
    - Clindamycin
    - Bactrim DS

- Macrolides
- Penicillin remains an option

TUBERCULOSIS

Tuberculosis Protocol and Screening

At the time of intake screening, PPD skin tests must be administered by nursing staff for all newly admitted inmates, unless documentation of a negative chest x-ray or negative test results not more than three (3) months old exist and have been verified.

Returning inmates with previously documented positive PPD tests (LTBI) will receive a chest x-ray **ONLY** if positive responses are noted with use of the TB surveillance-screening tool.

In addition to PPD testing, chest x-rays must be ordered for all new detainees who meet the following criteria:

- +PPD test
- HIV+
- Foreign-born inmates in the United States for less than one year's time or for whom documentation of a chest x-ray performed in the United States within the past three (3) months does not exist
- Inmates who have been out of the United States or Canada for six months or more prior to incarceration

Once a baseline chest x-ray is on record, annual and additional follow-up surveys, as appropriate, should be performed.

QuantiFERON-TB Gold

This is a blood test that aids in the detection of Mycobacterium tuberculosis, the organism which is the cause of tuberculosis disease. QuantiFERON-TB Gold [QFT] is an interferon-gamma release assay, commonly known as an IGRA and is a modern alternative to the tuberculin skin test [TST, PPD or Mantoux]

The assay establishes both T-cell lymphocyte function and past exposure to the TB antigen. Patients with immune suppression of T cell function may not respond to testing. They may be Anergic, a state of immune unresponsiveness. The QFT tests the subject's T cells against standard mitogens, which in a non-anergic patient will elicit a reaction. A second aliquot of blood is tested against specific tuberculosis antigens. Thus, when a patient successfully completes a QFT and the report is negative for tuberculosis exposure, the patient is known not to be anergic. If the QFT is reported as positive, then the due to the sensitivity of the test, a chest x-ray will need to be completed to rule out pulmonary tuberculosis disease.

Conditions presenting with Anergy include:

- AIDS
- T-cell leukemia
- T-cell lymphomas, such as Hodgins's Disease
- Sarcoidosis

PLEASE CONSULT THE INFECTION CONTROL MANUAL AND THE POLICIES AND PROCEDURES MANUAL (POLICIES B-02 AND E-02) FOR ADDITIONAL INFORMATION REGARDING TUBERCULOSIS

Latent TB Infection (LTBI) Flow Chart

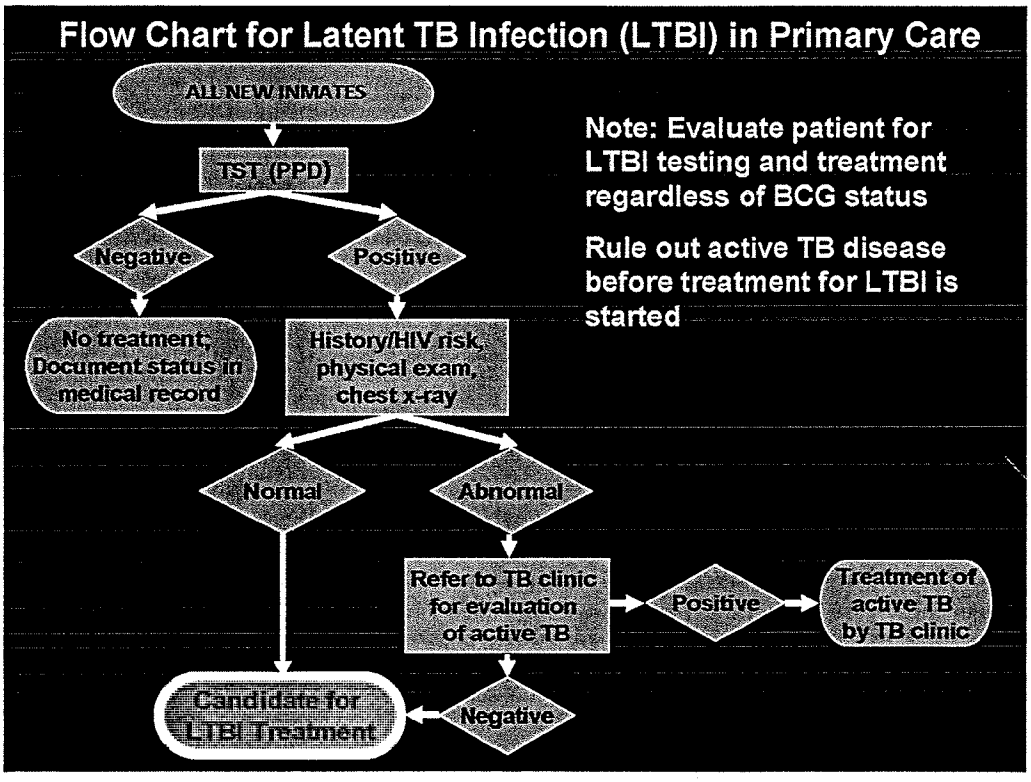


Table 1. Candidates for the Treatment of Latent TB Infection

Groups Who Should be Given High Priority for Latent TB Infection Treatment	
People who have a positive IGRA result *or* a TST reaction of 5 or more millimeters (TST = Tuberculin Skin Test)	**People who have a positive IGRA result *or* a TST reaction of 10 or more millimeters (IGRA= interferon gamma release assay)**
• HIV-infected persons • Persons in recent contact with a TB case • Persons with fibrotic changes on chest radiograph consistent with old TB • Organ transplant recipients • Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer; taking TNF-α antagonists)	• Recent immigrants from countries with a high prevalence of TB cases (in the USA < 5 years) • Injection drug users • Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other healthcare facilities) • Mycobacteriology laboratory personnel • Children under 4 years of age; children and adolescents exposed to adults in high-risk categories

Persons with no known risk factors for TB may be considered for treatment of LTBI if they have either a positive IGRA result **or** if their reaction to the TST is 15 mm or larger. However, targeted TB testing programs should only be conducted among high-risk groups. All testing activities should be accompanied by a plan for follow-up care.

Treatment for latent TB infection should reflect the most current CDC guidelines. Please see www.cdc.gov/tb

Table 1 is from:

http://www.cdc.gov/tb/publications/factsheets/treatment/LTBItreatmentoptions.htm

Mycobacterium Tuberculosis (MTB) and Latent Tuberculosis Infection (LTBI)

Did You Check For?	Did You Do?
Past history of tuberculosis/consumption	Confirm patient history
HIV/AIDS	Chest x-ray (CXR)
Severe anemia	CT scan
Elevated LDH (lactate dehydrogenase)	Chest
Steroid treatment of six (6) months' duration or more	Abdomen
Autoimmune disorders	Risk Stratification (based on size of swelling at PPD injection site):
Bacillus Calmette-Guerin (BCG) immunization	**5 mm** is considered positive for individuals with: • HIV • Autoimmune disorders • On Prednisone therapy • Recent contact with confirmed or suspected cases of TB • Fibrotic changes on a chest x-ray consistent with old/healed TB • On TNF alpha antagonists
Prior chest x-ray (CXR)	**10 mm** is considered positive for individuals who are: • In prison/jail • Current or past injection drug-users • Diabetes • Silicosis • Cancer of the head and neck • Hematologic and reticuloendothelial diseases • End-stage renal disease • Intestinal bypass or gastrectomy • Chronic malabsorption syndrome • Low body weight (10% or more below the ideal) • On immunosuppressive therapy
Prior CT scan	**16 mm** is considered positive in all individuals with no known risks
Chest	
Abdomen	

Tuberculosis Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **ICD code (Mycobacterium tuberculosis [MTB] or Latent tuberculosis infection [LTBI])**
- **Ensure TB findings are documented in the record**
- **Ensure PPD was administered and read**
- **Ensure CXR report was endorsed**

Orders and Care Plan

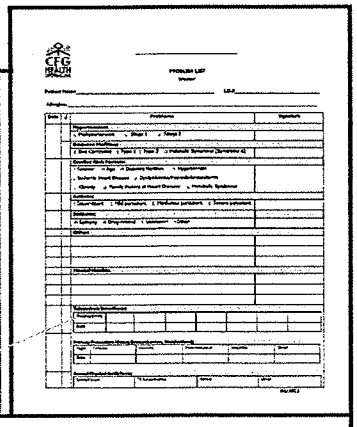
- **Prophylaxis offered**
- **6-month course of INH (isonicotinylhydrazine) offered:**
  - **Initiated**
  - **Refused**

Nursing Education

- **Printed patient materials - chart**

Discharge Planning

- **Provide patient with:**
  - **Department of Health (Tuberculosis Bureau) contact and referral information**
  - **Facilitate and document follow-up care**
  - **Related hand-outs and brochures**



Tuberculosis Surveillance:

Reading (mm)						
Date						

HIV/AIDS

(Treatment of HIV/AIDS as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Treatment Initiation

- Provide Primary Prevention Support
- Annual influenza vaccination
- Pneumovax vaccination
- Tetanus toxoid to be administered if last vaccination was >10 years
- Hepatitis vaccines (Hepatitis A, Hepatitis B, Twinrix)

Medications

- Discuss medication options (HAART – highly active anti-retroviral therapy) and contract for patient compliance with a goal >95%
- For MICA and substance-abusing patients, treat mental health issues and addictions as primary diagnoses before initiation of HAART to ensure patient commitment to treatment.

AIDSMEDS Drug Chart

Antiretroviral options abound for both those who are HIV treatment naive and those who are experienced. This quick-reference chart compares available medication options, including dosing and dietary restrictions. To learn more about these medications, including possible side effects and drug interactions, log on to AIDSmeds.com.

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)			
Combivir (zidovudine + lamivudine)		One Combivir tablet twice a day. Contains two NRTIs in one tablet.	Take with or without food.
Emtriva (emtricitabine)		One 200 mg Emtriva capsule once a day	Take with or without food.
Epivir (lamivudine)		One 300 mg Epivir tablet once a day, or one 150 mg Epivir tablet twice a day	Take with or without food. Also approved for the treatment of hepatitis B virus (HBV), but at a lower dose. People living with both viruses should use HIV dose.
Epzicom* (abacavir + lamivudine) *Sold as Kivexa in some countries		One Epzicom tablet once a day. Contains two NRTIs in one tablet.	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Retrovir (zidovudine)		One 300 mg Retrovir tablet twice a day	Take with or without food.
Trizivir (abacavir + zidovudine + lamivudine)		One Trizivir tablet twice a day. Contains three NRTIs in one tablet.	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Truvada (tenofovir + emtricitabine)		One Truvada tablet once a day. Contains two NRTIs in one tablet.	Take with or without food.
Videx EC* (didanosine) *Also available generically in the U.S.		One 400 mg Videx EC capsule enema day (or one 250 mg capsule once a day for those who weighs less than 130 lbs.)	Take on an empty stomach. Rest to avoid alcohol with this drug.
Viread (tenofovir)		One 300 mg Viread tablet once a day	Also approved for the treatment of hepatitis B virus (HBV). Take with or without food.
Zerit (stavudine)		One 40 mg Zerit capsule twice a day (or one 30 mg Zerit capsule twice a day for those who weighs less than 130 lbs.)	Take with or without food.
Ziagen (abacavir)		Two 300 mg Ziagen tablets once a day, or one 300 mg Ziagen tablet twice a day	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Protease Inhibitors (PIs)			
Aptivus (tipranavir)		Two 250 mg Aptivus capsules plus two 100 mg Norvir tablets twice a day	Take with food. Approved only for treatment-experienced patients. Aptivus should not be taken with other PIs, with the exception of Norvir.
Crixivan (indinavir)		Two 400 mg Crixivan capsules three times a day, or two 400 mg Crixivan capsules plus one or two 100 mg Norvir tablets twice a day (preferred dosing)	Take on an empty stomach or with a light, low-fat snack if used without Norvir. If Norvir is used, take with or without food. Drink six glasses of water a day to help prevent kidney stones.
Invirase (saquinavir)		Two 500 mg Invirase tablets plus one 100 mg Norvir tablet twice a day	Invirase must be used with Norvir and should be taken with food.
Kaletra* (lopinavir + ritonavir) *Sold as Aluvia in some countries		Two tablets twice a day or four tablets once a day, depending on nature of HIV drug resistance. Contains two PIs in one tablet.	Take with or without food.
Lexiva* (fosamprenavir) *Sold as Telzir in some countries		Two 700 mg Lexiva tablets twice a day, or two 700 mg Lexiva tablets plus one Norvir tablet once a day, or one 700 mg Lexiva tablet plus one Norvir tablet twice a day (recommended dose for those who have used other PIs in the past)	Take with or without food. People who have used other PIs in the past should only use twice-daily Norvir-boosted Lexiva.

Norvir (ritonavir)		Six 100 mg Norvir tablets twice a day	The full dose of Norvir is rarely used. It is most often used at much lower doses to "boost" the levels of other PIs in the blood. Take with food
Prezista (darunavir)		Two 400 mg Prezista tablets plus one 100 mg Norvir tablet once a day, or one 600 mg Prezista tablet plus one 100 mg Norvir tablet, twice a day, depending on extent of HIV drug resistance	Prezista must be used with Norvir and should be taken with food.
Reyataz (atazanavir)		Two 200 mg Reyataz capsules once a day, or one 300 mg Reyataz capsule plus one 100 mg Norvir tablet once a day	Take with food.
Viracept (nelfinavir)		Two 625 mg Viracept tablets twice a day, or five 250 mg Viracept tablets twice a day, or three 250 mg Viracept tablets three times a day	Take with food. If you have trouble swallowing the pills, you can dissolve a powder formulation in water for easy drinking.
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)			
Edurant (rilpivirine)		One 25 mg Edurant tablet once a day	Should be taken with a meal containing fat (eg., breakfast or dinner).
Intelence (etravirine)		One 200 mg Intelence tablet twice a day	Take with food.
Rescriptor (delavirdine)		Two 200 mg Rescriptor tablets three times a day	Take with or without food.
Sustiva® (efavirenz) *Sold as Stocrin in some countries		One 600 mg Sustiva tablet once a day	Take on an empty stomach and at bedtime to minimize dizziness, drowsiness and impaired concentration.
Viramune XR (nevirapine)		One 200 mg Viramune tablet once a day for the first 14 days, then one 400 mg Viramune XR tablet once a day	Take with or without food.
Integrase Inhibitors			
Isentress (raltegravir)		One 400 mg Isentress tablet twice a day	Take with or without food.
Fusion and Entry Inhibitors			
Fuzeon (enfuvirtide)		One 90 mg Fuzeon injection twice a day	Fuzeon comes as a white powder that must be carefully mixed with sterile water in a vial each day before being injected—a process called "reconstitution."
Selzentry® (maraviroc) *Sold as Celsentri in some countries		One 150 mg Selzentry tablet, one 300 mg Selzentry tablet, or two 300 mg Selzentry tablets twice a day (Because Selzentry interacts with many HIV drugs, the dose will depend on other medications being used)	Take with or without food. Selzentry is only effective against CCR5-tropic HIV (virus that uses the CCR5 receptor on CD4 cells). A tropism assay, such as Monogram Biosciences's Trofile, will determine whether treatment with Selzentry will be useful.
Single Tablet Regimens			
Atripla (efavirenz + tenofovir + emtricitabine)		One tablet once a day. Contains one HIV-1 and one HIV-2 virus tablet	Can be used with or without other HIV medications. Take on an empty stomach and at bedtime to minimize dizziness, drowsiness and impaired concentration (possible side effects of efavirenz).
Complera (rilpivirine + tenofovir + emtricitabine)		One Complera tablet once a day. Contains brand TDs and are HIV-1 in one tablet	Should be taken with a meal containing fat (eg., breakfast or dinner).

Drugs not shown actual size. Please refer to the complete prescribing information for each medication for details.

April 2012

HIV/AIDS Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List
Orders and Care Plan
Nursing Education
Discharge Planning • Establish medical and pharmaceutical community and local connections for discharge planning and follow-up care • Community mental health support

VARICELLA (CHICKEN POX)

PLEASE REFER TO THE INFECTION CONTROL MANUAL FOR STANDARD PROCEDURES.

Notify the Health Services Administrator (HSA) and the Infection Control Nurse. Facilities with County Department of Health liaisons require the DOH be informed of any cases of varicella. **The Corporate Medical Director *MUST* be notified.**

PEDICULOSIS (HEAD AND BODY LICE)

SEE THE INFECTION CONTROL MANUAL AND FACILITY CONTAINMENT PROTOCOLS.

OTIC INFECTIONS

Initial Health Assessment (Physical Examination Findings)

- External otitis
  - Painful ear canal with pain exacerbated by manipulation of the auricle
  - Erythema
  - Edema
  - Purulent exudate ("crusty" residue may be evident)

Treatment Initiation

- Patient must avoid using cotton swabs (i.e., - Q-Tips) or placing any foreign objects within the ear
- Administration of drying agents isopropyl alcohol/white vinegar (acetic acid) in a 50:50 solution
- Antibiotic drops
  - Fluoroquinolones
  - Aminoglycosides
  - Steroids

NOTE: Monitor diabetic patients closely and refer patients with persistent and/or recurrent otic infections to the ENT (ear-nose-throat specialist).

OPHTHALMOLOGIC INFECTIONS

BLEPHARITIS

Common purulent infection of eyelids and margins (may affect one eye or both)

Treatment Initiation

- Warm compresses

- Establish cleanliness of lid margins

Hordeolum

Initial Health Assessment (Physical Examination Findings)

- Staphylococcal abscess is common
- Swollen upper or lower eyelid with localized tenderness
- May be involvement of the meibomian gland

Treatment Initiation

- Application of warm compresses
- Instruct patient to avoid rubbing the area in an effort to thwart seeding

Acute Suppurative Bacterial Conjunctivitis

Causative organisms:

- Staphylococcus aureus
- Streptococcus pneumoniae
- Hemophilus
- Moraxella catarrhalis
- Neisseria gonorrhoeae

Treatment Initiation

- Standard universal precautions
- Tobramycin optic
- Polymyxin optic
- Neomycin/bacitracin ointment

Chalazion

Initial Health Assessment (Physical Examination Findings)

- Granulomatous infection of the meibomian gland

Treatment Initiation

- Application of warm compresses for small lesions

Referrals

- Complaints of compromised vision or visual deficits must be referred to the specialist

Pterygium

Initial Health Assessment (Physical Examination Findings)

- Fleshy, triangular growth on the nasal side of the cornea

Treatment Initiation

- No treatment, unless patient complains of visual deficit

Referrals

- Refer to specialist if patient complains of visual deficit

NEUROLOGY

SEIZURES

(Treatment of seizures as a key subspecialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Seizure Disorders Protocol

Initial Health Assessment (Physical/Examination Findings)

- Document clinical history (obtained during nursing screening) and review prior records and medications. Include:
  - Type of seizures
  - Age at onset
  - Date of last known seizure
  - Prior medical provider(s)
  - Substance abuse history
  - Verify Phenobarbital management
- Establish relationship between withdrawal and seizures *(see Withdrawal section under Multisystem Disorders)*
- Emergency if:
  - New onset
  - Head trauma- NOTE: Alcoholic with a history of a fall may present with a seizure. There is an increased propensity to develop subdural hematomas.
  - Febrile
  - Sepsis, e.g. HIV
- Urgent if:
  - Known history of seizures with acute withdrawal
  - Patient has long-term disease and has been on a "medication holiday"
- Evaluate for "pseudo-seizures"
  - If no secondary findings, (e.g. incontinence, confusion) consider pseudo-seizures
- Enroll in Chronic Care
  - Confirm primary care provider

- Indicate any concomitant conditions, such as:
  - Epilepsy
  - Secondary seizures
  - Diabetes
  - Cancer
  - HIV
  - Transient ischemic attacks (TIAs)
  - Cerebrovascular accidents (CVAs)
  - Thyroiditis
  - Sepsis
  - Ketoacidosis
  - Hyponatremia
  - Hypercalcemia
  - Hypomagnesemia
  - Hemoglobinopathy
  - Other metabolic disorders
- Access for cardiac ectopy or arrhythmia

- Establish working diagnosis (all three diagnoses listed below require initiation of an immediate care plan; management plan is dictated by diagnosis)
  - Epilepsy
  - Withdrawal seizures
  - Seizures, unknown

DIAGNOSTIC TESTING

- CT scan (MUST be ordered for head trauma with seizure)

MEDICATIONS

- Contact all prior and present treating physicians
- Transition from Phenobarbital

LABORATORY STUDIES

- Use laboratory studies to determine any primary causes, such as sepsis or hypoglycemia

Did You Check For?	Did You Do?
Evidence of seizure disorder	Request prior records
Prior attending physician, hospital or clinic sources	Identify comorbid conditions
Prior hospitalizations and ER transfers	Diagnostic testing
Prior electroencephalograms (EEGs) – note where and when performed	Confirm present medications (noting prescription and date of last order), including:
Prior CT scan (computed tomography)	Benzodiazepines
History of substance abuse	Phenobarbital
Potential relationship of seizures to substance abuse withdrawal	Selective serotonin reuptake inhibitors (SSRIs)
	Atypicals
	Prescribe any necessary medications

SEIZURE DISORDER DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **ICD code**
- **Provide diagnosis (epilepsy, withdrawal seizures, etc.)**

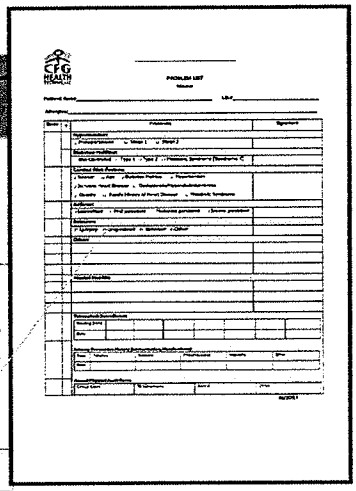
Orders and Care Plan

- **New onset seizures, febrile seizures, head trauma with seizures and undiagnosed seizures MUST be evaluated as an emergency**
- **Head trauma with seizure MUST have head CT scan**

Nursing Education

Discharge Planning

- **Discuss all diagnostic test results**
- **Organize post-release follow-up**



Seizures:

□Epilepsy □Drug-Related □Unknown □Other:

GASTROENTEROLOGY

GASTROINTESTINAL DISORDERS

Review of Nursing Intake Screening/Clinical History

- Scope of symptoms
  - Association with food
  - Accompanied by fever
  - Coughing up blood
  - Bloating and gas
  - Diarrhea (loose stools are NOT considered diarrhea)
    - Watery
    - Bloody
- Document any concomitant conditions
- Note use of medications associated with gastrointestinal issues, such as NSAIDs (non-steroidal anti-inflammatory drugs)
- Past history of surgery, irradiation

Initial Health Assessment (Physical/Examination Findings)

- Abdominal pain
- Fever
- Ascites
- Dyspepsia
- Stool color, consistency (Melena, watery, bloody red)

Diagnostic Testing

- CBC
- Coagulation parameters (INR), PTT
- CMP (including liver function and transaminase

Treatment Initiation

- H2 blocker (Zantac)
- If the patient finds relief with Zantac (or another H2 blocker), then counsel the patient regarding dietary changes
- If the patient fails to find relief with the use of H2 blockers, the clinician must consider other diagnoses
- Trial HMG Co-reductase inhibitors, e.g. Omeprazole

Endoscopy

- High diagnostic accuracy
- Upper GI Pathology
- Therapeutic capability

ROCKALL SCORE FOR RISK STRATIFICATION OF ACUTE UPPER GASTROINTESTINAL (GI) BLEEDING	
VARIABLE	**POINTS**
AGE	
<60 YR.	0
60-70 YR.	1
≥ 80 YR.	2
SHOCK	
HEART RATE >100 BPM	1
SYSTOLIC BLOOD PRESSURE < 100 MM HG	2
COEXISTING ILLNESS	
CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OTHER MAJOR ILLNESSES	2
RENAL FAILURE, HEPATIC FAILURE, METASTATIC CANCER	3
ENDOSCOPIC DIAGNOSIS	
NO FINDING, MALLORY-WEISS TEAR	0
PEPTIC ULCER, EROSIVE DISEASE, ESOPHAGITIS	1
CANCER OF THE UPPER GI TRACT	2
ENDOSCOPIC STIGMATA OF RECENT BLEEDING	
CLEAN BASED ULCER, FLAT PIGMENTED SPOT	0
BLOOD IN UPPER GI TRACT, ACTIVE BLEEDING, VISIBLE VESSEL, CLOT	2

GASTROINTESTINAL DISORDERS DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Include medication start and stop dates** • **ICD codes (Note – Gastritis is often omitted)**
Orders and Care Plan • **Ensure that Nursing Protocol Rx are endorsed (e.g. – Zantac)**
Nursing Education • **Include printed patient education materials**
Discharge Planning • **Comment on issues surrounding gastrointestinal symptomatology and NSAID usage**

Dysphagia and Odynophagia

- Detailed history – identification of lev

Oropharyngeal dysphagia	Difficulty in transferring liquids from mouth to esophagus	Nasopharyngeal regurgitation Aspiration	Neuromuscular Irradiation	ENT GI referral Neurology
Esophageal	Food stuck in transit down esophagus			
Odynophagia	Pain on swallowing food or liquids	Mucosal inflammation – esophagitis	Infectious Pill esophagitis	GI
Dysphagia [GERD]	Epigastric Burning Fullness post prandial 30 to 60 minutes	H2 blockers Proton Pump inhibitors	Gastritis Hiatal hernia	Patient education – chewing fully, dietary changes -Post prandial posture

Diarrhea

- Confirm the diagnosis prior to work up or treatment. A single loose stool is not diarrhea [>240 cc/24 hrs.]
- Often self-limiting
- Detailed history –
    - related to diet? e.g. malabsorption or explosive related to dairy products
    - associated bloating
    - abdominal pain
    - fever or chills
    - extreme odor
- Other cases reported from the same area? Same day
- Vital signs – tachycardia, fever
- Quantify – medical housing

Treatment if persists for over 24 hours or for evidence of volume depletion

- CBC with differential
- Stool analysis – E.coli 0157, bacterial overgrowth secondary to antibiotic therapy,
- Volume replacement, osmotic diarrhea replace with balanced fluid supplements
- Bulk resin agents, if tolerated
- Non-specific agents: Loperamide, opiates, Lomotil, bismuth subsalicylate
- Antibiotics – Metronidazole with confirmed bacteriologic diagnosis.

Severe persistent diarrhea refer to Gastroenterology

Constipation

- Confirm diagnosis – change from daily routine does not mean constipation
- Stress exercise
- Increase fluid intake
- Complete diet history which may differ from that of home and contribute to the change in bowel habits.
- Offer psyllium natural products with hydration prior to initiation of medications.
- Laxatives should be reserved until all other measures have failed.

The following disorders are reviewed below (in alphabetical order), followed by a section dedicated to the treatment of other possible causes of abdominal pain:

- Appendicitis
- Barrett's Esophagus (carcinoma)
- Choledocholithiasis/Acute Cholecystitis
- Crohn's Disease
- Diverticulitis
- GERD (gastroesophageal reflux disease)
- Pancreatitis

- Peptic Ulcer Disease
- Perforated Ulcer

APPENDICITIS

Initial Health Assessment (Physical/Examination Findings)

- Anorexia
- Periumbilical pain that becomes localized to the RLQ (right lower quadrant)
- Nausea and/or vomiting
- Low-grade fever
- RLQ tenderness
- Abdominal rebound
- Abdominal rigidity (often associated with perforation of the appendix)

The **Alvarado Score** is a clinical scoring system used in the diagnosis of appendicitis. The mnemonic for this score is:

MANTRELS

SYMPTOM	EXAMINATION FINDINGS	SCORE
1. Migration	Painful symptoms are migratory and localize to the right of the iliac fossa	2
2. Anorexia	History of loss of appetite	1
3.Nausea/vomiting	Patients often report emesis	1
4. Tenderness	Abdominal tenderness to abdominal distension	1
5. Rebound	Abdominal rebound is often seen	1
6. Elevated Temp	Fever	1
7. Leukocytosis	WBC elevation [10,000+]	2
8. Shift	WBC elevation with left shift	1

MANTRELS Scoring:

Inconsistent with acute appendicitis	0 - 4
Compatible with acute appendicitis diagnosis	5 – 6
Probable acute appendicitis	7 – 8
Very probable acute appendicitis	9 – 10

For Clinicians:

Treatment

No CT scan	< 3
Order an abdominal CT scan[6]	4 – 6
ER referral and Surgical Consultation	> 7

[6] McKay, R. Sheppard, J, The Use of the Clinical Scoring System by Alvarado in the Decision to Perform CT for diagnosis of Acute Appendicitis in the ED, American Journal of Emergency Medicine 2007, June 25(5):489-93

Barrett's Esophagus (carcinoma)

Initial Health Assessment (Physical Examination Findings)

- Persistent symptoms of GERD (gastroesophageal reflux disease) with no response to omeprazole coupled with antibiotics

Treatment Initiation

- Endoscopy with biopsy
- Surgery consultation

Choledocholithiasis/Acute Cholecystitis

Initial Health Assessment (Physical/Examination Findings)

- Positive for "4 Fs"
  - Female
  - Fat
  - Forty
  - Fertile
- RUQ (right upper quadrant) pain
- Diabetic
- Indigestion
- Diabetic ketoacidosis
- Positive Murphy's sign- A test for gallbladder inflammation- examiner's fingers at right costal margin (right hypochrondrium) patient is asked to inhale. Inflamed gallbladder taps the finger during the maneuver and the patient experiences pain. Positive sign order: Abdominal ultrasound onsite
- Occasional jaundice

Crohn's Disease

Initial Health Assessment (Physical/Examination Findings)

- Anemia
- Arthritis
- RLQ (right lower quadrant) pain
- Fever
- Diarrhea
- Melena
- Cramping
- Skip lesions

- Presence of cobblestones on endoscopy

Treatment Initiation

- Dietary modifications (possibly NPO [nil per os – nil by mouth])
- Volume and electrolytes replacement
- Medication
- Surgical consultation (for abscesses and fistulas)

DIVERTICULITIS

Initial Health Assessment (Physical/Examination Findings)

- Crampy abdominal pain
- Melena
- Hematohezia
- Diarrhea
- Constipation
- Fever
- LLQ (lower left quadrant) tenderness
- Palpable mass
- Positive stool guiac test
- +/- Peritoneal signs

GERD (GASTROESOPHAGEAL REFLUX DISEASE)

Initial Health Assessment (Physical Examination Findings)

- Dyspepsia
- Abdominal pain
- Negative rebound
- Anemia
- Positive stool guaiac test

Treatment Initiation

- Dietary modifications
- Behavioral adjustments
- Initiate two-week trial of Proton pump inhibitor (omeprazole)
- If patient finds relief with omeprazole, then continue to monitor and counsel patient regarding dietary changes
- If no relief is obtained with the use of omeprazole, the clinician must persist in finding the correct diagnosis

PANCREATITIS

Initial Health Assessment (Physical/Examination Findings)

- Clinical history of alcohol (ETOH) abuse
- Abdominal flat plate calcifications
- Deep epigastric pain radiating to the back that is relieved with the patient in the upright position
- Nausea and/or vomiting
- Dehydration- may require IV hydration
- Abdominal ultrasound- rule out Pseudocyst formation

Treatment Initiation

- Monitor
  - Glucose
  - Calcium
  - Potassium
- Begin narcotic analgesics

PEPTIC ULCER DISEASE

Initial Health Assessment (Physical Examination Findings)

- Persistent dyspepsia
- Abdominal pain (periumbilical)
- Weight loss
- Anemia
- Positive stool guaiac test

Treatment Initiation

- Initiate two-week trial of omeprazole
- If no relief or if symptoms return, perform the urea/H. pylori breath test; if positive, begin a two-week trial of omeprazole, plus clarithromycin and amoxicillin
- If symptoms still persist, refer patient for endoscopy

PERFORATED ULCER

Initial Health Assessment (Physical/Examination Findings)

- Sudden onset of severe abdominal pain
- History of PUD
- History of long-term NSAID use
- History of crack use

- Rigid abdomen
- Decreased bowel sounds
- Detection of free air with abdominal flat plate x-ray
- Dehydration

Treatment Initiation

- Emergency volume replacement with normal saline (to prevent shock)
- Emergency surgical consultation/referral to ER

OTHER CAUSES OF ABDOMINAL PAIN

- Ectopic Pregnancy
- Hiatal Hernia
- Nephrolithiasis
- Perforation
- PID (pelvic inflammatory disease)
- Renal Colic
- Ruptured Abdominal Aneurysm

ABDOMINAL PAIN PROTOCOLS

Know the Diagnosis BEFORE you mask the pain with analgesics

Review of Intake Screening/Clinical History

- Assess and document risk factors:
  - HBeAg + (hepatitis B e antigen positive)
  - HBsAB – (hepatitis B surface antibody negative)
  - 4 F's of gallbladder disease:
    - Female
    - Forty
    - Fat
    - Fertile

Initial Health Assessment (Physical/Examination Findings)

- Shifting dullness
- Bruits
- Masses

Diagnostic Testing and Referrals

- Abdominal ultrasound

- Spiral CT
- ERCP (endoscopic retrograde cholangiopancreatography)

Did You Check For?	Did You Do?
Concurrent Medications	Review current medication orders
Over-the-counter (OTC)	*Know the Diagnosis BEFORE you mask the pain with analgesics*
Prescribed NSAIDs	Trial of omeprazole
Bisphosphonates	Prescribe beta blockers **(propranolol)** for patients with a history of varices or prior bleeds
Antibiotics	Screen for H. pylori
Alcohol abuse	
Past treatment/Medical history	
ER visits	
Surgery	
Endoscopy	
Hemorrhage	
Varices	

ABDOMINAL PAIN DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **ICD codes, for example:** o **Chronic hepatitis** o **Pancreatitis** o **Cholelithiasis** o **Alcohol abuse**
Orders and Care Plan • **Progress notes – "Case Review"**
Nursing Education • **Provide patient with appropriate printed educational and follow-up materials**
Discharge Planning • **Review all diagnostic tests** • **Facilitate outpatient follow-up**

Ectopic Pregnancy

Initial Health Assessment (Physical/Examination Findings)

- Amenorrhea
- Pelvic pain, worse in the lower quadrants
- +HCG with predicted rising titer

Treatment Initiation

- ER referral

Hiatal Hernia

Incarceration/Strangulation
Initial Health Assessment (Physical/Examination findings)

- History of prior surgery
- Adhesions
- Hernia
- Sudden, acute, localized pain
- Erythema
- Fever
- Diminished bowel sounds

Treatment Initiation

- Injectable Toradol (ketorolac), then reassess

NASH (Non-Alcoholic Steatohepatitis)

This finding is of clinical significance given the propensity of patients diagnosed with NASH to progress to cirrhosis.

NASH is marked by the following laboratory studies:

- Rising/falling titers
- Elevated alanine and aspartate aminotransferase (ALT and AST)
- Elevated alkaline phosphatase (alk pho)
- Elevated PO4 (serum phosphorus)
- Definitively diagnose via GI referral and liver biopsy

Treatment Initiation

- Refer to specialist

Nephrolithiasis

Initial Health Assessment (Physical/Examination Findings)

- Referred abdominal pain

- Hematuria
- Dramatic relief with Toradol IM

PERFORATION

Initial Health Assessment (Physical/Examination Findings)

- Anorexia
- Periumbilical pain that migrates
- Nausea and vomiting
- Low-grade fever
- RLQ tenderness
- Rebound or rigidity

Treatment Initiation

- Refer to ER for surgical evaluation

PID (PELVIC INFLAMMATORY DISEASE)

Initial Health Assessment (Physical/Examination Findings)

- Fever
- Pelvic pain
- Cervical discharge (or history of recent treatment for cervical discharge)
- Pelvic fullness
- Positive Chandelier sign

Treatment Initiation

- Rocephin(+ Zithromax 1gm PO x1 or Doxycycline 100mg PO BID x 7 days for Chlamydia)

RENAL COLIC

Initial Health Assessment (Physical/Examination Findings):

- Hematuria
- Nausea
- Emesis
- +/- Fever
- Diaphoresis
- Tachycardia during bouts of colic
- U/A sedimentation

Treatment Initiation

- IV hydration with either normal saline or half normal saline
- Toradol IM

RUPTURED ABDOMINAL ANEURYSM

Initial Health Assessment (Physical/Examination Findings)

- History of smoking
- Vasculopathy (common causes: hyperlipidemia, HTN (hypertension), atherosclerosis and autoimmune disorders)
- Palpate for pulsatile abdominal mass greater than 3cm
- If mass detected upon palpation, refer patient for abdominal vascular ultrasound
- Abdominal pain
- Altered mentation
- Peripheral pulse gradient
- Patient may be hypotensive – in shock

Treatment Initiation

- **CALL 911 IMMEDIATELY**

WOMEN'S HEALTH

According to the Federal Bureau of Prisons, as of January 2016, women represent approximately 6.6% of the correctional population in the United States. The NCCHC recognizes the unique and specific needs of incarcerated women and views them as a distinct and special population. To address women's gender-specific health needs, including reproductive health issues and pregnancy, as well as issues pertaining to alcohol and drug abuse, sexually transmitted disease, sexual and physical abuse, and mental illness in women, CFG follows the NCCHC's *Standards for Health Services in Jails* (2018). Specific guidelines and recommendations directly impacting women's healthcare have been outlined below:

- As a Compliance Indicator of Standard J-E-02 (Receiving Screening), women reporting current opiate use are to be offered a pregnancy test immediately (to avoid risks to the fetus associated with opiate withdrawal). Selective means of early detection of and treatment for sexually transmitted diseases (STDs) also needs to be initiated, as well as establishing an inmate's pregnancy status, following inquiry into medicaland sexual history. Current STD screenings allow for the detection of some diseases/infections within hours of admission. The NCCHC's intent is to offer solutions to problems that might otherwise develop without early intervention. For example, infected and untreated females of childbearing age may develop complications that are both painful and costly, and can lead to adverse outcomes related to pregnancy.
- Standard J-E-04 (Initial Health Assessment) states that both age- and gender-specific clinical practice guidelines should be followed, to include clinical preventive services such as pelvic examinations and Pap smears.
- Standard J-F-05 (Counseling and Care of the Pregnant Inmate) acknowledges the special management of pregnant inmates with opioid-use disorders.

- Standard J-B-06 (Contraception) recommends that women inmates be provided with non-directive counseling concerning pregnancy prevention, as well as access to emergency contraception, as needed. The Standard also counsels consideration of the continuation of contraception for those women who enter the facility on some form of birth control (for both medical stability and as a means of preventing pregnancy). Compliance Indicators of this Standard stress that written information about various contraception methods and community resources should also be made available.
- Standard J-F-05 (Counseling and Care of the Pregnant Inmate) specifies that pregnant inmates receive timely and appropriate pre-natal care, specialized obstetrical services (as needed), pre-natal vitamins and post-partum care (including mental health services). Pregnant inmates should also be provided counseling and assistance supportive of a woman's expressed desire to either maintain or terminate a pregnancy. During active labor and delivery, the Standard cautions that restraints should not be used (unless absolutely necessary to prevent serious harm to the patient, staff and/or others). Because fetal exposure to alcohol and drugs can be detrimental, pregnant inmates should be counseled on the dangers of alcohol use while pregnant, with opiate substitution therapy and counseling made available for pregnant women who are opiate-dependent. The Standard's intention is that the health of the pregnant inmate and the fetus are protected, with pregnant inmates receiving services as they would within the community.
- Breast Feeding – Detainees who are actively breast feeding at the time of arrest will be assisted in the daily collection of milk for retrieval for administration to the baby. The nursing staff will provide for storage of the patient's breast pump in the clinic. The staff will coordinate with custody who will retrieve the milk, from what location and the time of day. NOTE: If the detainee is an active substance abuser or if she exhibits signs and symptoms of intoxication and would otherwise be evaluated for withdrawal management, the clinician will meet with the mother to discuss the safety and risks of continued breast feeding for the infant. If urine drug testing is performed at the facility in association with withdrawal management, the mother will be informed of the findings. Urine testing positive for buprenorphines must be determined to be from Subutex. The mother will be asked to sign a consent form that clearly states that she has been fully informed of the risks but wishes to continue to breast-feed her baby.

Review of Intake Screening/Clinical History
(see Initial Health Assessment [Historical Findings])

- Identification of chronic conditions (e.g., heart disease, hypertension, diabetes mellitus)
- Gynecological history
- Pregnancy status
- Review of appropriate immunizations (adolescents)

Initial Health Assessment (Physical/Examination Findings)
(see Initial Health Assessment [Physical Examination Findings])

- Should be comparable to the general assessment performed for male detainees, with the addition of:
    - Pelvic examination
    - Pap smear

- Breast exam/mammogram

Clinical Breast Exam

The clinical breast exam should be performed by either the APN or OB/GYN, either at Intake or within several days of a female inmate's admission to the correctional facility. It should be conducted with the patient either in the prone position or sitting. The patient should raise their arms over their heads. Breasts should be inspected for differences and changes in size and shape, puckering, dimples and redness of the skin. Breasts and axillae should be palpated to detect any changes or anomalies. The nipples may be gently squeezed to check for discharge. Clinical breast exams should be performed according to the following schedule, as recommended by the American Congress of Obstetricians and Gynecologists (ACOG) and the American College of Obstetricians and Gynecologists (April 2015):

- Women aged 29-39 – every 1-3 years
- Women aged 40 and older – performed annually

Mammography

- Mammography screening should be performed annually for all women aged 40-49
- Per the US Preventative Services Task Force (USPSTF), mammography screening should be performed bi-annually for all women aged 50-74

Cervical Cancer Screening (PAP Smear) and HPV Testing

Current cervical cancer screening guidelines have been prepared byThe American College of Obstetricians and Gynecologists (March 2016) and have been developed to maximize the benefits of screening while minimizing any potential harm:

- Screening should begin for all females at the age of 21
- For women aged 21-65, cytology should be performed every three years
- Women aged 30-35 at high-risk should also have HPV (human papilloma virus) testing performed every five years
- Screening is not recommended for women beyond age 65 or for women who have undergone hysterectomy with removal of the cervix

Intoxication and Withdrawal

Please see the section entitled Substance Abuse Withdrawal for additional information.

Pregnant, opiate-abusing females are considered "high risk," priority patients and require specialized OB/GYN and Maternal/Fetal Medicine care. Depending on the substance(s) being used, pregnant women may be managed on methadone. Hydration therapy should be initiated as indicated below:

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

- IV Hydration - IV 0.45% or NS x two (2) liters, administered over 12 hours. May repeat in 12 hours, as needed.
- Intake and output assessments
- 8-Day Nursing Plan (see Flow Sheet for Alcohol/Poly-Substance Withdrawal)

CONTRACEPTION

Continuation of contraception (birth control pills, shots, etc.) is advised, especially for detainees with short-term stays/sentences. Stopping birth control medications, especially for individuals who might return to the community in a few days may significantly increase the risk of unwanted pregnancy upon release. Removal of intrauterine devices simply because a woman is incarcerated is neither necessary nor advisable. Hormonal medications taken for medical reasons other than or in addition to contraception should be reviewed with regard to a patient's medical health conditions and other concurrent treatment(s).

TREATING THE PREGNANT INMATE

In the correctional setting, all pregnancies are considered high risk. Consultations for pre-natal care are ordered by the clinician, with special attention afforded those inmates whose pregnancies are complicated by substance abuse. A multidisciplinary approach works best to optimize care of the pregnant inmate.

- Pregnant inmates may be referred to the gynecology nurse practitioner in those facilities with such staff; however, all patients must be referred for management by a"high-risk" pregnancy team.
- Hydration therapy should be started.
- All pregnant females should be prescribed pre-natal vitamins.
- Specialized laboratory tests (such as cystic fibrosis genotyping assay) and diagnostic evaluations (such as genetic counseling) are to be provided by the consultant gynecology team.
- Pregnant and opioid-addicted patients are to be referred for initial evaluation and initiation of a treatment regimen. Each facility should have a designated methadone provider for routine medication

administration and scheduled counseling. Newly admitted opioid-addicted mothers shall be sent to the emergency room for initial management, pending enrollment in the methadone treatment program.

- Termination of pregnancy shall be facilitated upon request of the mother; however, in these circumstances, it is imperative that the provider make a referral to mental health and that the mother confirms that the decision to terminate the pregnancy has been made of her own volition and not under duress or pressure from clinical staff.

Sexually Transmitted Disease (STD) Screening for Pregnant Women

- VDRL (Venereal Disease Research Laboratory test)
- Chlamydia test
- Ureaplasmaurealyticum test

Did You Check For?	Did You Do?
Pregnancy status	Hydration therapy (for pregnant inmates)
Sexually Transmitted Diseases (STDs)	Pre-natal care (including pre-natal vitamins)
Current status	Fetal monitoring (completed by nursing)
History	Obstetrical care
Substance abuse	Mental health referral
Physical abuse	Gynecological evaluation
Primary healthcare history	PAP smear
PAP smear/HPV immunization	Clinical breast exam
Mammography, as appropriate	Mammography referral, as indicated

Women's Health Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Notations from sub-specialists** • **ICD codes**
Orders and Care Plan
Nursing Education • **Include materials from sub-specialists**
Discharge Planning

BREASTFEEDING

Background

Breastfeeding has well-established physical and psychological benefits for newborns and mothers, and enhances long-term bonding. Breast milk supply relies heavily on being able to continue to produce milk, either through direct feeding or expressing milk. Fair Labor Standards Act (29 U.S. Code 207) now requires employers in community workplaces to provide reasonable break-time and clean, private space (excluding a bathroom) for an employee to express breast milk for her nursing child for one year after the child's birth each time the employee needs to express milk. These laws also apply to employees working in correctional facilities. This accepted community and legal standard for employees highlights the importance of making accommodations for postpartum detainees and inmates who wish to breastfeed. The Agency for Healthcare Research and Quality conducted a comprehensive analysis of scientific literature that concluded that compared to infants fed commercial formula, breastfed infants have fewer incidents of respiratory tract, infections, ear infections, GI tract infections, necrotizing enterocolitis, sudden infant death syndrome, infant mortality, allergic disease, celiac disease, obesity, diabetes, childhood leukemia, and lymphoma (Breastfeeding and Matemal and Infant Health Outcomes, 2007). For the mothers, improved health outcomes include less postpartum blood loss, less postpartum depression, and greater postpartum weight loss (American College of Obstetricians and Gynecologists [ACOG], 2013). Breastfeeding is also protective against later development of breast and ovarian cancer, cardiovascular disease, diabetes, and other conditions (acog, 2013). Psychological benefits include improved bonding between mother and child, which is particularly important when the mother is incarcerated (ACOG, 2013).

Many women in custody have substance use disorders. Breastfeeding is safe and encouraged for women who are taking methadone or buprenorphine as there are benefits to their infants. However, breastfeeding is discouraged among women who are actively using illicit substances. Breastfeeding is also safe for women with hepatitis C, but is not recommended for HIV-positive women (American Academy of Pediatrics, 2013). Most common medications are safe with breastfeeding. Smoking is known to reduce a mother's milk supply. Exposure to tobacco smoke is harmful to children.

Position and Practices

1. Clinical staff will screen women on entry to determine if they are postpartum and breastfeeding.
2. Clinical staff will counsel pregnant women on the benefits and nutritional needs of breastfeeding and inform them of the systems and supports in place at the facility.
3. Clinical staff will provide breastfeeding women with a special diet with appropriate caloric, fluid, calcium, and vitamin D intake. Prenatal vitamins offer a convenient way to provide essential nutrients that are often missing from correctional diets.
4. Clinical staff will provide personal education support in assessment of breast pain, Let-down reflex and Oxytocin release, use of the breast pump, milk collection and storage procedures.
5. Clinical staff will coordinate with custody to allow for daily retrieval of breast milk by a designated family member.
6. Clinical staff will identify the appropriate storage procedures at each facility.

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SUBSTANCE ABUSE MANAGEMENT IN THE PREGNANT DETAINEE

Procedure:

1. Confirm pregnancy with urine testing and/or phenotypic presentation
2. Confirm substance abuse disorder with urine drug test.
3. Rule out ketosis and urosepsis with urinalysis and dipstick
4. Oral hydration with water is appropriate
5. Determine if the patient is already receiving MAT [Subutex, Methadone] and confirm the program participation.
6. Notify the designated facility treatment who provides services for the clinic. NOTE: Patients registered in other programs may be registered as a "guest" and their therapy continued.
7. Confirm that ALL HIV infected detainees receive a referral to Infectious Diseases.

MULTISYSTEM DISORDERS

PHYSICAL MEDICINE

Initial Health Assessment (Physical Examination Findings – see the table below and on the following pages)

SITE	PHYSICAL EXAM	DIAGNOSTIC	TREATMENT
HAND	– Visual alignment – Deformities – Swelling – Erythema	– Neurovascular assessment – Grip – X-ray	– Splint – NSAIDs – Orthopedic hand specialist referral
SHOULDER	– Drooping – Spontaneous movement – Splinting	– A/PROM testing – Focal point tenderness to palpation – Abduction to 90° – Thumb extension – Pronation – MRI	– NSAIDs – Splint sprains – Orthopedic referral for rotator cuff surgery
HIP	– Pain lying on hip – Pain to groin – Hx of arthritis/steroid injections	– Leg extension – Straight leg raise – Trochanteric or sacroiliac – X-ray – MRI	– NSAIDs vs. Steroids
KNEE	– Crushing pain day of injury – Locking or popping after injury – Swelling – Warmth	CRUCIATE – Crushing – urgent care warranted – Drawer test – Squatting OK MINISCUS – Popping or locking – + McMurray test – Unable to squat ARTHROCENTESIS – Crystals – Cultures – Fluid exam FOR ALL – X-ray – MRI	– Birefringence – Allopurinol (though *NOT during acute phase)* – NSAIDs – Antibiotics – Orthopedic referral

ANKLE	– Visual exam – Achilles' tendon – Swelling – Alignment	– Drawer test – Pronation – Supination – Point tenderness – Spring ligament rupture – Possible x-ray	– Immobilization (splinting or casting)
SPINE	– Kyphosis – Scoliosis – Fluid gait – Involvement – Illness or disease	– Waddell's sign (with axial loading) – Trunk rotation – Heel-toe walking – Squatting – X-ray	– Physical therapy – Orthopedics vs. Rheumatology

- Chronic Musculoskeletal Pain
- Chronic Back Pain
- Old Gun Shot Injuries

DIAGNOSTICS

- Repeat physical exam
- X-ray – DON'T MISS SIGNS OF SECONDARY INFECTION

MEDICATIONS

Therapeutic doses of NSAIDs

- Motrin 2400 – 3200mg/daily
- Naproxen 1000 – 2000mg/daily

CUSTODY SURVEILLANCE

- Seen playing basketball
- Free ambulation

IDENTIFICATION AND TREATMENT OF PSYCHOTIC DISORDERS AND MOOD DISORDERS

PSYCHOTIC DISORDERS

(Treatment of major mental illness as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Psychotic Disorders can be an acute or chronic condition, depending on the nature and course of the condition. Psychotic symptoms can be the result of acute intoxication (e.g., amphetamines, hallucinogens), symptoms of schizophrenia, an overwhelming traumatic event, or an aspect of a severe manic episode. Mental health disorders, with respect to diagnosis and treatment, are not as cleanly differentiated as medical conditions, so careful assessment to rule out medical reasons for change in mental status is always the first differential diagnosis. Many times what appears to be a formal mental health disorder is actually a disruption in mental status related to the ingestion of substances, or a physical condition. Please refer to the table below for the differential assessment of formal vs. cannabis-induced psychosis.

TABLE. **A comparison of the clinical features of idiopathic versus cannabis-induced psychosis**

Primary psychosis (eg, schizophrenia)	Cannabis-induced psychosis
Cannabis urine toxicology sometimes positive	Positive cannabis urine toxicology
Variable reported cannabis use (25% prevalence of positive cannabis urine toxicology in schizophrenia)	Heavy cannabis use within past month
Symptoms appear before heavy substance use	Symptoms appear only during periods of heavy substance use/sudden increase in potency
Symptoms persist despite drug abstinence	Symptoms abate or are reduced with drug abstinence
Antipsychotics markedly improve symptoms	Antipsychotics may/may not improve symptoms
Most often presents with delusions, hallucinations, and thought disorder	Often associated with visual hallucinations and paranoid ideation (eg, features of an "organic" psychosis)
Less insight about psychotic state	More aware of symptoms/insight about disease
Disorganized thought form (eg, loose associations, tangential or circumstantial speech)	Thought form more organized and sequential

Source: Psychiatric Times. Cannabis-Induced Psychosis: A Review. Ruby S. Grewal, MDTony P. George, MD, FRCPC July 2017

Symptoms of schizophrenia include psychotic symptoms such as hallucinations, delusions, and thought disorder (unusual ways of thinking), as well as reduced expression of emotions, reduced motivation to accomplish goals, difficulty in social relationships, motor impairment, and cognitive impairment. Precise prevalence estimates of schizophrenia are difficult to obtain due to clinical and methodological factors such as the complexity of schizophrenia diagnosis, its overlap with other disorders, and varying methods for determining diagnoses. Given these complexities, schizophrenia and other psychotic disorders are often combined in prevalence estimation studies. A summary of currently available data is presented here.

- Across studies that use household-based survey samples, clinical diagnostic interviews, and medical records, estimates of the prevalence of schizophrenia and related psychotic disorders in the U.S. range between 0.25% and 0.64%.[1,2,3]
- Estimates of the international prevalence of schizophrenia among non-institutionalized persons is 0.33% to 0.75%.[4,5]
- Co-occurring medical conditions, such as heart disease, liver disease, and diabetes, contribute to the higher premature mortality rate among individuals with schizophrenia.10 Possible reasons for this excess early mortality are increased rates of these medical conditions and under-detection and under-treatment of them.[6]
- Approximately half of individuals with schizophrenia have co-occurring mental and/or behavioral health disorders.[7]

Despite its relatively low prevalence, schizophrenia is associated with significant health, social, and economic concerns.

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MANAGEMENT OF ACUTE PSYCHOSIS

Intense symptom reduction and behavioral control are of paramount importance in managing acute psychotic symptoms in a correctional setting. Typically, individuals suffering from these symptoms are non-compliant with treatment and unable to house safely with other inmates. It is imperative that all mental health and healthcare staff participate in encouraging treatment compliance, particularly with proffered medication. Individuals with acute psychosis can show the following signs and symptoms:

- Agitation
- Intense crying or laughing

- Nonsensical, disorganized speech
- Attending to internal stimuli (auditory and/or visual hallucinations)
- Intense paranoia and/or delusions
- Withdrawn from interaction, not speaking
- Rigid posturing (catatonia)
- Extremely poor hygiene
- Unable to follow commands or directions
- Aggressive behavior

It is important that all healthcare staff interacting with the person project a therapeutic attitude to encourage treatment compliance. Mental health staff should take the lead in therapeutic interactions with the person and determine the necessary housing level/watch status to manage the behavior. Should the person's symptoms and behavior escalate to a psychiatric emergency, psychiatric staff can employ the policy for emergency forced medication, which requires a referral and transfer to the local acute psychiatric emergency service. Alternatively, psychotic patients requiring a higher level of psychiatric care can be transferred to the local psychiatric emergency service without receiving emergency forced medication. If the patient's mental health problems can be managed on-site, all staff interactions with the patient should be documented in the medical record.

MANAGEMENT OF CHRONIC PSYCHOSIS

Symptom management and treatment compliance are of primary importance to treat chronic psychotic symptoms in a correctional setting. Often, individuals suffering from these symptoms are frequent residents of the facility and are intermittently involved with mental health treatment in the community. They may have co-morbid substance abuse problems, but their primary clinical issue is an ongoing, serious and persistent mental illness that interferes with their ability to meet the daily demands of living, and as a result, often run afoul of the legal system. Typically, individuals with this problem will comply with treatment when it is offered, and show improvement when regularly taking psychotropic medication. Often, these individuals require special housing in a facility, and may have difficulty in general population. Depending on the facility, and the management of a housing unit, some treatment compliant individuals can be housed in a general population unit. It is imperative that mental health staff monitors the person regularly and follows them on a mental health roster. Individuals with chronic psychosis can show the following signs and symptoms:

- Poor hygiene
- Difficulty communicating needs
- Repeat incarcerations for minor offenses
- Disorganized thinking
- Hallucinations and delusions to a moderate degree
- Peculiar thought pattern
- Poor judgment, lack of insight
- Receive some form of disability income in the community
- Respond to therapeutic efforts to treat and manage them

TREATMENT INITIATION

- General principles applied to all patients with psychosis include:
  - Medication Education (psychiatry and nursing staff)
  - Nutritional management (education)
  - Daily exercise (time out of cell)
  - Special housing (if indicated)
  - Regular contacts with mental health staff while housed in the facility
  - Discharge planning arrangements for return to the community
  - Education and referral for any co-morbid medical and/or substance abuse problems

ANTIPSYCHOTIC MEDICATIONS

Following the first psychotic episode, antipsychotic medication is usually stopped by the patient after 1-2 years, although long-term therapy is the rule for patients with recurrent illness. Antipsychotic medications prevent relapse in patients with remitted positive and mood symptoms, and maintenance treatment helps to reduce symptoms in patients with chronic illness. These drugs enable many patients who previously would have been institutionalized to live in the community.

The most commonly used conventional antipsychotics in the long-term treatment of psychoses are high-potency oral antipsychotics, such as haloperidol or depot formulations, such as fluphenazine. The major drawback with conventional antipsychotics is their tendency to produce extrapyramidal adverse effects at effective doses. These include dystonias, parkinsonism, akathisia and tardive dyskinesia, a disfiguring, stigmatizing and often irreversible neurological disorder.

Atypical antipsychotics are a diverse group of drugs with a lower risk of extrapyramidal adverse effects at therapeutically effective doses. Some atypicals may be more effective than conventional antipsychotics in long-term treatment. Clozapine is particularly effective for treatment resistant cases. While its toxicity restricts initiation of treatment to specialist centers, increasingly general practitioners are involved in long-term care and monitoring of patients on clozapine therapy. Risperidone has shown superior efficacy to haloperidol in long-term prevention of relapse.3Recently, high-dose olanzapine was shown to have greater effectiveness than conventional and other atypical antipsychotics (apart from clozapine) in terms of discontinuation rates over an 18-month period.

While reducing problems with extrapyramidal adverse effects, atypicals have caused other problems such as postural hypotension, weight gain and hyperglycemia. Each drug seems to have adverse effects which are particular problems, for example, clozapine can cause neutropenia, agranulocytosis and myocarditis. Olanzapine frequently causes considerable weight gain and increases glucose and lipids which can lead to hyperlipidemia and diabetes. Although weight gain is less of a problem with risperidone, it may cause sexual dysfunction and amenorrhoea due to hyperprolactinaemia. Quetiapine may cause mild weight gain, while amisulpride and aripiprazole are generally well tolerated in long-term treatment (although aripiprazole can initially cause troubling nausea and restlessness).

Medication Guidelines and Associated Laboratory Studies for Patients with Psychotic Symptoms

ANTIPSYCHOTICS

If an atypical is needed then a trial of Abilify or Risperdal, should be tried first and used to its maximum dosage (except if side effects limit dosage). Zyprexa (olanzapine) has the largest weight gain so this should be utilized less in our populations, who are sedentary. Clinicians should follow appropriate laboratory protocols for use of antipsychotics.

Medication	Monitor	Recommendation
Antipsychotics	AIMS	Performaclinicalassessmentforabnormalvoluntarymovementsevery6monthsfor generationantipsychoticsandevery12monthsforpatientstakingsecondgeneration Forpatientsatincreasedrisk,such astheelderly,assessmentsshouldbemadeevery3monthsforfirstgenerationantips generationantipsychotics
	FastingglucoseorHgA1C&lipidsortriglycerides	Baseline,atfourmonthsandthenannually
	Electrolytes,Renal,Liver,TSH	Annuallyoras clinicallyindicated
	Medicationreview-mitigatingrisk	Documentedrationaleformorethanoneantipsychoticmedication.Everyprescriptic
	WeightandBMI	Baselineandevery 3months BMICalculation:weight(kg)/[height(M)]2
(Clozaril,FazaClo) (inadditiontoaboveguidelines for"Antipsychotics")	Neutrophil Count(ANC)	Ifnormalresults:weeklyduringfirst6monthsoftreatment;every2weeksduringse y FollowClozapineREMSprotocolforabnormalANCresults[2]

NOTE: Please consult the CFG Health Systems formulary for available atypical and typical antipsychotic medication.

General Prescribing Guidelines and Monitoring for Psychiatry

Use ONE DRUG at a time unless there is clear indication to do otherwise, such as in a major psychiatric crisis (as in clearly manic or psychotic individuals). FOR EXAMPLE: inmates out of the facility for months who are not on medications but ask to be started back on medications in the facility, often two etc., because they "were on them last time". Question the need multiple for medications if they were not on them in the community. Also, treat the anxiety/dysphoria first with an SSRI and inform them that the medicine will take a few weeks, but will eventually help with sleep, anxiety, irritability. Many of the inmate patients are substance abusers that want, even demand, quick relief from their feelings, etc. and need to learn to live without substances. We need to support them in this by NOT prescribing meds to cover up their true emotions, worries, etc. In select cases, non-formulary medication will be initiated or continued when clinical need is apparent and other medications have failed to effectively treat the problem. Practicing in a correctional environment is unique, especially with the threats of intentional diversion of medication by inmate patients. That problem notwithstanding, we must show that we consider the clinical needs of the inmate patients and ensure that our practice does not fall outside of the community standard of clinical care.

As a general practice,we do not treat with medication

- Sleep, unless part of a major active psychiatric disorder (mania or psychosis); (this is a federal guideline that we take very seriously). This includes not treating complaints of "my mind is racing, doc, and so I can't get to sleep"—I start an SSRI and tell them it will get better in a couple weeks.
- Erectile Dysfunction
- ADHD unless impacting functioning at jail, and then only Bupropion XL.
- "Stressing"
- Anxiety with benzodiazepines, gabapentin, or antipsychotics

Psychiatric personnel are **NOT** to treat chronic pain with TCA'S or gabapentin; refer these patients to Medical.

If a medication such as Seroquel is used outside of the facility for sleep, anxiety, or anger issues, **this will not be continued**. We markedly limit use of Seroquel, as inmates often abuse it, and there are many better medications. If a patient is on Seroquel, then you need to cross taper to a formulary antipsychotic or mood stabilizer over no more than TWO weeks.If there is clinical evidence or documented information that Seroquel effectively manages mental health symptoms, and no other medication does so, then it will be continued as a non-formulary medication.

If an inmate has been inconsistently on medications or off medications for MORE than TWO weeks prior to incarceration then the formulary needs to be adhered to strictly.

Equivalent medications will be utilized instead of brand names when possibleand provide similar treatment benefits.

- Citalopram for Lexapro
- Venlafaxine XR for Pristiq

Bupropion has the potential to be abused by patients in a correctional setting. The use of bupropion should be limited. Only the long acting form of bupropion in on the formulary.

Neurontin, (gabapentin) has limited usage in psychiatric treatment and is abused by inmates. It is not a mood stabilizer and there are many other medications for anxiety (SSRI). Correctional Psychiatric Professionals should not prescribe it, except to rapidly taper it off.

ADDRESSING ADHERENCE TO TREATMENT

The mental health treatment team is responsible for monitoring the patients with psychotic disorders, providing adjunctive therapeutic contact, make appropriate housing recommendations, and interact on behalf of the patient with custody staff. Compliance with treatment efforts, particularly medication, is very important with patient with psychotic disorders.

MANAGEMENT IN THE COMMUNITY AFTER DISCHARGE

All Mental Health staff will work with available resources within the facility to plan for the eventual discharge of patients into the community.

MOOD DISORDERS

(Treatment of major mental illness as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

OVERVIEW

Amood disorder is a mental health classification that health professionals use to broadly describe all types of depression and bipolar disorders.Therapy, antidepressants, and support and self-care can help treat mood disorders.Many factors contribute to mood disorders. They are likely caused by an imbalance of brain chemicals. Life events (such as stressful life changes) may also contribute to a depressed mood. Mood disorders also tend to transmitted genetically.

The most common types of mood disorders are:

- **Major depression.** Having less interest in usual activities, feeling sad or hopeless, and other symptoms for at least 2 weeks may indicate depression.
- **Dysthymia.** This chronic, low-grade, depressed, or irritable mood lasts for at least 2 years.
- **Bipolar disorder.** This is a condition in which a person has periods of depression alternating with periods of mania or elevated mood.
- **Mood disorder related to another health condition.** Many medical illnesses (including cancer, injuries, infections, and chronic illnesses) can trigger symptoms of depression.
- **Substance-induced mood disorder.** Symptoms of depression that are due to the effects of medicine, drug abuse, alcoholism, exposure to toxins, or other forms of treatment.

Depending on age and the type of mood disorder, a person may have different symptoms of depression. The following are the most common symptoms of a mood disorder:

- Ongoing sad, anxious, or "empty" mood
- Feeling hopeless or helpless
- Having low self-esteem
- Feeling inadequate or worthless
- Excessive guilt
- Repeating thoughts of death or suicide, wishing to die, or attempting suicide (**Note:** People with this symptom should get treatment right away!)
- Loss of interest in usual activities or activities that were once enjoyed, including sex
- Relationship problems
- Trouble sleeping or sleeping too much
- Changes in appetite and/or weight

- Decreased energy
- Trouble concentrating
- A decrease in the ability to make decisions
- Frequent physical complaints (for example, headache, stomachache, or tiredness) that don't get better with treatment
- Running away or threats of running away from home
- Very sensitive to failure or rejection
- Irritability, hostility, or aggression

In mood disorders, these feelings are more intense than what a person may normally feel from time to time. It is also of concern if these feelings continue over time, or interfere with one's interest in family, friends, community, or work. The risk of suicide is higher in patients with mood disorders.

Mood disorders can often be treated with success in a correctional facility. Treatment may include:

- **Antidepressant and mood stabilizing medicines**—especially when combined with psychotherapy have shown to work very well in the treatment of depression
- **Psychotherapy**—most often cognitive-behavioral and/or interpersonal therapy. This therapy is focused on changing the person's distorted views of himself or herself and the environment around him or her. It also helps to improve interpersonal relationship skills, and identifying stressors in the environment and how to avoid them

Depression (major or clinical depression)

Depression is a common mental disorder. Grief or sadness is a typical response to a traumatic life event or crisis, such as the death of a spouse or family member, loss of a job, or a major illness. However, when the depression continues to be present even when stressful events are over or there is no apparent cause, physicians would then classify the depression as clinical or major depression. For a person to be diagnosed with clinical depression, symptoms must last for at least two weeks.

Bipolar disorder (manic-depressive disorder)

Bipolar disorder is defined by swings in mood from periods of depression to mania. When someone experiences a low mood, symptoms may resemble those of a clinical depression. Depressive episodes alternate with manic episodes or mania. During a manic episode, a person may feel elated or can also feel irritable or have increased levels of activity.

- **Bipolar I** - This is the most severe form. Manic episodes last at least seven days or may be severe enough to require hospitalization. Depressive episodes will also occur, often lasting for at least two weeks. Sometimes symptoms of both mania and depression are present at the same time.
- **Bipolar II disorder** - This disorder causes cycles of depression similar to those of bipolar I. A person with this illness also experiences hypomania, which is a less severe form of mania. Hypomanic periods

are not as intense or disruptive as manic episodes. Someone with bipolar II disorder is usually able to handle daily responsibilities and does not require hospitalization.

Intermittent explosive disorder

This is a lesser-known mood disorder marked by episodes of unwarranted anger. It is commonly referred to as "flying into a rage for no reason." In an individual with intermittent explosive disorder, the behavioral outbursts are out of proportion to the situation. This diagnostic category is frequently seen in a correctional setting.

What causes mood disorders?

There may be several underlying factors, depending on the type of the disorder. Various genetic, biological, environmental, and other factors have been associated with mood disorders.

Risk factors include:

- Family history
- Previous diagnosis of a mood disorder
- Trauma, stress or major life changes in the case of depression
- Physical illness or use of certain medications. Depression has been linked to major diseases such as cancer, diabetes, Parkinson's disease and heart disease.
- Brain structure and function in the case of bipolar disorder

What are the symptoms of common mood disorders?

Symptoms depend on the type of mood disorder that is present.Symptoms of major depression may include:

- Feeling sad most of the time or nearly every day
- Lack of energy or feeling sluggish
- Feeling worthless or hopeless
- Loss of appetite or overeating
- Gaining weight or losing weight
- Loss of interest in activities that formerly brought enjoyment
- Sleeping too much or not enough
- Frequent thoughts about death or suicide
- Difficulty concentrating or focusing

Symptoms of bipolar disorder may include both depression and mania. Symptoms of hypomanic or manic episodes include:

- Feeling extremely energized or elated
- Rapid speech or movement

- Agitation, restlessness, or irritability
- Risk-taking behavior, such as spending too much money or driving recklessly
- Unusual increase in activity or trying to do too many things at once
- Racing thoughts
- Insomnia or trouble sleeping
- Feeling jumpy or on edge for no apparent reason

MEDICATION GUIDELINES AND ASSOCIATED LABORATORY STUDIES FOR PATIENTS WITH MOOD DISORDERS

The correctional psychiatric clinician must have the wellbeing of the individual patient in mind, but also the wellbeing of the community of inmates. Our goal is to eliminate emotional pain and reduce psychiatric symptoms, but also to avoid misuse of medication by inmates, as well as medication diversion in the correctional facility. We need to conform to evidence based management and be consistent with the on-label usage of psychiatric medication.

ANTIDEPRESANTS

SSRI'S serve as both first and second line treatments for depression and anxiety. We treat only if symptoms IMPAIR functioning. TIME LIMITED use of Vistaril/Benadryl (about ten days) while SSRI'S are "kicking in" is acceptable. Use of Vistaril, etc. should be the exception rather than the rule, and only for individuals that YOU see as in CLEAR distress, such as individuals that have never been in jail before or are accused of a major crime.

Do not use tricyclic antidepressants or Remeron, as we are not providing antidepressant medication as a sleep aid. Duloxetine and venlafaxine are formulary. Use Bupropion XL sparingly as there is a risk of abuse in correctional environments. The shorter acting forms of Bupropion are off the formulary to prevent abuse and diversion.

MOOD STABILIZERS

Use mood stabilizers as first line for bipolar disorder, and to adequately evaluate for TRUE symptoms of mood cycling vs "moodiness", and/or mood shifts while involved in drug/alcohol abuse. We are all aware of the over diagnosis of Bipolar Disorder. The diagnosis of Bipolar Disorder, in adults, has doubled in the last ten years and increased 40 times in children! Also, there is the over diagnosis of bipolar in individuals with impulsivity driven by adult ADHD. Which is highly represented in the correctional "community". Frequently patients come from substance abuse rehabs with a bipolar diagnosis, but there is no clear systems of cycling. As you are aware, "MOODINESS" or "mad one minute and then okay the next" is NOT bipolar, though frequently individuals erroneously carry this DX. We do not have to agree, nor treat the DX. Treat the patient based on the symptoms at hand, and treat most conservatively. Lastly, gabapentin studies have demonstrated it is NOT a mood stabilizer, and should not be used for this purpose.

Medication	Monitoring	Recommendation	ChartReviewMinimum
Lithium (Eskalith,Lithobid)	Pregnancytest	Baselineinwomenof childbearingageandwhen clinicallyindicated	Same
	BUN/Cr	Baseline;every2-3monthsinfirst6monthsand every6-12monthsinstablepatientsorwhen clinicalstatus changes	Baselineandevery6months
	TSH	Baseline;1-2timesinfirst6monthsandevery 6-12monthsinstablepatientsorwhenclinical statuschanges	Baselineandevery6months
	Liblood level	Monthlyuntilbaselinereached,and after baseline,Minimumevery6monthsandwhen clinicalstatuschanges(includingdosage changes)	Baselineandevery6months,after dosagechanges
ValproicAcid (Depakote, Depakene)	Pregnancytest	Baselineinwomenofchildbearingageandwhen clinicallyindicated	Same
	Liverfunction test	Baselineandaminimumofevery6months	Baselineandevery6months
	CBC,Diff	Baselineandaminimumofevery6months	Baselineandevery6months
	VPAblood level	Weeklyuntiltherapeuticandafter dosage changes, minimum every 6 months or when clinical status changes	Same
	Amylase/lipase	ObtainonlyifsuspectValproateinduced pancreatitis(rare)	Same
	Ammonia	Obtainonlyifsuspectvalproateinduced hyperammonemia/hyperammonemic encephalopathy	Same
Carbamazepine (Tegretol}	Pregnancytest	Baselineinwomenofchildbearingage andwhenclinicallyindicated	Same
	CBC/diff &platelets	Baseline; every2 weeksduringfirst2weeksoftreatment thenevery3months	
	Liverfunction tests(CMP}	Baseline;every2weeksduringfirst2 monthsoftreatmentthenevery3months	Baseline,after2weeksandevery6months
	BUN/Cr(CMP)	Baselineandifclinicallyindicated	Same
	CBZblood level	1weekand1monthafterstart, 1 weekafterdosagechangeorwithnew	Baseline,1monthandthenevery6months,andafterdosage changes

		sideeffects;every6monthsinstablep atients	
	Electrol ytes(C MP)	Ifhighriskforhyponatremia(elderly)	Same
	HLAB*1 502	PriortostartinginAsianpatients	Same

ACUTE SUBSTANCE INTOXICATION AND SUBSTANCE ABUSE DISORDERS

Substance Use Disorder

Within the jail setting, practitioners encounter a broad spectrum of clinical diagnoses arising from acute intoxication and/or withdrawal. Most clinical presentations are complex and multi-faceted due to polysubstance use or use of multiple difference substances including alcohol.

The intent of this protocol is to initiate specific clinical support that forestalls or completely avoids the debilitating and potentially life-threatening consequences associated with the abrupt cessation of specific substances. Healthcare staff aims to identify those inmates with the potential for significant withdrawal morbidity or mortality in order to effect pre-emptive interventions. Identification of these patients occurs through focused questioning at intake and the gathering of critical historical information through patient self-report, as well as clinical evaluation.

Inmates often attempt to minimize their degree of intoxication, deny or downplay their history of substance use or dependence, and make false claims of being in full control. Practitioners must therefore remain focused and constant in helping individuals admit to and recognize the full extent of their illness, especially since significant morbidity and mortality are often associated with acute intoxication and withdrawal syndromes. Bearing all this in mind, clinicians must be attuned to patients' presenting problems, vigilant and thorough in conducting initial evaluations, and expedient and assertive in the initiation of interventions and treatments. Face-to-face evaluations with patients must occur on a daily basis. Those patients refusing key aspects of withdrawal care, such as hydration therapy or medications, must be fully assessed and referred to the clinician for intervention *at the earliest signs of decompensation* (please see the 8-Day Nursing Form and the Nursing Withdrawal Handbook for additional detail).

It is the policy of CFG Health Systems to ***proactively*** and ***aggressively*** treat all inmates who exhibit signs of physical dependence, intoxication, and/or symptoms of withdrawal at intake. Treatment is considered preventative, begun in an attempt to avoid the onset of symptoms/conditions associated with substance dependence such as Korsakoff's syndrome, Wernicke's encephalopathy and delirium tremens.

COMMONLY USED SUBSTANCES

- Opioids/Opiates

    - Percocet, Vicodin, Hydrocodone, Oxycodone, etc.
    - Heroin
    - Buprenorphine (Suboxone/Subutex)
    - Methadone
- Alcohol
- Sedative Hypnotics: (Benzodiazepines and Barbiturates)
    - Xanax ("footballs or bars")
    - Klonopin
    - Phenobarbital
    - Gamma-Hydrobutyric acid (GHB) and GHB derivatives
- Synthetic Marijuana (a.k.a. K2, Spice)
- Stimulants:
    - Cathinones (a.k.a. "Bath Salts")
    - Cocaine ("Powder" or "Crack")
    - Amphetamine/Methamphetamine

MEDICATION ASSISTED TREATMENT [MAT]

There are two clinical objectives facing the clinician treating a patient with substance use disorder [SUD]. The first goal is to manage their symptoms, the ranging from the intoxication caused by an unknown cocktail of substances to that of withdrawal with incapacitating depression, intense drug cravings and a myriad of somatic complaints. The second objective is targeted intervention to prevent overdose death.

Medication therapy is available to target classes of commonly abused substances prescribed to mitigate withdrawal symptoms or to prevent death. Buprenorphine hydrochloride, as a single agent, and in combination with naloxone hydrochloride, methadone, and naloxone hydrochloride all provide therapeutic support for opioid use disorders [OUD]. Intermediate and short-acting benzodiazepines are prescribed for both alcohol and benzodiazepine use disorders. Naltrexone provides long-term support for alcohol and opioid use disorders. Vitamin and mineral replacement therapy are essential to a sustained response to therapy. With the broad-based problem of poly-pharmacy, the physiologic principles of dilution and renal elimination take on pivotal importance in the management of patients with substance use disorders.

Patients under treatment for substance use disorder [SUD] receive behavioral counseling along with FDA-approved medications in an effort to provide a comprehensive approach to the management of their illness.

Medications such as methadone, buprenorphine, naltrexone and naloxone could be prescribed in different situations and in a responsible manner to someone with an opioid addiction. These

medications are used to manage dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.

Disulfiram, Acamprosate and naltrexone are often used to help treat someone with an alcohol addiction.

Methadone used in the treatment of opioid addiction can be prescribed and dispensed only through a SAMHSA-certified OTP. Buprenorphine-containing drugs, such as Suboxone can be prescribed by physicians who obtain a waiver from the DEA after taking specified training in the use of these drugs. Naltrexone, oral or injectable, can be prescribed by any licensed physician.

POPULATION SPECIFIC INFORMATION

Pregnancy:

Pregnant females are considered "high risk," priority patients and require specialized OB/GYN and Maternal/Fetal Medicine care. Opioid-dependent pregnant women should be stabilized on either buprenorphine or methadone, and may require hospital or ED admission for stabilization. Pregnant women with alcohol or sedative dependence may require inpatient detoxification for safety. Pregnant women with acute, severe stimulant intoxication may require inpatient evaluation for fetal monitoring.

The ever-present consequence to continued substance use in the pregnant female is fetal viability. It is recommended that early during first trimester, determinations of fetal viability must be obtained preferably prior to housing at the facility. Level Two Ultrasound studies may be obtained from community emergency room facilities, which will inform the clinical staff at baseline.

Prompt consultative follow up with neonatology or high-risk pregnancy is essential to sustainable fetal viability. Buprenorphine and methadone management is important for opioid use disorder. Gravid patients with active benzodiazepine use may need frequent obstetrical evaluations, along with continued maintenance of a benzodiazepine.

Termination of Pregnancy [TOP] is an option available to all pregnant female detainees in our system. Working with community providers, such as Planned Parenthood, services are made available in a timely manner to all who are eligible. Especially with this population, close collaboration with Mental Health staff is imperative to assure that all decisions made by the detainee are informed.

Finally, detainees with active substance use disorders who are maintained on Buprenorphine or Methadone to assure fetal viability may be re-evaluated after TOP for voluntary enrollment in MAT.

Medical Co-morbidities:

Substance use disorders often are the harbingers of chronic progressive end-organ deterioration and failure. Screening assessment tools, such as CIWA-Ar and PAWSS focus on neurologic consequences of alcohol abuse. Patients who report adult onset seizure disorders often attribute them to withdrawal and absence from alcohol. Black outs, drop attacks, confabulations, and Werneke's encephalopathy, along with tremors and paresthesia are all extreme neurologic consequences of long-standing alcohol use disorder.

Cardiac arrhythmias, congestive heart failure, endocarditis, acute myocardial infarctions may all be the endpoint of poly-substance use disorders, including alcohol. Some conditions progress to a stage not amenable to medical management, such as congestive heart failure due to alcohol or cocaine abuse.

Hepatic transaminitis due to substance abuse are commonplace, with 3-4 fold elevations hampering the use of treatment medications.

Renal disease may appear as toxic with a sediment or obstructive with acute renal failure, such as seen with Rhabdomyolysis.

Cellulitis and abscess formation must be aggressively treated, oftentimes with parenteral antibiotics.

Severe Psychiatric Co-morbidities:

The proliferation of synthetic stimulants, alone and in combination with fentanyl opioid products lead to a myriad of psychologic presentations. Wildly aggressive behaviors, paranoias, to catatonic states have all been attributed to substance use disorders. Patient management must include mental health staff early on in the development of a care plan.

With the wide-use of MAT for opioid use disorder in the facility, medical staff may prescribe low-dose buprenorphine – naloxone to patients identified by mental health as impulse, labile, willful. These patients often make verbal gestures of impending self-harm as a ploy to control and manipulate their circumstances surrounding incarceration. These medications often assist mental health in stabilizing and redirecting these patients.

Traumatized Patients:

Screening for PTSD is done in order to initiate trauma-informed care. Highly traumatized patients may react disproportionately to routine interactions, verbal assessments, clinical evaluations, or incarceration itself.

TRIAGE

WHICH PATIENTS NEED IMMEDIATE TREATMENT?

- Pregnant Patients
    - Pregnant patients with opioid dependence require immediate stabilization on opioid treatment (methadone or buprenorphine)
    - Pregnant patients are recommended to be cleared for fetal viability at the time of incarceration
    - Pregnant patients with sedative or alcohol dependence require inpatient detoxification
    - Pregnant patients with acute stimulant intoxication require immediate assessment and may require fetal monitoring
- Sedative Dependence: patients with sedative dependence, acute sedative intoxication, or exhibiting signs/symptoms sedative withdrawal:
    - It is important to assess frequency, quantity, and duration of sedative use, history of sedative withdrawal symptoms, and history of withdrawal severity (i.e. delirium or seizures). Like alcohol, sedative withdrawal can be life threatening.
        - The abrupt cessation of sedatives can lead to severe neurologic events. Symptoms may range from labile mood swings, severe anxiety, diaphoresis and insomnia to frank delirium, myoclonus, grand mal seizures and death.

  Note: Sedative use should be assessed even when it is not primary drug used or drug of choice. Some patients use sedatives regularly to enhance other substances (i.e. heroin). These patients will require monitoring and potential treatment of sedative withdrawal if they use daily and/or have signs and symptoms of physical dependence.
- Alcohol Use: Patients with reported or suspected alcohol use:
    - Assessment must include how often the patient uses alcohol (frequency), how much alcohol is consumed (quantity), how long (days, weeks, months, years) they have been consuming alcohol (duration), if alcohol consumption is supplemented with other sedative use, and the last time they had alcohol prior to their arrest.
    - Assessment must also include history of alcohol withdrawal and severity of withdrawal (history of seizures or delirium tremens).
    - Patients often underreport drinking. A patient's report of having "just a couple of drinks a day" must be explored further, as this can result in dependence and withdrawal. Reports of "the occasional cocktail" or "social drinking" or "only with friends" also need further evaluation to rule out possibility of physical dependence.
    - All patients with reported or suspected alcohol use should undergo screening with ***PAWSS*** and ***CIWA-AR*** to stratify risk and to initiate treatment when needed.
- Patients exhibiting clinical signs or symptoms of stimulant, PCP, or synthetic marijuana intoxication
    - Acute stimulant intoxication can result in cardiovascular events, stroke, rhabdomyolysis, and self-injurious behavior.

- Stimulant withdrawal can induce severe depression or suicidal behavior, but is not typically physically dangerous. Mood should be monitored.
- Patients exhibiting signs of dehydration (abnormal urine specific gravity, no urine, dry mucosal membranes)
- Patients with a positive history for substance use and elevated blood pressure, advanced age, or significant medical or psychiatric co-morbidities (i.e. CHF, severe renal disease, history of stroke, history of suicide attempt).

All inmates presenting with signs and symptoms of intoxication and/or withdrawal shall be subject to comprehensive treatment protocols and will be monitored by nursing staff for a minimum of eight (8) days for signs and symptoms of persistent withdrawal.

Treatment strategies, involving both clinicians and nursing staff, are designed to mitigate neurologic and physical risks of acute withdrawal or intoxication, correct aberrations in fluid volume and electrolyte levels, and to also address infectious and comorbid conditions.

SUBSTANCE WITHDRAWAL PROTOCOLS

Screening, Clinical Assessment, and Diagnostic Testing

The following screening tools are used at time of Intake:

Diagnostic information is obtained by nursing staff during Receiving Screening (NCCHC standard E-02), evaluated by the RN during the initial clinical assessment, and used to corroborate the decision to initiate withdrawal treatment. Diagnostic and screening tools used as part of substance withdrawal protocols may include:

- Substance(s) identification by history
- NIDA Drug Use Screening Tool: https://www.drugabuse.gov/nmassist/
- CAGE (a screening test used to identify alcohol dependence)
- T-ACE (a screening test used to identify alcohol dependence)
- CIWA-Ar (an assessment for monitoring withdrawal symptoms)
- CIWA-B (withdrawal assessment for sedatives/benzodiazepines)
- PAWSS (a screening test used to identify alcohol dependence)
- Vital signs
- Random glucose testing (finger stick)
- Urinalysis (checking for the presence of ketones, abnormal osmolality, glucose, rhabdomyolysis [dark-colored urine], clinical signs of dehydration, leukocyte esterase)
- Point of Care (POC) urine drug screen
- Primary Care-Post Traumatic Stress Disorder Screen (PC-PTSD) Screen

NURSING TREATMENT PARADIGM

	Information Obtained During Receiving Screening	Next Step	Nursing Action
Self-Report at Intake	Female of reproductive age with recent (past 30 day) substance use	Urine pregnancy test (UPT)	• +Pregnancy Test –assess for need for acute stabilization and/or hospitalization • Level 2 Ultrasound fetal viability • Sedative, alcohol, or opioid dependence or withdrawal or acute stimulant intoxication
	Male/Female - visibly intoxicated	Clinical assessment • Females: UPT • vital signs, urinalysis, *urine drug screen • physical exam for substance assessment • substance history intake (if possible)	Nursing should initiate substance specific treatment(s)
	History of "social drinking" or "occasional drinker" and not intoxicated at intake or exhibiting signs of withdrawal: complete the CIWA-Ar; if score is <8 **THEN** completeCAGE or T-ACE	**CAGE** and **T-ACE, PAWSS** are screening tools that quantify the potential risk for underlying alcoholism. If a patient's history is benign, but the CAGE or T-ACE scores are >2, there exists the likelihood that the patient may be underestimating their consumption of alcohol.	Nursing should initiate treatment when: • **CAGE score = >2 OR** • **PAWSS score =>4 OR** • **T-ACE score = >2**
	History of chronic/daily substance use	Inquire as to time/date of last intake and the amount consumed [e.g. - pt. consumes 1 pint daily of vodka; last drink - day of arrest]	Nursing should initiate substance specific treatment(s)
CIWA-Ar	RN assessment	CIWA-Ar score = 8 or more PAWSS score =4 or more	Nursing should initiate treatment
Modified Treatment if:	• Occasional Substance Use (i.e., intermittent use, social drinker) • No s/sx physical dependence • No history of withdrawal symptoms • No s/sx acute intoxication	**Clinical Screening Tools:** • COWS: score < 6 • CIWA-Ar: score = <8 • CAGE or T-ACE score = <2	Refer to the clinician for non-urgent further assessment.

See Physician's Orders for Withdrawal and the Flow Sheet for Alcohol/Poly-Substance Withdrawal; orders must be patient-specific and signed by the clinician

Hydration Therapy:

Hydration therapy should be initiated as indicated below:

- Oral Hydration

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

- IV Hydration - IV 0.45% or NS x two (2) liters, administered over 12 hours. May repeat in 12 hours, as needed.
- Intake and output assessments
- Caution with fluid resuscitation and call care provider if:
  - PMH Congestive Heart Failure
  - PMH Renal disease on dialysis
  - Patient exhibiting edema or shortness of breath
- 8-Day Nursing Plan (see Flow Sheet for Alcohol/Poly-Substance Withdrawal)

THE CLINICIAN MUST REVIEW AND ENDORSE RECEIVING SCREENING, ESTABLISHED BASELINES AND TREATMENT DATA AS PROOF OF REVIEW.

Treatment is to be initiated by Clinicians

MISSED SUBSTANCE DEPENDENCE AT RECEIVING SCREENING

Oftentimes patients divulge information regarding substance use and/or dependence to the clinician during the Initial Health Assessment (NCCHC standard E-04) that they did not reveal at Receiving Screening. The onset of signs or symptoms of clinical withdrawal might be the patient's motivation for full disclosure to the clinician at this time. The clinician will need to review all information obtained during the nursing intake (Receiving Screening E-02), and perform screening for alcohol and drug use and clinical diagnostic withdrawal tools as needed.

Alcohol Use: Patients who denied alcohol use and who were not subjected to screening with CAGE or T-ACE or PAWSS will need to have screening and assessment with CIWA-AR performed by the clinician now. Once treatment has been initiated, serial CIWA-Ar evaluations with objective quantification scores may be used as an indicator of response to treatment.

Opioid Use: Patients who denied opioid use and had negative NIDA drug use screens upon Receiving Screening, but who are now complaining of opioid withdrawal should have the Clinical Opioid Withdrawal Scale (COWS) performed by the clinician now. If patient exhibiting moderate to severe opioid withdrawal, initiate opioid withdrawal treatment pathway. If treatment is initiated, serial COWS evaluations with objective quantification scores may be used as an indicator of response to treatment. [See Opioid use Disorder plan].

Sedative Use: Patients who denied sedative use and who had negative NIDA drug use screening at Receiving, but who are now complaining of or exhibiting s/sx sedative withdrawal will need to have assessment with CIWA-Ar or PAWSS performed by the clinician now. NIDA drug use screening can be re-done at this time by the clinician as well. If treatment is initiated, serial CIWA-Ar or PAWSS evaluations with objective quantification scores may be used as an indicator of response to treatment.

CONTINUATION OF SUBSTANCE USE DISORDERMANAGEMENT

Patients started on substance use disorder treatment by the nursing staff will need to be assessed by the clinician at the Initial Health Assessment to determine the adequacy of intervention. Severe, multifaceted dehydration due to heroin withdrawal, with diaphoresis, emesis and diarrhea all exacerbating underlying volume contraction may require the clinician to order intravenous fluid replacement administered via a PICC line (peripherally inserted central catheter). Patients with a history of seizure or abuse of multiple sedatives may need the initial dose of chlordiazepoxide increased or the titration scheme revised in order to provide extended support for long-term withdrawal. Patients taking methadone* or Suboxone* for opioid-dependence will transfer and enrollment into the facility's MAT program to assure needed counseling.

Please see individual substance withdrawal pathways for more detail for screening, diagnosis, and treatment of withdrawal for each substance.

There will be individuals referred by nursing staff to the clinician for evaluation based solely on the Receiving Screening interview (NCCHC standard J-E-02). These individuals will have positive findings related to potential alcohol use disorder based on the intake screening questionnaire, but final scores of "0" or "1" on the CAGE and T-ACE assessments and/or CIWA-Ar scores of 7 or less and/or PAWSS scores of 3 or less. The clinician will determine the need for treatment in these cases. Patients with visible stigmata of long-

standing opioid use disorder, even with a negative urine drug screen MUST be offered MAT to prevent discharge reuse and death.

SPECIAL POPULATIONS

I. Treatment of Withdrawing Inmates with Elevated Blood Pressure

As a normal physiologic response to dehydration, patients with underlying volume depletion disorder may demonstrate secondary blood pressure elevations, wide pulse pressure readings and/or tachycardia. These patients must be treated with aggressive volume repletion therapy and be reassessed within twenty-four (24) hours of baseline evaluation. The same holds for withdrawing patients with known underlying hypertension – baselines must be established during the initial clinical evaluation and the patient must undergo aggressive hydration therapy as medications are reinstated.

Hydration therapy must be initiated for any patient meeting any two of the criteria in List A and any one of the criteria in List B:

List A

- Diastolic blood pressure >100
- Blood pressure reading >160/>100
- Pulse >92
- Urine specific gravity >1.025
- Strongly concentrated urine
- Urinalysis positive for ketones
- Urinalysis positive for sediment
- Urinalysis positive for abnormal cells
- Lack of urine
- Dry skin and/or dry mucus membranes (no tears, no axillary moisture)

List B

- Obtunded or confusion
- Unsteady gait
- Recent emesis
- Recent diarrhea

Effective hydration treatment intervention shall be defined as:

- a ten percent (10%) reduction in pulse rate,
- narrowing of pulse pressures,

- decline in high blood pressure

Patients who remain hypertensive following hydration intervention must be referred for anti-hypertensive therapy.

Patients with post-hydration therapy blood pressure elevations who present without prior anti-hypertension treatment regimens should be placed on a beta-blocker, unless clinically contraindicated.

- **NOTE:** Patients with underlying reactive airways disease may be sensitive to beta-blockers; as such, antihypertensive therapy using an ACE or ARB in place of a beta-blocker should be initiated instead.
- **NOTE:** CFG Medical Directors strongly caution against the use of alpha-adrenergic therapy, such as Catepres/Clonidine, in an attempt to lower a patient's blood pressure quickly. **The goal of treatment is to *slowly* lower the patient's blood pressure under continuous monitoring.**

Patients with evidence of end-organ impact and any of the following symptoms (indicative of accelerated hypertension) MUST BE REFERRED TO A TERTIARY CARE FACILITY:

- altered mental status
- complaints of angina or chest pain
- new onset hematuria
- new onset severe headache
- new onset visual impairment
- new focal neurologic impairments

II. Patients Requiring Opioid Medications:

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.
- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is

suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off the opioid, as appropriate.

- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

ON-GOING TREATMENT BY THE CLINICIAN

Day-4 Evaluation

- Mental health referral needs to be completed if not already done
- Patients with eventful Day 4 evaluations must be seen for follow-up by the clinician until there is objective evidence of a favorable response to the withdrawal protocol.
- Patients who continue to deteriorate, in spite of aggressive withdrawal treatment, must be placed on an infirmary level of care.
- Clinician will need to determine when a patient's withdrawal is life threatening and warrants admission to the hospital for additional stabilization and treatment
- **Medical office visit –**
  - On Day 4 of the treatment regimen,
    - Clinician must examine the patient and determine if a reduction in chlordiazepoxide is indicated.
    - Clinician must complete a comprehensive review of the appropriateness and efficacy of treatment.
    - Objective data, beyond the history and physical examination, should include a review of the 4-Day Nursing logs, which provide intake and output data, vital signs and pertinent information regarding mood and affect.
    - Clinician should complete a new CIWA-Ar evaluation as objective criteria of response. Patients that arrived at the jail intoxicated, but with a low CIWA-Ar score (less than 8) at intake, may have a higher score on Day 4.
    - Clinician will need to provide a clinical assessment and will need to amend the treatment plan as directed by findings.
    - Day 4 orders may call for an increase in chlordiazepoxide dosing or extended treatment at entry level dosing prior to beginning tapering of treatment.
    - Clinician must also certify that adequate hydration has been restored.
    - Clinician is to note the use of Ativan for seizures and adjust Librium levels accordingly.
      - Nursing staff must inform the clinician whenever Ativan is to be administered

- Patients started on buprenorphine-naloxone or methadone regimen may be deemed stable at Day 4 by the clinician.
- Continued counseling will be provided by the MAT provider protocol.

Clinician Review and Treatment Titration

Did You Check?	Did You?
• Substance history • Time and type of last substance ingestion • Symptoms of withdrawal • Comorbid conditions • Pregnancy status • Inconsistencies between patient self-report of alcohol use and CAGE scores • Alcohol hallucinations occurring without shakes • Visible intoxication • Kidney stones • Prior visits to the ER for intoxication and/or withdrawal • Seizures • Seizures with pregnancy • Pancreatitis • Diabetes • Hepatitis • Opioid addiction • Mental status • Completed Day-4 syndrome	• Aggressively hydrate (see Order Sheets) o Two (2) liters every twelve (12) hours for eight (8) days *(even if inmate is eating)* • Assess intake and output • Provide essential vitamin supplementation • Complete critical evaluations • Complete necessary referrals and consultations • Order o Thiamine o Folate o Magnesium oxide o Serum glucose testing o Urinalysis • Check ketones • Check leucocyte esterase • Check glucose • Observe for rhabdomyolysis • Check for clinical signs of dehydration • Complete Day-4 screening

Withdrawal Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • ICD code • Identify substance(s) of intoxication, dependence, and/or withdrawal.
Orders and Care Plan • Physicians' Orders • Flow Sheet for Alcohol • Single Substance or Poly-substance Withdrawal and Care Plan o **For Alcohol or sedative withdrawal:** ▪ Review Chlordiazepoxide treatment ▪ Note the use of Ativan for seizures and adjust Librium levels accordingly o **For Alcohol or sedative withdrawal:** ▪ Review Chlordiazepoxide treatment ▪ Note the use of Ativan for seizures and adjust Librium levels accordingly • Prolong treatment with chronic patients • Urine Drug Screen • MAT referral • MAT bridge orders
Nursing Education
Discharge Planning

OUD TREATMENT

Background: There are two clinical objectives facing the clinician treating a patient with OUD. The first goal is to manage their symptoms, ranging from the intoxication caused by an unknown cocktail of substances to that of withdrawal with incapacitating depression, intense drug cravings, generalized pain and a myriad of somatic complaints. The second objective is targeted behavioral modification to prevent overdose death.

A consequence of bail-reform, is the rapid transit through the justice system of patients at various stages of acute intoxication and chronic OUD disease. Drug tolerance is maximally impacted by the activities of the clinical staff through aggressive hydration and dilution, vitamin and mineral replacement therapy and nutritional supplementation, as tolerated. OUD patients, who then return to substance abuse 48 to 72 hours later, at the pre-incarceration doses, are at higher risk for overdose. Information provided by the New Jersey State Department of Correction[7] reports that 75% of the incarcerated population have a substance use disorder with 25% of that group suffering from OUD. Nearly 75% of those with OUD relapse with three months of release from incarceration. Fewer than 10% enter a substance abuse treatment program, post-release. National statistics have reported the risk of overdose death for the previously incarcerated is approximately 130 times greater than the general public, with many of the deaths occurring the first week of release.

This protocol is intended to afford guidance to the clinical team in the initial stratification of patients with underlying OUD for immediate support therapy, integration to Medication Assisted Treatment [MAT] or more extensive psycho-social behavioral management.

Receiving Screening:

Nursing

1. Comprehensive history of SUD, including OUD, alcohol, chemicals or stimulants.
   Use of the Opioid Risk Tool – Dash 100 [Table 1. Opioid Risk Tool]
   Developed to screen potential patients prescribed chronic narcotic analgesic medications, Dash 100 provides an objective evaluation

[7]Adam Bacon LSW, NJ Stater Opioid Treatment Authority, Office of the Medical Director, Division of Mental Health and Addiction Services.

instrument to determine the risk of male and female patients with the likelihood to future abusive drug-related behaviors. This survey will be completed and scored initially for all detainees who report OUD.

2. Duration of abuse history, including the type of past medical treatment interventions:
    a. Emergency room treatment,
    b. Naloxone hydrochloride [Narcan] administration,
    c. IV fluids with "banana bags"
    d. Treatment for seizures
    e. Past overdose history
3. Has the patient ever received medication assisted treatment [MAT] in the community? Obtain all contacts and confirm past participation.
4. What SUD does the patient admit to?
5. What treatment, if any, does the patient request. **NOTE:** Many of the detainees seen at our facilities are informed of MAT services being offered and will request treatment.
6. Overall evaluation of the patient
    a. Grossly intoxicated
    b. Aggressive behavior, paranoid ideations, hallucinations
    c. Physically ill – pain, fever, diarrhea
7. Assessment: Vital signs, including wide pulse pressure, diastolic hypertension, tachycardia, tachypnea, nystagmus, pupillary dilatation, bounding pulse, epistasis, track marks to skin.
8. CAGE, CIWAr, Dash-100 score, COWs score
9. Urine drug screen **NOTE:** The point of service urine drug test kits employed at most of the facilities do not consistently identify synthetic opioid chemicals, such as fentanyl. Most urine test kits will measure for benzodiazepines. Alcohol is not tested. **NOTE:** A negative UDS for opioids with physical track marks must be counted as a positive OUD.

Urgent Treatment Interventions: **Nursing** [See Withdrawal Protocols]

1. Calculate the Dash-100 and COWs scores and activate the appropriate withdrawal management protocols.
    a. Group 1. Score 0 – 3
    b. Group 2. Score 4 – 7
    c. Group 3. Score 8 or higher
2. Aggressive hydration as tolerated, intravenous supplementation if needed.
3. Treatment of withdrawal symptoms, such as antiemetics, analgesics
4. Confirm MAT treatment information

5. Confirm treatment medications with pharmacy, including last dose filled.
6. House in the clinical area which will allow access for treatment intervention.

Discussion: The nursing staff has sufficient information at this juncture to refer to the clinician for a care plan and treatment. Facilities with 24-hour clinician staff will receive the patient for the intake evaluation. When clinician staff are unavailable and the patient is deemed to be unstable, the nurse will page the clinician on call for directions.

The two treatment goals are to Prevent Death and to Link to MAT.

OUD with No past MAT and no consent for MAT on this Admission

1. Clinician reviews the reported pharmacology – What is the patient taking?
2. The vital signs and the presentation of the patient is assessed. Does the patient require emergency room intervention?
3. Urine drug screen [UDS] – **NOTE**: Negative for opioids would not rule out fentanyl. Ask the patient if there is an OUD history. Negative for benzodiazepines would suggest no need for STAT chlordiazepoxide [Librium] versus observation.
4. Dash-100 [Group 1, 2, 3] and COWs score Less than 11, 11 or greater
5. **Use of SuboxoneHCl Taper to prevent withdrawal**

Dash -100 Group 3	COWs 11 or greater
• Day 1	SuboxoneHCl 8mg/2mg 2 q day
• Day 2	SuboxoneHCl 8mg/2mg 2 q day
• Day 3	SuboxoneHCl 8mg/2mg 1 q day
• Day 4	Clinician reassessment - o Continue daily 8mg/2mg, OR o Increase 8mg/2mg 2 day, OR o Discontinue Suboxone

NOTE: Discuss need for MAT with the patient

Dash -100 Group 2	COWs Less than 11
• Day 1 -3	SuboxoneHCl 8mg/2mg 1 q day
• Day 4	Clinician reassessment o Continue daily 8mg/2mg

OR

- Discontinue Suboxone

NOTE: Discuss need for MAT with the patient

Dash -100 Group 1 COWs Less than 11

- Aggressive hydration
- Symptomatic support

OUD with history of MAT

For patients with a history of ongoing treatment, efforts will be made to assure continuity of care. Methadone maintenance programs are highly regulated by Federal Law and documentation necessary for patients to receive guest dosing at a local facility are exacting. Patients may be transported back to their original facility for treatment until a chain of custody is established with the correctional facility for Methadone pick up and administration by nursing.

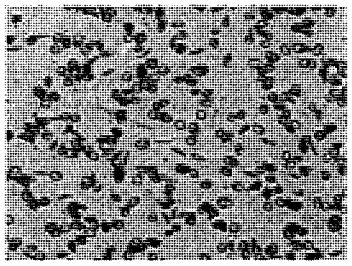
Patients enrolled in buprenorphine programs may be dosed at the facility, while awaiting an initial evaluation and care plan from the facility-based and/or collaborating MAT provider. Under these circumstances, the clinician with the DEA-X certification at the facility will write a bridge order for: SuboxoneHCl 8mg/2mg daily [3 - 7 days] for "continuity of care pending evaluation and treatment plan from the MAT provider". Once evaluated by the MAT provider, the facility clinician will write an order directing nursing staff to administer medication as ordered by the MAT provider.

Because of bail-reform, detainees are often lost to follow up throughout the treatment process. To assure that patient care plans are maintained, consent forms are signed at intake which allow for a bi-directional sharing of clinical information with the clinic and the community-based MAT provider. The patient knows from intake where follow up care will be available.

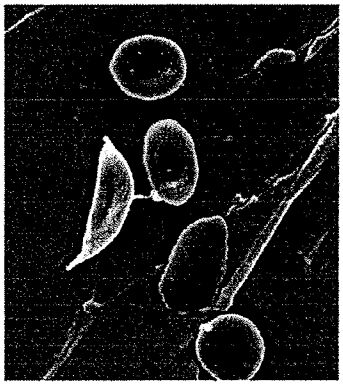
SICKLE CELL ANEMIA

Sickle-cell disease (SCD), also known as sickle-cell anemia (SCA) or drepanocytosis, is a hereditary blood disordercharacterized by red blood cellsthat assume an abnormal, rigid, sickleshape. This change in red blood cells, or sickling, decreases the cell's flexibility, resulting in significant risk for various acute and chronic complications, several of which have a high mortality rate.

The sickling is the result of a mutation in the hemoglobingene. individuals with one copy of the mutant gene will produce a mixture of both normal and abnormal hemoglobin.



Sickle cells in human blood: both normal red blood cells and sickle-shaped cells are present in this slide



Normal blood cells (round) next to a sickle blood cell (colored image from a scanning electron microscope)

Sickle Cell Crisis

The terms "sickle cell crisis" or "sickling crisis" are used to describe several independent acute conditions occurring in patients with sickle cell disease and include anemia, vaso-occlusive crisis, aplastic crisis, sequestration crisis, hemolytic crisis, as well as others. Most episodes of sickle cell crisis last between five and seven days. Although infection, dehydration, and acidosis (all of which favor sickling) can act as triggers, in most instances no predisposing cause can be identified.

Vaso-Occlusive Crisis

Vaso-occlusive crisis is seen when sickle-shaped red blood cells obstruct capillaries and restrict blood flow to an organ, resulting in ischemia, pain, necrosis and, often, organ damage. The frequency, severity and duration of vaso-occlusive crises vary considerably. Painful crises are treated with hydration, analgesics and blood transfusion, plus the administration of opioids at regular intervals until the crisis has settled. For milder crises, sub-groups of patients may manage pain through the use ofNSAIDs (such as diclofenac or naproxen). For more severe crises, most patients require inpatient management, so opioids* may be administered intravenously - patient-controlled analgesia (PCA) devices are commonly used in the hospital setting. Vaso-occlusive crises

involving organs such as the penis or lungs are considered emergent and must be treated with red-blood cell transfusions. Incentive spirometry, a technique to encourage deep breathing, is recommended to minimize the development of atelectasis.

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.
- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off of the opioid, as appropriate.
- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

Splenic Sequestration Crisis

Because of its narrow vessels and function in clearing defective red blood cells, the spleen is frequently affected in patients with sickle cell disease, with the spleen generallyinfarcted before the end of childhood. This auto-splenectomy increases the risk of infection from encapsulated organisms. Preventive antibiotics and vaccinations are recommended for those patients withasplenia.

Splenic sequestration crises are characterized by acute, painful enlargements of the spleen, caused by intrasplenic trapping of red cells, resulting in a precipitous fall in hemoglobin levels. In these instances, the potential for hypovolemic shock exists, thereby rendering sequestration crises emergency situations - if not treated, patients may die within 1–2 hours, due to circulatory failure.

Management is supportive, but will sometimes necessitate blood transfusion.

Instances of splenic sequestration crises are transient, generally lasting between 3–4 hours to one day.

Acute Chest Syndrome (ACS)

Acute chest syndrome (ACS) is defined by evidence of new pulmonary infiltrate upon chest x-ray, with the manifestation of pulmonary symptoms such as tachypnea and dyspnea, as well as fever. As both pneumonia and sickling in the lung can produce these symptoms, patients should be treated for both conditions. ACS can be triggered by trauma, respiratory infection, bone-marrow embolization, and possibly by atelectasis, opiate administration and surgery.

ACS is the second most common complication of sickle cell disease and accounts for about 25% of deaths in patients with SCD. The majority of ACS cases present as vaso-occlusive crises that develop into ACS. In

addition, according to Dessap et al., in a 2007 study, about 80% of patients experience vaso-occlusive crises during ACS.

Aplastic Crisis

Aplastic crises are characterized by an acute worsening of the SCD patient's baseline anemia - producing pallor, tachycardia and fatigue. This crisis is normally triggered by Parvovirus B19, which directly affects theproduction of red blood cells by invading red blood cell pre-cursors, multiplying within them and then destroying them.

Parvovirus infection nearly completely prevents the production of red blood cells for two to three days in all individuals. In normal individuals, this is of little consequence, but in combination with the shortened life of red blood cells in sickle-cell patients, Parvovirus results in an abrupt, life-threatening situation for this cohort. Reticulocyte counts drop dramatically, causing reticulocytopenia, with the rapid turnover of red cells leading to a drop in hemoglobin.

Aplastic crises can take anywhere from four days to one week to resolve. Most patients can be managed supportively, though some may require a blood transfusion.

Hemolytic Crisis

Hemolytic crises are characterized by acute, accelerated drops in hemoglobin levels, with red blood cells breaking down at a faster rate. This is particularly common in patients with co-existent G6PD deficiency. Management is primarily supportive, though sometimes necessitates blood transfusion.

Other

One of the earliest clinical manifestations of SCD is dactylitis, or sausage digit, a condition that causes extreme swelling of digits, both fingers and toes. In patients with SCD, dactylitis arises as a result of vaso-occlusive crisis with bone infarct and may present in patients as early as six months of age. Episodes of dactylitis can last up to a month.

Assessment and Treatment

- **Initial Health Assessment (Physical Examination Findings)**
  - Vital signs
  - Sclera – may be icteric, bone-white or show signs of conjunctivitis
  - HEENT
  - Lungs
  - Cardiac – precordial heave, thrills, S3, murmurs
  - Abdominal – splenomegaly versus auto splenectomy; abdominal pain; rebound
  - Genitourinary – priapism
  - Musculoskeletal – joint deformity, abscesses
  - Determination of crisis

- **Causative Organisms**
  - cold
  - stress
  - sepsis
  - dehydration
  - infection
- **Diagnostic Tests**
  - CBC with differential – reticulocytes, immature cells, anisocytosis, poikilocytosis.
  - Reticulocyte count
  - Absolute platelet – large or clumped platelets
  - Urinalysis – sediment, RBCs, hemoglobin, leucocyte esterase, WBCs
  - Cultures – throat, wound, urine
- **Treatment Initiation**
  - Aggressive hydration
  - Analgesic support
  - Folate supplementation
  - Symptomatic treatment – application of localized heat for mild crises
  - Laboratory information – if bone marrow failure is indicated, the patient must be sent to the ER
  - For instances of priapism
    - Assess pain
    - Forced hydration
    - Ensure patient can urinate – consult Urology or send the patient to the ER if blocked
  - CXR – infarcts versus infection
- **Chronic Care Follow-Up**
  - CBC with differential
  - Reticulocytes
  - U/A
  - Echocardiogram – for evidence of high output heart failure
  - Targeted joint x-rays

GOUT AND PSEUDOGOUT

Gout and pseudogout are the two most common crystal-induced arthropathies. The pain and joint inflammation of these debilitating illnesses are caused by monosodium urate monohydrate (MSU) crystal formation within the joint space. If uric acid levels are allowed to remain uncontrolled in patients with gout,

tophi (deposits of MSU crystals) can form on the ears, finger joints and elbows. The goal of long-term gout management is to lower serum uric acid levels to <6 mg/dL to clear tophi and dissolve MSU crystals. Recent data (Perez-Ruiz, F., et al) confirms that the therapeutic target for clearing crystals is five(5) years of serum uric acid levels <6mg/dL and suggests that once the therapeutic target goal has been achieved, the preventive target should be a serum uric acid of 6-6.9mg/dL.

Pseudogout is caused by calcium pyrophosphate (CPP) crystals; it is sometimes referred to as calcium pyrophosphate disease (CPPD). Pseudogout may be clinically indistinguishable from gout.

Some differences between the two disorders are as follows:

Variable	Gout	Pseudogout
Frequency	2.7 of every 1000 adults	1.3 of every 1000 adults
Male-to-female ratio	9:1	1.5:1
Most common joint affected	Big toe	Knee
Other joints affected	Early flares: mid-foot, ankle, heel, knee later flares: wrist, fingers, elbow	Ankle, wrist, elbow
Risk factors	Diet, age, obesity, genetics	Age, joint trauma, genetics, excess iron stored in the body (hemochromatosis)

- Asymptomatic Hyperuricemia
  - Only 1 in 4 people with hyperuricemia will develop symptoms of gout
  - There is no data to support treatment of asymptomatic hyperuricemia with hypouricemic agents

Initial Health Assessment (Physical Examination Findings)

Sudden onset of severe debilitating pain with progressive worsening over first 24 hours; symptoms typically resolve within 3-10 days

Treatment Initiation

TREATMENT INITIATION FOR GOUT AND PSEUDOGOUT

GOUT	PSEUDOGOUT
• Remove offending drugs, if applicable: thiazide diuretics, niacin, levodopa, cyclosporine, Ethambutol, Pyrazinamide, aspirin (low dose aspirin [75-150 mg/daily] is okay) • Limit alcohol intake, particularly beer • Limit high purine foods (e.g., red meat) • Eat protein in moderation • Avoid eating liver, kidney, shellfish and yeast extracts • Manage obesity and hypertension, if present • Non-pharmacologic treatments include resting the affected joint for 1 to 2 days and applying ice to the affected joint • **DO NOT INITIATE CHRONIC TREATMENT DURING AN ACUTE ATTACK; BEGIN 1 TO 2 WEEKS AFTER THE ACUTE ATTACK HAS SUBSIDED**	• Treatment is tailored to presenting symptoms • In patients with 1 or 2 points of acute synovitis, joint aspiration and **steroid injection** (intra-articular) provide rapid relief of pain and inflammation if no infection is present (refer to medications below for dosing, side effects and toxicities) • When more than two joints are involved, systemic therapy with **NSAIDs or systemic corticosteroids** is recommended (refer to medications below for dosing, side effects and toxicities) • Unlike gout, there are no "hypouricemic equivalents" to improve long-term control of pseudogout and to prevent or reverse CPPD (calcium pyrophosphate dehydrate disease) or crystal deposit disease

Medications

- Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)
  - Effective in about 90% of patients
  - Avoid NSAIDs in patients with creatinine clearance <50 mL/min, peptic ulcers, hepatic dysfunction, congestive heart failure (CHF) and those on anticoagulant therapy
  - Monitor creatinine, blood pressure, CBC and chemistry profile periodically
  - Screen patient's medications for potential drug-drug interactions
  - Adverse effects include:

- GI intolerance, bleeding, ulceration or perforation (co-administration of PPIs [proton pump inhibitors] may reduce risk)
- Headache
- Dizziness
- Depression
- Fatigue
- Nephrotoxicity
- Fluid retention
- Edema
- Risk of cardiovascular events
- Severe anaphylactic reactions
- Stevens-Johnson syndrome (treat with sulindac/Clinoril)

- Indomethacin (Indocin)
  - Start at 50mg TID for three(3) days, then 50mg BID for 4 to 7 days
- Naproxen (Naprosyn)
  - Start at 250mg TID for three (3) days, then 250mg BID for 4 to 7 days
- Sulindac (Clinoril)
  - 200mg BID for 7 to 10 days; **give with food**
  - Avoid in elderly due to increased central nervous system side effects in this age group
- Other NSAIDs, including Celebrex (celecoxib), can be used for the treatment of acute gout attacks
- Corticosteroids
  - Very effective in acute gout attacks
  - Useful in patients who cannot tolerate NSAIDs
  - Systemic steroids are the preferred agent in patients with renal failure for whom NSAIDs are contraindicated
  - Corticosteroids may be used locally (intra-articular injection) or systemically (oral, IM, IV)
  - Avoid in patients with systemic infection or septic arthritis
  - Adverse effects include:
    - Hyperglycemia
    - Hypertension
    - Weight gain, fluid retention, electrolyte shifts
    - Infection
    - Mood changes/mental problems
    - Peptic ulcer with possible perforation and hemorrhage
- Intra-articular corticosteroids
  - One of the safest options, particularly if only one joint or larger joints are involved
    - Methylprednisolone acetate (Depo-Medrol) 5mg to 25mg per joint
    - Triamcinolone acetonide (Kenalog 10mg/mL) 2-5mg in smaller joints, 5-15mg in larger joints
    - Betamethasone sodium phosphate/acetate (CelestoneSoluspan) 3mg to 6mg per joint

- Oral corticosteroids
  - Prednisone (Deltasone)20mg to 60mg daily for 5 to 7 days
  - Prednisolone 35mg daily for 5 to 7 days
  - No need to taper as recent data shows that rebound is not an issue when corticosteroids are used short-term (for 5 to 7 days)
- Parenteral corticosteroids
  - Single-dose IM or IV injections are found to be effective
  - Betamethasone sodium phosphate/acetate (CelestoneSoluspan) 7mg IM
  - Triamcinolone acetonide (Kenalog 40mg/mL) 60mg IM
  - Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV
- For chronic gout, prophylactic therapy with NSAIDs decreases the likelihood of acute flares when starting chronic therapy with xanthine oxidase inhibitors, uricosuric agents or pegloticase
  - Indomethacin (Indocin) 25mg BID
  - Naproxen (Naprosyn) 250mg BID
- Xanthine Oxidase Inhibitors
  - Contraindicated in patients receiving azathioprine or mercaptopurine
- Allopurinol (Zyloprim)
  - Allopurinol is effective in both underexcreters and overproducers of uric acid
  - In patients with normal renal function, start with 100mg QD; increase 100mg/day at weekly intervals until goal is met (doses greater than 300mg/day are to be given in divided doses)
  - Average daily dose is 200-300mg/day for mild gout, 400-600mg/day for moderate gout, and 700-800mg/day for severe gout; **maximum daily dose is 800mg/day**
  - In patients with renal insufficiency, start with 50-100mg/day
  - Patients with CrCl 10-20 mL/min should receive no more than 200mg/day; patients with CrCl<10 mL/min should receive no more than 100mg/day; patients with CrCl<3 mL/min should have the interval between doses lengthened
  - Monitor creatinine and LFTs
  - Screen patient's medication for potential drug-drug interactions
  - Adverse effects include:
    - Rash
    - GI disturbance
    - Elevation in liver enzymes
    - Acute gout attacks
    - Drowsiness
    - Nephrolithiasis
    - Rare, potentially fatal hypersensitivity reactions (more common in patients with renal insufficiency and those taking diuretics)
- Febuxostat (Uloric)
  - Start dosing at 40mg QD; **maximum dose is 80mg/day**

- No dosage adjustment is required in patients with mild/moderate renal or hepatic impairment
- Monitor creatinine and LFTs
- Adverse effects include:
  - Increased liver enzymes
  - Nausea
  - Gout flares
  - Arthralgia
  - Rash
- Due to cost, consider febuxostat in patients with Allopurinol hypersensitivity, intolerance or prior treatment failure

- Uricosuric Agents
  - Recommended in younger patients (<60 years old) who:
    - are documented underexcreters of uric acid
    - do not have reduced renal function (CrCl>60 mL/min)
    - do not have a history of kidney stones
    - do not require aspirin (600mg – 2400mg/day)
    - do not require diuretic therapy
  - Adverse effects include:
    - Headache
    - GI disturbance
    - Rash, hypersensitivity reactions
    - Kidney stones
- Probenecid (Benemid)
  - **Contraindicated in patients on methotrexate**
  - Caution in patients with a history of peptic ulcer
  - Screen patient's medication for potential drug-drug interactions
  - Start dosing at 250mg BID for one(1) week, then 500mg BID; increase every four(4) weeks in 500mg increments until goal is met
  - Maintenance dose is 1000mg to 3000mg QD in divided doses
- PEGylated uric acid specific enzyme/pegloticase (Krystexxa)
  - Used in the management of patients with refractory gout who are unresponsive to appropriately-dosed, oral, urate-lowering therapies; treatment lowers serum uric acid level and significantly improves and/or reverses the course of severe, crippling and debilitating refractory gout
  - **Prophylaxis with NSAIDs is recommended for one(1) week prior to starting pegloticase**
  - **Use with caution in patients with heart failure**

- **Contraindicated in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency due to risk of hemolysis and methemoglobinemia; screening for patients at high risk for G-6-PD deficiency is recommended PRIOR TO INITIATING THERAPY**
- Administer under supervision of healthcare professional due to risk of infusion reactions and anaphylaxis
  - **Pre-medicate with antihistamines and corticosteroids prior to each dose and MONITOR CLOSELY**
  - **Risk of infusion reactions and anaphylaxis is higher in patients who have lost therapeutic response; monitor serum uric acid levels PRIOR to infusions and consider discontinuing treatment if uric acid level increases above 6 mg/dL, particularly when two (2) consecutive levels above 6 mg/dL are observed**
- 80% of patients treated with pegloticase experience gout flare(s) in the first few months of therapy; discontinuation of pegloticase is not necessary if gout flare(s) occurs.
- Pegloticase therapy should be continued for up to six(6) months, unless there are contraindications
- Recommended dose of pegloticase is 8mg IV infusion every two(2) weeks
- Adverse effects include:
  - Gout flares
  - Infusion reaction
  - Nausea
  - Contusion or ecchymosis
  - Nasopharyngitis
  - Constipation
  - Chest pain
  - Anaphylaxis
  - Vomiting

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SUMMARY

The mission of this manual is to provide practitioners with clinical guidelines or a template to follow; thereby, ensuring the delivery of care in an ambulatory setting that is both appropriate and consistent across all facilities.

In administering care, clinicians must consider the following provisions:

- Elective and cosmetic interventions requested by inmates shall not be approved.
- The transient nature of jail admissions necessitates early discharge planning by clinical staff.
- All documentation must be legible, thorough and in SOAP (**S**ubjective, **O**bjective, **A**ssessment, **P**lan) format.
- Problem Lists must be complete and must include ICD codes, where appropriate.

FORMS

- Chronic Care Clinic Forms
  - Chronic Care Clinic face page
  - Cardiovascular
  - Endocrine
  - Gastrointestinal
  - General Medicine and Special Needs
  - HIV
  - Infectious Disease
  - Neurology
  - Pulmonary
- Consent for Hormone Therapy
- Consultation Request Form
- Consultation Response Form
- Consult Return Review
- Day 4 Alcohol/Drug Withdrawal Evaluation
- Infirmary Medical Rounds
- Infirmary Medical Rounds – Admission
- Infirmary Medical Rounds – Discharge
- MD/NP Sick-Call/Follow-Up Note
- Medication Reconciliation Form
- Medication Verification Form
- Non-Formulary Requests (Medical and Psychotropic Medications)
- Off-Site Emergency Notification
- Patient Specific Drug Ordering
- Peer Review
- Physician's Orders for Withdrawal
- Problem List
- Sample Monthly Drug Invoicing
- Vivitrol Administration (applicable to Hudson County ONLY)
  Includes:
  - Consent to Vivitrol Treatment
  - Vivitrol Administration Log

  Comment [DD1]: Added 12/19/2016
- Withdrawal Management
  Includes:
  - CAGE Assessment
  - CIWA-Ar
  - T-ACE Assessment

ATTESTATIONS

- All standards & clinical pathways established herein reflect information obtained from the most recent published materials of the appropriate governing oversight and regulatory agencies.
- All standards & clinical pathways included are duly referenced in the Bibliography.
- CFG's Clinical Care Guidelines for Clinical Practitioners Manual has been issued as a resource document.

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SIGNATURE PAGE

CFG Health Systems, LLC

Approved by:

X_____/_____

Corporate Medical Director **Date**

X_____/_____

Site Medical Director **Date**

_____ **(Name of facility)**

X_____/_____

Health Services Administrator **Date**

_____ **(Name of facility)**

ATTACHMENT E

Prepared by Heidi Reifenberg
Coordinator of Monitoring and Evaluation

STAFFING MATRIX CURRENT
Essex County Correctional Facility
September 21, 2020

POSITION	FTE's
Medical Director	1
Staff Physicians	3.8
NPs/PAs	8.6
Dentist	40
Dental Assistant	1
Dental Hygienist	0.5
Psychiatrist	1
Psychiatric APN	1
Psychologist	1
Mental Health Counselors	3.6
Mental Health - Administrative Assistant	0.5
Drug/Alcohol Counselor	1
Pharmacy Technicians	3.8
Phlebotomists	1.4
Health Services Admin.	1
Asst. Health Services Admin. (ICE)	1
Administrator Assistant	1
Unit Clerks	3.4
Medical Records Clerk/Coordinator	4.2
Director of Nursing	1
Infection Control/QI RN	1
RN's	11.2
LPN's	22.4
LPN's (ICE)	1.7
CNA's	4.2
CMA's	3.8
OB/GYN	0.3
Orthopedist	0.3
Oral Surgeon	0.3
Affordable Care Act Coordinator	1
Billing Analyst	1
Help Desk Technician	1
GRAND TOTAL	**88.8**

ATTACHMENT F

STAFFING MATRIX
Minimum Staffing Patterns *

Position	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Days							
Medical Director	8	8	8	8	8	-	-
Health Services Administrator (HSA)	8	8	8	8	8	-	-
ICE Program Admin	8	8	8	8	8	-	-
Director of Nursing	8	8	8	8	8	-	-
Administrative Assistant	8	8	8	8	8	-	-
Staff Physicians	16	16	16	16	16	8	8
Nurse Practitioners (NPs)/Physician Assistants (PAs)	32	32	32	32	32	8	8
NP/PA – ICE	8	8	8	8	8	8	8
Registered Nurses (RN's)	16	16	16	16	16	16	16
Sick Call Nurses (RNs)	8	8	8	8	8	8	8
Infection Control/QI Nurse	8	8	8	8	8	-	-
Quality Assurance Coordinator (RN)	8	8	8	8	8		
Licensed Practical Nurses (LPN's)	56	56	56	56	56	56	56
LPN's (pre-book)	8	8	8	8	8	8	8
Certified Nursing Assistants (CNA's)	8	8	8	8	8	8	8
Certified Medical Assistants (CMA's)	16	16	16	16	16	8	8
Psychiatrist	8	8	8	8	8	-	-
Psychiatric APN	8	8	8	8	8	8	8
Psychologist (Mental Health Supervisor or Director of MH)	8	8	8	8	8		
Mental Health Counselors	16	16	16	16	16	8	16
Mental Health Counselors (ICE)	8	8	8	8	8		
Mental Health - Administrative	4	4	4	4	4		

Assistant							
Drug/Alcohol Counselor	8	8	8	8	8	-	-
Discharge Planner	8	8	8	8	8	-	-
Dentist	8	8	8	8	8	8	8
Dental Assistant	8	8	8	8	8	8	8
Dental Hygienist	4	4	4	4	4	-	-
Pharmacy Techs	8	8	8	8	8	8	8
Phlebotomist	8	8	8	8	8	8	8
Medical Records Director	8	8	8	8	8		
Medical Records Clerks	8	8	8	8	8	16	16
Unit Clerks	8	8	8	8	8	8	8
Affordable Care Act Coordinator	8	8	8	8	8	-	-
Billing Analyst	8	8	8	8	8	-	-
Support Analyst (Level 1) EHR	8	8	8	8	8	-	-
Development Analyst (Level 2) – EHR	8	8	8	8	8	-	-
Position	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Evenings							
Physicians	8	8	8	8	8	8	8
NP's/PA's	8	8	8	8	8	8	8
RN's	16	16	16	16	16	16	16
Sick Call Nurses (RNs)	8	8	8	8	8	8	8
LPN's	56	56	56	56	56	56	56
LPN's (pre-book)	8	8	8	8	8	8	8
LPN's (ICE) *	12	8	12	8	12	8	8
CNA's	8	8	8	8	8	8	8
CMA's	8	8	8	8	8	8	8
Mental Health Counselors	8	8	8	8	8	-	-
Pharmacy Techs	8	8	8	8	8	8	8
Medical Record Clerks	8	8	8	8	8	8	8
Unit Clerk	8	8	8	8	8	-	-
Nights							
NP's/PA's	8	8	8	8	8	8 **8**	8 **8**
RN's	16	16	16	16	16	16	16

LPN's	16	16	16	16	16	16	16
LPN's (pre-book)	8	8	8	8	8	8	8
CNA's	16	16	16	16	16	16	16
Pharmacy Techs	-	8	8	8	8	-	8
Unit Clerk	8	8	8	8	8	-	-

**** Time could vary based on facility's needs.***

Professional staff shall also include the following:

OB/GYN	12 hours/week
Orthopedist	12 hours/week
Oral Surgeon	4 hours/week

ATTACHMENT G

Essex County Correctional Facility

Infection Prevention and Control Recommendations for Persons under Investigation for COVID-19 in Healthcare Settings.

Name: _____ DOB_____

Date/Time_____ Allergies_____ Gender_____

Policy: Essex County Correctional Center shall adhere to CDC guidelines for Prevention and Control of Coronavirus Disease
Purpose: To prevent the spread of Corona Disease 2019 (COVID-19)
Procedures:

-All pre-booked patients will be screened by a health professional (CMA/LPN/RN/NP/PA/MD) for the following:

1. Does the patient have a fever> or = 100.4 Fahrenheit (38'C) Yes___ No___

2. Does the patient suffer from:

- Cough: Yes___ No___
- Sore Throat: Yes___ No___
- Shortness of Breath : Yes___ No___

3. Has the patient within the past 14 days:

- Spent Time in China/ Japan/ Italy/ Iran/ South Korea: Yes___ No___
- Had close contact with a person who is under investigation for Corona Virus novel 2019: Yes___ No___

If the patient answers **YES** to #3 **AND/OR** has symptoms of fever **and/or** cough **and/or** sore throat **and/or** shortness of breath:

- Place a surgical mask on the patient and initiate droplet and contact precautions.
- Contact the Main Medical provider and the Medical Director
- Move the patient to Main Medical and await further instruction for placement.

Facility Requests: Essex County Civilian Task Force, Dr. Pernell's initial questions

As requested by Civilian Task Force board member Dr. Chris Pernell, September 28, 2020 –

1) Transitions of Care: What processes (i.e. handoff measures) are in place to ensure safe and effective transitions of care whenever an inmate/detainee moves from one care setting to another, especially upon reentry to community, as well as transitions from the facility to an outside facility?

2) It was presented that the medical vendor is required to supply monthly statistical reports. What data is contained in the report and may we receive regular updates? Is this report distinct from the monthly CQI report? If they are separate documents, then what data is contained in the monthly CQI report and again, may we have access to this report on a regular basis?

3) It was mentioned that studies are done on various key performance indicators such as timeliness of sick calls, physical assessments and chronic conditions which are under control/uncontrolled. Are there standard KPIs that are run with some regular frequency or is the data that is pulled more episodic in nature?

3) COVID-19 testing protocols: Please confirm the criteria that leads to the performance of a PCR test since the testing strategy that is largely used is the serological testing of all inmates/detainees. Please confirm infection prevention protocols in place to ensure a safe environment for all inmates/detainees and staff. For instance, please confirm whether staff undergo temperature screening at the start of each shift and if the temperature is elevated, are these persons queried for other symptoms?

4) I recall it being mentioned that only half of a unit's population is permitted outside of their cells at one time. Roughly how many people is that?

5) If a person files a grievance related to the care they received or a sick call that was issued, typically how long is the grievance process and what are the KPIs to measure performance?

6) How often do medical staff and all facility staff complete cultural competency training? How soon will medical staff and all staff undergo implicit bias training? I understand this may just be in the planning/exploration phases.

7) Do all female inmates/detainees undergo pregnancy testing during their initial intake? What gynecological/women health care services are offered at the facility?

All the best,

Facility Requests: Essex County Civilian Task Force, Dr. Pernell's initial questions

9/2/8/2020

On Mon, Sep 28, 2020 at 9:34 PM Dr. Chris T. Pernell <chris.t.pernell@gmail.com> wrote:
Evening, everyone.

I've reviewed the Medical Director and Medical Monitoring presentations again in preparation for our meeting on Saturday. During the training there were some requests made for additional data. I've added some additional questions based on my second review of the material. Please advise on whether this data can be shared in advance of Saturday's meeting. I realize that Heidi Reifenberg may be the best person to pull some of this data and provide the answers. Please share with her and all relevant staff to complete the requests. Thank you!

1) It was presented that the ACA, NCCHC, NJDOC, ICE/PBNDS, and the federal Office of Detention Oversight assess the facility on some regular basis. May you provide what the schedule/frequency is and the process of review including the specific criteria that each agency uses to evaluate the facility as well as the most recent performance on any assessments/evaluations that ECC may have undergone.? How does the most recent performance compare to past trends? On Slide 4 in the Medical Monitoring Presentation this was alluded to but no specifics were provided.

2) It is my understanding that each building has its own medical unit with a provider for that particular building, in addition to 2 medical stations in central processing and a 42-bed infirmary in building 5. Is this accurate? Please be specific on which provider types/titles are in each building and hours of access. And, do inmates and detainees receive medical care by the same staff though inmates may be housed separately from the non-detainee population?

3) On Slide 4 in the Safety and Security Protocols presentation, I'm assuming the total population stats provided are inclusive of both inmates and detainees. Is it possible to have a breakdown for the detainee vs. non-detainee population for race/ethnicity, age, and gender?

> As well, no stats were included on language. Please provide stats on the percentage of the respective populations and percentages for whom English is not the primary language.
>
> Finally, in terms of gender identity, are inmates/detainees able to identify as non-binary? Does the facility currently house transgendered persons or has in the past?
>
> In a related question, are medical services provided in the preferred language? Is there access to interpretation/translation services as needed? How often are these services used?

4) It is my understanding that **every** inmate/detainee must complete an intake screen performed by a nurse, including a questionnaire and mandatory TB, RPR and COVID Antibody testing. Please advise if this is complete and accurate.

> Also, may a copy of the questionnaire be provided for our review?

In a second step, and within 24 hours of being processed, each person undergoes a physical exam/assessment -- who performs that exam? If this is so then why on Slide 5 in the Medical Monitoring Presentation are nurse screens reported to be about 1460/month and physical assessments are about 815/month. Based on the avg census on total population stats provided in the Safety and Security Protocols presentation, there is a discrepancy. Please advise.

5) The other stats reported on Slide 5 in the Medical Monitoring Presentation, do those numbers represent unique visits or are they inclusive of persons who may have had multiple encounters?

Can you provide a report that summarizes the numbers with a breakdown by inmates vs. detainees?

What demographic information is captured about the person submitting the sick call request? Stratifying the data would be useful by REAL data at least (Race/Ethnicity, Age and Language) as well as Sex. (I'm assuming SOGI data isn't collected, i.e., sex, orientation and gender identity.)

6) May you provide an updated slide with FTEs broken down by type. (see Slide 6 in the Medical Monitoring presentation -- comments were made that the staffing was changed to reflect gaps in care. What is the context for those statements? We don't have access to those reports/performance-based outcomes that may have prompted a different staffing model.)

Who is available in the facility (exact site) and across which hours?

Who is available on a 24hr basis (exact site/location)?

Also, please summarize/confirm how many hours per week the specialists are on duty.

7) Access to Care: Please provide data on how frequently (# of visits) inmates/detainees are referred to outside facilities for medical care, including to local hospitals and state forensic hospitals.

8) It was reported that approximately 1600/2000 inmates are on meds. Is this accurate? How many meds is each inmate on average?

What are the top 5 prevalent medical conditions, inclusive of mental/behavioral health diagnoses? It was reported that approx 1200-1400 have chronic conditions hence the prior question. It was also reported that 20-30% of the population has mental health conditions.

9) On average, how many sick calls are placed per day, per month, per quarter and per year? Can you trend the most common complaints/reasons for sick calls? What other trend data is available about the sick calls?

Which buildings or units do the majority of the calls come from?

How do these numbers break down by demographic data? Via inmates vs. detainees?

10) Continuing with sick calls, the standard is that the concern should be triaged within 8 hours and evaluated by a nurse who can refer to a mid-level provider or MD within 24 hours unless the concern is deemed urgent/emergent. Is this accurate?

Who triages the sick calls and determines what is urgent or emergent? What percentage of calls are urgent/emergent?

How often is the standard of 8 hrs and 24 hours met? When it is not met, has the facility done a root-cause analysis to understand the contributing factors to the delay?

How many sick calls are generated by the individual via the tablet vs. by contact with a nurse or officer? Is the electronic device equipped in the preferred language of the person using it?

10/03/2020

Facility Requests: October 3 Essex County Civilian Task Force Hearing

Questions:

- What are the top 5 physical diagnoses of those cleared for incarceration?
- What are the top 3 mental and behavioral health diagnoses of those cleared for incarceration?
- How many individual languages does the language line include? What is the percentage of inmates who speak a language other than English?
- How many sick visits occur in one month, on average?
- How often are ICE medical determinations appealed by the facility?

Please provide:

- A copy of the evidence-based medical screening guide developed by the Medical Department which outlines guidelines for determining "controlled" versus "uncontrolled" diagnoses of incarcerated individuals.
- The list of criteria for determining which ICE detainees are most vulnerable to contracting COVID-19 and should be recommended for expedited release.
- Records of use of translation services for ICE detainees encountering mental health services.
- A brief report on the ICE detainee death that occurred under facility incarceration, including the year, month, and cause of death.
- On Grievance Requests:
    - A breakdown of daily/monthly/weekly averages, common types, and submission demographics.
- On Social Services:
    - Data from Social Services Classes
        - Capacity of classes versus overall interest
        - Funding status
        - Demographics of participates (i.e. inmate being resentenced)
        - Waiting list existence or capacity

10/03/2020

Facility Requests: October 3 Essex County Civilian Task Force Hearing

Questions:

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    - A breakdown of daily/monthly/weekly averages, common types, and submission demographics.
- On Social Services:
    - Data from Social Services Classes
        - Capacity of classes versus overall interest
        - Funding status
        - Demographics of participates (i.e. inmate being resentenced)
        - Waiting list existence or capacity

Appendix N

COUNTY OF ESSEX

DEPARTMENT OF CORRECTIONS
ESSEX COUNTY CORRECTIONAL FACILITY
354 Doremus Avenue – Newark, New Jersey 07105
973-274-7818 --- 973-274-6987 (Fax)

Joseph N. DiVincenzo, Jr.
Essex County Executive

Alfaro Ortiz, Jr.
Director

TO: Essex County Civilian Task Force

C/O Ms. Alexa Vizquera

FROM: Alfaro Ortiz, Director ECCF

DATE: December 29, 2020

RE: Response to Medical Questions from Dr. Purnell and Dr. Szerbo

Attached please find responses to the second set of questions submitted by Dr. Purnell and Dr. Szerbo the responses were provided by medical Director Lionel Anicette, Psychology Director Dr. Dennis Sandrock and our ECCF Medical Quality Assurance Coordinator Heidi Reifenberg.

As always, feel free to contact my office should you have any issue or questions

Respectfully

Alfaro Ortiz, Jr.
Director ECCF

Essex County Civilian Task Force Questions
Dr. Pernell
December 30, 2020

For Mental Health:

1. When is a mental health screen conducted for newly admitted inmates?

   Response: ***A mental health screening as part of the nurse screening is conducted within 4 hours of the booking time.***

   a. Who performs the screen? (level of training, credentials)

      Response: ***The nursing intake screening is conducted by an LPN or RN.***

   b. Is it conducted in a space in which the inmate has privacy?

      Response: ***Yes***

   c. What are the screening questions?

      Response: ***Please see attachment.***

   d. For a positive screen, what are the next steps? How soon is the inmate assessed and by what level of provider?

      Response: ***Based on answers to the mental health screening questions, a risk score is generated, indicating no referral, low, medium or high level referral. High scores on the nurse intake automatically place the person on a suicide watch. If that occurs after hours, the person is seen the very next day by mental health staff. If mental health staff is on site they are seen the same day. For medium and low scores, nursing staff can make 2 referrals to mental health using Fusion Order Manager in the EMR, Routine and Priority. Priority referrals are seen within 72 hours, Routine is within a week.*** **At any point in** ***time, nursing staff can make an emergent referral for mental health staff to see the person immediately.***

2. What training is provided for jail staff regarding recognizing and identifying mental health issues? Do any trainings address stigma?

   Response: ***Custody staff receive training via the curriculum offered through the ECCF training department. Healthcare staff are provided annual mental health training by the mental health director.***

3. If an inmate is suicidal, what is the protocol?

Response: ***If a patient is suicidal, mental health staff are called immediately to evaluate and determine the level of suicide watch. If a patient is suicidal during after hours, that person is assessed by healthcare staff and placed on suicide watch until an evaluation with mental health staff. If there is a question about which level of suicide watch to place the person during after hours, mental health on-call staff is contacted.***

a. If they are kept in the isolation unit, what does the isolation look like? Do they have windows/view of the hallway?

Response: ***Each cell has a window for external light and a view of the hallway.***

Are they confined to a cell and for how many hours?

Response:***Patients are confined to their cells for 22 hours/day. Please note that 9 of these hours are allowed for sleep.If stable, they are permitted time out of their cells for showers, exercise and phone calls.***

How often are in person assessments made and by what staff members?

Response: ***If a person is placed on watch, they are seen daily by mental health staff, particularly the mental health director. Only a psychiatrist or psychologist can decrease or remove a level of watch. Time spent on watch is used to help address circumstances contributing to suicidal ideation. When a person is removed from watch, they are seen within 48 hours to monitor adjustment off watch, then seen again in 2 weeks. Anyone placed on a watch remains on the mental health caseload for the duration of their stay.***

Are these assessments done in the presence of correctional officers or other staff members, or can the inmate speak privately with the mental health staff?

Response: ***Assessments are conducted privately.***

b. How do inmates indicate they wish to speak to a provider?

Response: ***Inmates/detainees can submit requests through the tablet, ask a nurse who comes through housing areas at least twice daily or ask an officer to submit a request on their behalf.***

Does it have to go through a CO or another staff member, or do they have a direct way to indicate their request?

Response: ***They do not have to go through a CO or another staff member. There are direct ways to indicate their request.***

How are such requests triaged and what is the timeframe for response?

Response: RNs triage ***requests by the next shift. The patient is seen by a sick call RN, Nurse Practitioner, Physician's Assistant or physician within 24 hours. Referrals are made to mental health, as appropriate, and seen with 72 hours, unless urgent.***

4. **For inmates in the general population:**

   a. How can an inmate request a mental health assessment?

   Response: ***Inmates/detainees can submit requests through the tablet, ask a nurse who comes through housing areas at least twice daily or ask an officer to submit a request on their behalf.***

   Are they able to do so without involving a CO or other staff member?

   Response: ***They do not have to go through a CO or another staff member. There are direct ways to indicate their request.***

   Is there a confidential way to make a request and does the inmate feel that this information is kept confidential, or does it appear to be public?

   Response: ***Patients can request medical services confidentially.***

   b. In what timeframe is an assessment completed?

   Response: ***An RN triages requests by the next shift. Patient is seen initially seen by a sick call RN, Nurse Practitioner, Physician's Assistant or physician within 24 hours. Referrals are made to a higher level of care or mental health, as appropriate and seen with 72 hours, unless urgent.***

   What level of provider performs the assessment?

   Response: ***A sick call RN, Mental Health Counselor, Psychologist, Advanced Practice Nurse Practitioner or Psychiatrist.***

   Does the inmate have a private space in which to discuss their concerns?

Response: ***Patients have a private space to discuss concerns.***

Do inmates have a confidential way to report abuse or neglect by staff members?

Response: ***Inmates/detainees can report abuse or neglect through a formal grievance. According to ECCF policy, an inmate/detainee can express concerns and complaints by filing a formal grievance and can expect to receive "timely responses relating to any aspect of his/her confinement/detention." "Inmates/detainees will not be subjected to personal abuse, corporal punishment, personal injury, discipline, punishment, property damage or other retaliation against them as a consequence of filing a complaint or grievance."***

How are these complaints addressed and what kind of investigation is performed?

Response: ***These complaints are addressed through the jail's grievance policy (PS. CUS.017).***

How many such complaints have been filed in the last 5 years?

Response: ***This requires further research and findings will be provided at a later date, once the data is available.***

What kind of therapy or counseling services are offered (both group and individual)?

Response: ***Individual counseling, group treatment and crisis intervention are provided. Group treatment has been limited due to pandemic, but will resume when public health concerns are lifted.***

How are inmates aware of these services and in what ways are they advertised?

Response:***Services are described in the inmate handbook that is provided upon arrival and also by all healthcare staff.***

Can an inmate request psychotherapy for emotional support without having a mental health diagnosis?

Response:***Yes, a patient can request psychotherapy for emotional support without having a mental health diagnosis. Examples of this include for loss of a family member, breakup with a partner or bad legal news.***

Is there any collaboration with family or loved ones for the inmate's treatment?

Response: ***Family members are often contacted for collateral information and to help plan for discharge (e.g., if they will be a support when the person is released)***

Are there any time limits on treatment?

Response: ***No, there are no limits on treatment.***

c. What is the process for establishing aftercare? Is there a warm hand-off?

Response: ***The Collaborative Justice Program (CJP) helps patients on a case by case "warm" basis. Other patients are linked to community based groups.***

Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?

Response: ***Jail staff generally do not provide follow up calls afterward to determine if a former inmate was successfully connected to treatment, although it does happen on occasion.***

5. Medications

a. How are medications chosen for the mental health formulary?

Response: ***Medications on the formulary are chosen based on clinical indications.***

Is there a possibility to provide non-formulary medications when needed or requested by the inmate?

Response: ***Yes, there is a non-formulary pathway.***

Are medication regimens for inmates automatically changed upon admission if their medications aren't on the formulary?

Response: ***Regiments for inmates are not automatically changed upon admission if their medications aren't on the formulary.***

What kind of assessment process is performed to ensure that medication changes are tolerated?

Response: ***Patients are medically monitored twice/day by a nurse and medication monitoring encounters are scheduled as appropriate by the clinical provider.***

b. How frequently do inmates taking mental health medications see a prescriber?

Response: ***Inmate staking psychotropics are seen at a minimum of every 3 months.***

How often do they have their labs checked and what is the process for this?

Response: ***Labs are checked as clinically indicated (ie., certain labs are readily drawn, such as lithium levels). The frequency of lab monitoring is at the discretion of the clinical provider.***

c. Do they receive actual medication supply on discharge from the jail, or just a prescription?

Response:***Patients being discharged may receive a combination of either one or at times both.***

How long is the prescription for?

Response:***The prescription is usually for 2 weeks***

What recourse do inmates have if their insurance is not reactivated in a timely manner

Response: ***We do not have the capability of connecting inmates with insurance, but we do connect them with community providers.***

For SUD:

a. Is a substance use/withdrawal screen completed for newly admitted inmates?

Response: ***A substance use/withdrawal screen is completed for newly admitted inmates.***

b. Who performs the screen? (level of training, credentials)

Response: ***The screening is performed by an LPN or RN.***

c. Is it conducted in a space in which the inmate has privacy?

Response: ***It is conducted in a space in which the inmate has privacy.***

d. What are the screening questions?

Response: ***Please see the attached document.***

2. Withdrawal symptoms can present hours to days after initial assessment. What protocols are in place to identify inmates who are experiencing withdrawal symptoms?

Response: ***Withdrawal protocols are implemented based on the drug of choice for that patient. There are a number of opportunities for that patient to access care. They receive a full physical by a provider, which is conducted within 72 hours of their booking. They are assessed by a nurse twice/day while in quarantine. Finally, the patient can place a sick call request within the tablet system or through officer.***

3. What type of staff are monitoring them and how are they trained to identify symptoms?

Response: ***Nurses, providers and officers are trained on withdrawal protocols perthe National Commission on Correctional Health Care (NCCHC).***

What is the next step once a withdrawal syndrome is identified and how soon is the inmate seen by medical staff?

Response: ***If a withdrawal syndrome is identified at intake, the screening nurse contacts the onsite provider and the medication regiment will be initiated immediately. If a withdrawal syndrome is identified at any other time during incarceration, by non-prescribing medical staff, that staff person contacts the onsite provider and the medication regiment will be initiated immediately.***

4. Do inmates have a direct and confidential way to report substance use issues such as withdrawal?

Response: ***Yes, inmates have a direct and confidential way to report substance use issues, such as withdrawal.***

Do they have to go through a CO or other staff member?

Response: ***No, they do not have to go through a CO or other staff member.***

Is there a confidential way to make a request and does the inmate feel that this information is kept confidential, or does it appear to be public?

Response: ***Yes, there are confidential ways to make a request.***

5. What is the protocol for treating intoxication and withdrawal?

   Response: ***Please refer to the clinical guidelines previously submitted to the task force.***

6. When are inmates kept on site versus being referred out to a hospital?

   Response: ***Patients who present with sub-acute manifestations of withdrawal syndrome that are not amenable to medical management in infirmary.***

   What kind of follow up assessments are performed if they come back from a hospital admission?

   Response: ***Upon return from a hospital admission, the patient is presented to the main medical unit where he/she is screened by the charge nurse and onsite provider.***

7. Are all jail staff trained to use Narcan?

   Response: ***Yes, jail staff are trained to use Narcan.***

   Is Narcan available in all areas of the jail?

   Response: ***Yes, Narcan is available in all areas of the jail.***

   How many overdoses happened in the last 5 years in the facility and what were the staff response times and the clinical outcomes?

   Response: ***About 10-20% of all Code Whites (medical emergencies) involve overdoses. Patients are treated immediately with Narcan. The exact number of overdoses, response times and clinical outcomes will be researched and findings will be submitted at a later time when the data is obtained.***

8. What training is provided for jail staff regarding addiction, intoxication and withdrawal?

   Response: ***Officers and staff receive quarterly and yearly in-service training.***

   Do any trainings address stigma?

   Response: ***Yes, trainings address stigma.***

9. **Medications for tobacco and alcohol use disorder**

a. Are medications provided for smoking cessation?

Response: ***At this time, medications are not provided for smoking cessation. However, it is strongly being considered as a treatment enhancement.***

Nicotine replacement (in what forms), Varenicline, or other options?

Response: ***At this time, medications are not provided for smoking cessation.***

What is the method for inmates to be identified for this treatment and/or how can they refer themselves?

Response: ***N/A***

Are medications provided for anti-craving for alcohol use disorder (Acamprosate, Naltrexone, Gabapentin, etc)?

Response: ***Yes, medications are provided for anti-craving for alcohol use disorder.***

If so, when is this assessment done?

Response: ***This assessment is a part of the intake screening, but can be addressed by clinical staff anytime the disorder becomes evident.***

If available, how are these services advertised to the inmates or how are they made aware?

Response: ***Inmates are educated about these services during intake.***

b. What is the process for establishing aftercare?

Response: ***The process for establishing aftercare is through the ECCF's MOUD-MAT program.***

Is there a warm hand-off?

Response: ***Yes, the MOUD-MAT program has set up affiliations with several community based providers who can accept referrals upon discharge***

Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?

Response: ***Yes, jail staff do on occasion provide follow up calls afterward to determine if an ex-inmate was successfully connected to treatment.***

10. Medications for Opioid Use Disorder (MOUD)

a. Out of the 3 MOUD options (Buprenorphine, Methadone, Naltrexone), which are available for inmates at Essex County?

Response: ***All 3 MOUD options are available for inmates at the ECCF.***

b. What opportunities do inmates have to report substance withdrawal after an initial negative screen?

Response: ***Inmates/detainees can report substance withdrawal through the tablet. They can ask a nurse who comes through housing areas at least twice daily or ask an officer to submit a request on their behalf.***

Are they regular staff assessments?

Response: ***We are unclear about this question.***

Can inmates privately request to discuss MOUD with a provider at any time, and does that require other staff involvement such as a CO?

Response: ***Inmates can privately request to discuss MOUD with a provider at any time. This does not involvement CO involvement.***

c. How is opioid withdrawal treated?

Response: ***Opioid withdrawal is treated through education, therapy and medications. There are a several medications that are used including Buprenorphine, Naltrexone and Methadone. Additionally, a clonodine-based regiment may be used.***

Are all inmates detoxed entirely and then offered MOUD, or can be they be immediately started on maintenance MOUD and avoid detox?

Response: ***Detox treatment is based on the clinical judgment of the provider.***

d. If an inmate is identified as having an opioid use disorder, is MOUD offered?

Response: ***Yes, MOUD is offered to patients identified as having an opioid use disorder.***

What kind of education are they provided about it and what kind of staff does this education?

Response: ***Patients receive education from the intake nurse, MOU staff, and the treating provider.***

Are all inmates offered all options for MOUD, or is a specific MOUD chosen for them?

Response: ***Options offered to patients are based on the clinical judgment of provider and full consent of patient.***

e. If methadone is available – what is the protocol?

Response: ***Methadone is currently available for pregnant females. Due to a lack of access within the community, other patients are referred to an affiliated Intensive Outpatient Program (IOP) where they are evaluated by an addictions specialist.***

Is there a local opioid treatment program who is involved?

Response: ***The referring provider, MOUD staff, affiliated IOP program staff and custodial escorts are involved.***

How are dose adjustments made?

Response: ***Dose adjustments are made based on the COWs scale, as well as clinical judgment and feedback of the patient.***

f. If Naltrexone is available – is it only the oral form or is the injection available?

Response: ***Naltrexone is currently available only in the oral form.***

Is it administered for the entire stay or only prior to discharge?

Response: ***N/A; this area is under consideration for further development.***

g. If Buprenorphine is available – are there any dosing guidelines?

Response: ***Buprenorphine is available and advisories from Substance Abuse and Mental Health Services Administration (SAMHSA) are utilized.***

How do providers respond to reports of craving but no objective withdrawal symptoms?

Response: ***Providers respond to reports of craving without withdrawal symptoms according to SAMHSA guidelines. The patient would warrant review for Buprenorphine.***

How is dosing performed (mouth checks, etc)?

Response: ***Mouth checks are done during medication administration twice/day by either an LPN or RN.***

Are any inmates denied Buprenorphine due to lack of insurance or issues with finding an aftercare appointment?

Response: ***Inmates are not denied Buprenorphine due to lack of insurance or issues finding an aftercare appointment. Staff assist with finding an aftercare provider.***

h. What happens if an inmate is found to be diverting MOUD?

Response: ***If an inmate is found to be diverting MOUD, he/she is counseled by MOUD staff.***

Are they able to continue on MOUD themselves or is it discontinued?

Response: ***Yes, patients are able to continue on MOUD with counseling and increased supervision.***

If it is discontinued, is there a process for re-assessment in the future?

Response: ***Yes, there is a process for reassessment in the future.***

i. Are there any restrictions placed on inmates who are on MOUD? I.e., changes in privileges, moving to a new location in the jail, etc.

Response: ***No, there are no restrictions placed on inmates who are on MOUD.***

Are there any jail-specific incentives or disincentives for inmates to go on MOUD?

Response: ***No, there are not jail specific incentives or disincentives. Incentives may be explored in the future to increase participation.***

j. What is the process for establishing aftercare?

Response: ***A broad network of community providers are used, taking the patient's need, geography and consent into consideration.***

k. Is there a warm hand-off?

Response: ***Yes, there is a warm hand-off.***

Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?

Response: ***Jail staff do not have the ability to follow up.***

l. Do they receive actual medication supply on discharge from the jail, or just a prescription?

Response: ***Depending on circumstances, actual medication supply and/or a prescription is provided.***

How long is the prescription for?

Response: ***Patients are given a prescription for a 3-day supply of medication.***

What recourse do inmates have if their insurance is not reactivated in a timely manner?

Response: ***While at the facility, patients are treated. Following discharge, jail staff cannot provide the services.***

m. Is Narcan provided on discharge from the jail?

Response: ***Yes, Narcan is dispensed upon discharge. However, this is not feasible in all situations.***

Essex County Civilian Task Force Questions
Dr. Szerbo
December, 2020

General

1) The National Institute of Health declared that the following personality disorders are frequent in prison: Narcissistic, antisocial and paranoid. Does ECCF document these conditions?

RESPONSE: ***Personality disorders are documented in the "Problems" section of the Electronic Health Record (EHR) if the patient meets all the necessary diagnostic criteria in accordance to standards set in the DSM-5. If the patient has those traits, but does not meet the full criteria, the traits are documented in the individual contact notes.***

How are they handled at the Jail?

RESPONSE: ***People with these disorders typically have clinical symptoms that are treated with medication and therapy contacts. Clear, open, respectful and consistent communication is the best way to handle these patients.***

2) What is the state of ECCF infrastructure dedicated to handling mental health cases?

RESPONSE: ***Mental health issues are first documented in the initial nurse screening intake. The patient is asked questions for suicide prevention and to determine the need for a mental health referral, based on the screening. If the patient is in urgent need, mental health staff will be called immediately to the intake area to assess the patient. If the referral acuity level is minimum to moderate, the patient is referred to mental health for later screening by a masters level counselor. Based on the outcome of that patient encounter, the patient may be referred to the psychologist or psychiatrist.***

Staffing consists of 4.6 mental health counselor FTEs, a full-time psychologist, full-time psychiatrist and 1.4 psychiatric nurse practitioner FTEs.

The ECCF has a forensic unit consisting of 16 beds and 2 cells in the Infirmary which can be used for suicide prevention.

Does ECCF need investments in this area? If yes, please describe.

RESPONSE: ***Investments in the area of mental health would be advantageous. First, the ECCF medical department is looking for more linkages to enhance care in the community. Another way to enhance services would be to add forensic beds for long term placement. Finally, it would be helpful for patients to obtain long acting psychotropics upon discharge.***

3) What is the time frame of requesting a mental health visit to the time of being attended by a licensed mental health professional?

RESPONSE: ***Patients referred to mental health on an urgent/emergent basis are seen immediately. The less acute referrals are seen according to policy and procedure.***

4) What mental health services are available for those who while incarcerated may have had family members pass from COVID?

RESPONSE: ***As with anyone who lose someone while incarcerated, referrals are made to the mental health department by medical staff, social workers, officers, or administration since they often first receive the communication. Patients are seen regularly by mental health to help them process their grief while confined. Social services and administrative staff arrange for funeral visits/viewings, where possible.***

5) What are general COVID mental health services available?

RESPONSE: ***Anyone directly exposed to COVID-19 is quarantined for14 days. They can request mental health services via tablets.***

What relevant services are available 24 hours a day at a 24-hour facility?

RESPONSE: ***Mental health services are available 24x7.***

6) There exist public concerns that individuals with mental health challenges are not receiving proper treatment, particularly regarding detainees receiving the same diagnosis of adjustment disorder and being simply prescribed sedatives. Please comment on how you plan to address and change mental health practices at ECCF?

RESPONSE: ***The mental health department does not subscribe to the practice of using sedatives or any type of chemical restraints. This is against policy and procedures. Patients that receive a mental health diagnosis are treated with counseling and clinically indicated psychotropic medications, which are consistent with community standards.***

7) There exist public concerns regarding curtailment of programs due to COVID-19, some of which are important for mental health reasons and/or for individuals' legal cases [e.g., anger management classes]. How does ECCF plan to address this issue moving forward?

RESPONSE: ***Mental health, social services and Medication for Opioid Use Disorder (MOUD) - Mediation-Assisted Therapy (MAT) staff have outlined a comprehensive plan for re-establishing anger management, conflict resolution and a number of other therapeutic classes.***

When will these programs resume?

RESPONSE: ***As restrictions are eased, this multi disciplinary team is prepared to re-launch programs. In the meantime, they are creating avenues to integrate tele health courses into their programming.***

8) **How is accessing external partner services impacted by the COVID-19 pandemic, if, for example, an inmate is in crisis and the Facility cannot treat them on site?**

RESPONSE: ***Referrals to crisis services has not been impacted by the pandemic. Arrangements have been made for psychiatric screeners meet with individuals in crisis at the Facility. Other patients are transported to Newark Beth Israel Medical Center or University Hospital for assessments.***

Is ECCF finding timely community partner help difficult with COVID-19?

RESPONSE: ***For psychiatric crises, it has not been difficult finding community partners.***

9) Some individuals have recent experience with patients who are released from the Facility, but are not guided in continuing treatment. Has this protocol been reviewed and changed?

RESPONSE: ***For known releases, patients are provided with a list of community health professionals, medications or prescriptions, as clinically appropriate and referrals to community providers. At the same time, there are built in challenges for patients who are released without the knowledge of the medical staff. For example, inmates/detainees may be released directly from court. This is an area of concern which is actively being discussed in special needs meetings. The ECCF is always reconciling to identify any unanticipated release.***

How and how recently?

RESPONSE: ***Review of the discharge policies and all policies occur at least once/year. The last formal review of policies was on and around October 1, 2020. The discharge policy is reviewed at weekly meetings as patient cases are discussed. In addition, the Record Room custody staff reviews for any unexpected court releases on a daily basis***

10) What training do officers receive regarding safe interaction with inmates suffering from a mental health issue?

RESPONSE: ***Officers are trained every year during quarterly in-service training for signs of mental health symptoms, among other issues.***

What is the extent of an officer's individual authority?

RESPONSE: ***Officers may refer an inmate/detainee to the mental health department if the inmate exhibits concerning characteristics observed by the officer. Officers CANNOT determine if an inmate has mental health issues. Diagnoses and assessments are determined solely by the mental health department.***

11) Are their additional mental health services regarding the impact of COVID-19, for example if an inmate's family member has passed?

RESPONSE: ***Referrals are made to the mental health department by medical staff, social workers, officers, or administration since they often first receive the communication. Patients are seen regularly by mental health to help them process their grief while confined. Social services and administrative staff arrange for funeral visits/viewings, where possible.***

12) Is ECCF paying for tablets or are they donated by GTL?

RESPONSE: ***Tablets are provided by GTL.***

13) How does ECCF proactively evaluate persons who cannot describe or otherwise self-report what mental health issues they may be experiencing in private or isolation?

RESPONSE: ***Mental health staff review EHR records to see if there is a history. In addition, other healthcare staff and officers who see the person daily will report their observations to mental health staff. Social work staff will also inform mental health of any phone calls made by family members. Mental health staff use their counseling skills to elicit information.***

14) Is there a capacity to use telecommunication for necessary mental health and addiction programs?

RESPONSE: ***Telehealth services are actively being discussed for implementation in the near future. Essex County's 2021 contract for medical services provided at the ECCF requires the medical provider to implement telemedicine.***

15) The previously issued Health Service Report (Attachment B) shows no on-site inmate health services utilizations. Is this accurate?

RESPONSE: ***A sample Health Services Report is attached here.***

Medical Health

1. In the view of ECCF, what are current trends and prevalence rates across all diagnoses among the total inmate population?

RESPONSE: ***The top 5 medical diagnoses are diabetes, hypertension, COPD, HIV and substance abuse.***

2. Please provide a breakdown of co-occurring mental health and substance use disorder diagnoses among the total inmate and detainee population

RESPONSE: ***ECCF's current system does not provide the ability to parse such details. However, it is estimated that 1/3 of current MAT cases are also receiving mental health services.***

Mental Health

3. What is the total number of inmates& ICE detainees receiving mental health services? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***Readily available data includes the following:***

Type of Encounter	May 2020	June 2020	July 2020	August 2020	Sept 2020	Oct 2020
Face to Face contact with Forensic	25	169	135	134	55	137
Mental Health Clinician Encounters	431	682	713	655	641	688
Face to Face contacts with Watches	89	175	211	225	153	137
Psychiatrist Encounters	195	229	206	221	213	180
Psych APN Encounters	236	293	315	330	272	308
Psychologist Encounter	105	140	84	79	56	27

4. What is the number of inmates and ICE detainees referred to mental health, who do not present with mental health symptoms during intake, but later make mental health complaints or display mental health symptoms? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***While all patients who receive mental services have such documentation in their charts, ECCF's current system does not provide the ability to parse such details.***

5. Please provide a comprehensive list of the medications prescribed to treat mental health diagnoses?

RESPONSE: ***Please see the following list:***

- CholinesteraseInhibitors

Aricept (Donepezil) 5mg, 10mg, 23mg

- Benzodiazepine-Anxiolytics

Ativan (Lorazepam) 0.5mg, 1mg, 2mg tab

Librium (Chlordiazepoxide) 10mg, 25mg cap

- Non-Benzodiazepine-anxiolytics

Buspar (Buspirone HCL) 5mg, 15mg tab

Vistaril (Hydroxyzine–pamoate) 25mg, 50mg cap

Vistaril (Hydroxyzine) HCL vial 25mg/mL

Mood Stabilizers (anticonvulsant)

Depakene (Valproic Acid) 250mg cap

Depakene Liquid Valproic Acid Liquid)

Depakote (Divalproex) 125mg, 250mg, 500mg tab

Depakote Sprinkle (Divalproex SOD Sprinkle) 125mg tab

Lamictal (Lamotrigine) 25mg, 100mg, 150mg, 200mg tab

Tegretol (Carbamazepine) chew tab 100mg

Tegretol (Carbamazepine) 100mg, 200mg tab

Tegretol XR (Carbamazepine ER) 100mg cap, 200mg, 400mg tab

Topomax Topiramate) 25mg, 50mg, 100mg, 200mg tab

Trileptal (Oxcarbazapine) 150mg, 300mg, 600mg tab

Mood Stabilizers (non-anticonvulsant)

Eskalith (Lithium carbonate) 300mg tab

Eskalith (Lithium citrate) (473mL) 300mg/5mL syrup

Anticonvulsants

Dilantin (Phenytoin sod ext) 100mg, 200mg, 300mg cap
Keppra (Levetiracetam) 250mg, 500mg, 750mg tab

Neurontin (Gabapentin) all formulations

Phenytoin Infatab
Zonegran (Zonisamide) 25mg, 50mg, 100mg cap

- Barbituates

Patient Specific Phenobarbital (Phenobarbital) 32.4mg, 64.8mg, 97.2mg tab

- Anticholinergics

Artane (Trihexyphenidyl) tab 2mg, 5mg

Cogentin (5x2mL) 2mg/2mL inj

Cogentin (Benztropine) tab 1mg, 2mg

- Antiparkinson

Requip (Ropinirole) .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg tab

Sinemet (Carbidopa/Levodopa) 10/100mg, 25/100mg, 25/250mg tab

Stalevo (Carbidopa/Levodopa Entacopone)

Antipsychotic (typical)

Haldol (Haoperidol) 0.5mg, 1mg, 2mg, 5mg, 10mg, 20mg tab

Haldol (Haloperidol) 5mg/mL vial

- Antipsychotic medications (atypical)

Risperdal (Risperdone) tabs 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg

Zyprexa (Olanzapine) 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg tab

SSRI - Antidepressant

Celexa (Citalopram HBR) 10mg, 20mg tab

Paxil (Paroxetine) 10mg, 20mg, 30mg, 40mg tab

Prozac (Fluoxetine) 10mg, 20mg cap

Zoloft (Sertraline) 25mg, 50mg, 100mg tab

SNRI - Antidepressant

Cymbalta (Duloxetine) 20mg, 30mg, 40mg, 60mg cap

Effexor (Venlafaxine) 25mg, 37.5mg, 50mg, 75mg, 100mg tab

Effexor XR (Venlafaxine Extended Release) 37.5mg, 75mg, 150mg cap

Other - Antidepressant

Remeron (Mirtazapin) 15mg, 30mg, 45mg tab

Wellbutrin (NDRI) (Bupropion HCL)75mg, 100mg tab

Wellbutrin SR (NDRI) (Bupropion HCL SR) 100mg, 150mg, 200mg tab

Wellbutrin XL (NDRI) (Bupropion HCL XL) 150mg, 300mg tab

Antiemetic and Antivertigo medications

Antivert (Meclizine) 12.5mg, 25mg tab

Zofran (Ondansetron) 4mg, 8mg tab

Among these, what are the most common medications prescribed to treat mental health diagnoses?

RESPONSE: ***Librium, Risperdal, Zoloft and Benadryl***

6. Please provide the frequency these medications are prescribed accompanied by corresponding diagnoses for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

a. Please provide stratified data breakdown that considers, inmates vs. detainees, diagnoses, length of stay, demographics, housing area, additional inmate prescriptions, and any other categories as available to ECCF.

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

7. In the view of ECCF, what are current trends in mental health treatment among the total inmate and ICE detainee population?

RESPONSE: ***The overall trends in mental health treatment have been trauma informed, cognitive-behavioral and supportive counseling to help people cope with the stress of the criminal justice system and the restrictions that come with incarceration. An additional trend is to monitor for the presence of substance use disorder and make referrals as needed to the MAT/MOUD program.***

What are the non-pharmacological treatments/interventions used in the care of persons with mental health diagnoses and symptoms?

RESPONSE: ***Interventions used include individual and group treatment and crisis intervention. Group treatment has been limited due to the pandemic, but will resume when public health concerns are lifted.***

8. Describe the current trends, i.e. using data, on whether inmates with mental health diagnoses have well-controlled symptoms.

RESPONSE: ***The majority of patients are stabilized within 24-48 hours. Patients who are not stabilized in that time frame are sent to hospitals for further care, based on clinical direction.***

Please explain how the facility, inclusive of the medical and mental health departments, determines "well-controlled."

RESPONSE: **The definition of** ***"well-controlled" is based on the guidelines of the U.S. Preventative Task Force.***

9. What are the different types of Suicide Watch procedures followed by ECCF?

RESPONSE: ***In order to protect the patient, actively suicidal patients are placed on constant observation, while those with potential risk are closely monitored on a regular schedule at 15 minute intervals. Suicidal patients receive preventive supervision, treatment and therapeutic follow up.***

Please explain the medical department's and mental health department's logic behind these levels.

RESPONSE: ***The main purposes of constant and close watches is to keep people safe, and to give them a way to gradually transition to watch levels of less supervision, and ultimately be removed from watch. Individuals on constant or close watch are seen every day by mental health staff***

Constant Watch is for acutely suicidal individuals who are actively voicing suicidal ideation with a plan. There is an officer placed at the door of the cell, who watches the person constantly. The patient is provided a safety mattress, safety blanket, and safety gown. Any other possessions in the cell are determined by mental health staff. This level of supervision ensures that if the person engages in any self-injurious behavior, healthcare staff can be notified by the officer and arrangements made to send the person to crisis.

Close watch has two levels, with a safety gown and with clothing. Close watch is for individuals who are not acutely suicidal, who have feelings of suicide with no specific intent or plan. For close watch with a safety gown, the person has a safety blanket and mattress, as well as other possessions authorized by mental health. The officers make cell checks on these watches at staggered intervals no greater than 15 minutes. This level of watch allows for less supervision, with limited possessions, to determine if the person can be safe and then moved to the next level of close watch with clothes. These individuals are seen daily by mental health.

Close watch with clothing and other possessions is for patients who have progressed through the levels of watch, cooperated with treatment efforts, but still pose a potential risk of suicide. As mentioned, officers make cell checks at staggered intervals no greater than 15 minutes. A good response on this level of watch suggests the person can be cleared off watch altogether and moved to a regular housing unit. Individuals on this level of watch are seen daily by mental health. When they are clear off watch are seen for a follow-up at either 24, 48, or 72 hours based on the individual needs of the person. Individuals off watch are maintained on the mental health caseload and followed regularly for the remainder of their stay.

Intake

1. What do the medical and mental health departments designate as serious mental health conditions warranting refusal for incarceration?

RESPONSE: ***Reasons for refusal for incarceration includes active psychosis or suicidality.***

Please provide the internal guidance and training provided to staff on the proper identification of such conditions.

RESPONSE: ***Medical vendor follows clinical guidelines set by the National Commission on Correctional Health Care (NCCHC) and the N.J. Department of Health and Mental Hygiene.***

How many individuals are referred offsite each year for serious mental health conditions?

RESPONSE: ***Individuals sent to the ER for crisis include:***

May 2020	June 2020	July 2020	August 2020	Sept 2020	Oct 2020

2	2	5	4	2	3

Offsite transfers to psychiatric hospitals can be provided.

2. How do nurses at nurse intake assess where an individual should be housed?

RESPONSE: ***The intake nurses do not assess where an individual should be housed. The determination for forensic or infirmary placement is made by providers and carried out by custodial authority, based on the medical department's recommendations.***

Please provide the internal guidance and training provided to staff on how to make appropriate referrals on where to house inmates

RESPONSE: ***Medical vendor follows clinical guidelines set by NCCHC and Department of Health and Mental Hygiene.***

Suicide Watch

1. Please provide the internal guidance and trainings provided to staff on distinguishing the necessary levels of Suicide Watch.

RESPONSE: ***Medical vendor follows clinical guidelines set by NCCHC and Department of Health and Mental Hygiene.***

a. Please provide a breakdown of all inmates placed on a form of Suicide Watch over the past 6 months, including: number of inmates, demographics, type of Suicide Watch, any mental health diagnoses, any medical diagnoses, and any other relevant categories as collected by ECCF.

RESPONSE: ***This would need to be compiled, so need more time to work on a comprehensive response.***

2. Regarding mental health: Please provide a list of community partners& FQHCs CFG has utilized in the last 2 years

RESPONSE: Community partners include ***NJCRI, , Newark Community Health, MHA of Essex County, Collaborative Justice System, Ann Klein, Trenton Psychiatric Hospital, Essex County Hospital Center, as well as others.***

a. How often each partner is contacted per month**

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

b. Diagnoses or cases each partner is contacted for**

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

Substance Abuse

1. What is the total number of inmates & detainees receiving substance abuse services?

RESPONSE: ***101 inmates and detainees are currently receiving substance abuse services.***

Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***November - 38***
October - 31
September - 25
August - 21
July - 25
June - 24
May - 5

*** Please be advised that these numbers are greatly affected by the limitations of the pandemic.***

2. **How many of those identified as having substance abuse disorders have co-occurring mental health diagnoses?**

RESPONSE: ***ECCF's current system does not provide the ability to parse such details. However, it is estimated that 1/3 of current MAT cases are also receiving mental health services.***

3. What is the number of inmates & detainees receiving substance abuse treatment, who do not present substance abuse disorder symptoms during intake, but are later discovered?

RESPONSE: ***We do not currently track this data.***

Please provide this number and date of discovery for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***We do not currently track this data.***

4. What is the total number of inmates & detainees identified as experiencing withdrawal upon pre-booking?

   RESPONSE: ***We do not currently track this data.***

   Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***We do not currently track this data.***

5. What are the most common medications prescribed to treat withdrawal?

   RESPONSE: ***Librium, Suboxone, Ativan, Clonodine***

6. What are the total medications prescribed to assist substance abuse disorder detox?

   RESPONSE: ***Please refer to previously provided ECCF's withdrawal protocol.***

7. Which medications are currently utilized in ECCF's Medication-Assisted Treatment program?

   RESPONSE: ***Suboxone, Vivitrol, Methadone***

8. How often is each of these medications prescribed? Please provide for the following months in 2020: November, October, September, August, July, June, and May

   RESPONSE: ***We do not currently track this data.***

   a. Please provide stratified data breakdown that considers, inmates vs. detainees, length of stay, demographics, housing area, additional inmate prescriptions, and any other categories as available to ECCF.

   RESPONSE: ***We do not currently track this data.***

9. In the view of ECCF, what are current trends regarding substance abuse disorder treatment among the total inmate population?

RESPONSE: ***The current substance use disorders that are trending in the ECCF are Opiate, Benzodiazepine, Alcohol disorder..***

10. What are the current trends of successfully controlled substance abuse disorders, as identified by ECCF?

    RESPONSE: ***The following substance use disorders are successfully treated at ECCF with Opiate, Benzodazipine , Alcohol***

    Please explain how the facility, inclusive of the medical and mental health departments define "well-controlled."

    RESPONSE: ***The Medical and mental health department define "Well-Controlled" as patients scoring mild in the CIWA and/or COWS.***

11. Regarding substance abuse treatment: Please provide a list of community partners CFG has utilized in the last 2 years

    RESPONSE: ***Greater Essex Counseling Services, Cope Center, Center of Excellence (UBHC), Bethel, Suburban Clinic, New Pathways, People Helping People in Need, East Orange Substance Abuse, Kaleidoscope Health Care, Team Management 2000,Crossroads Treatment Center, Eva's Village, Turning Point, Integrity House, Cura, Damian House, Straight and Narrow***

    in addition to the following:

    a. How often each partner is contacted

       RESPONSE: ***The service providers are contacted based on the clients need and if they reside in that municipality.***

    b. Service each partner is contacted for

       RESPONSE: ***The services are based on client's needs, i.e. co-occurring, housing, Outpatient substance use program, inpatient substance use program, half-way house, family counseling, DVR services, grants services for treatment (prior to the 999 or 9998 code being lifted), case management services. These are some of the services the community partners provide and based on the client's needs and where they will be residing upon release determines which community partner will be contacted.***

Special Housing Unit (SHU)& Segregated Housing

Please provide all statistics and data regarding SHU's use as collected by ECCF.

Some specific inquiries:

1. Please provide a breakdown of inmates& detainees in SHU over the past 6 months diagnosed with mental health issues, including: number of inmates, rate of release from SHU, demographics, prescribed medication, time of presentation, time of SHU admission, and any other relevant categories as collected by ECCF.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

2. How many inmates & detainees are admitted to SHU with mental health diagnoses?

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

3. How many individuals are currently in SHU?

   RESPONSE: Approximately 163 individuals

   Please provide this number for both inmates and ICE detainees for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***More time is needed to provide these details.***

   How many SHU inmates have mental health diagnoses after being admitted to SHU? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***If patients have underlying mental health issues, they cannot be placed in the SHU. Therefore, we do not collect this information. If they exhibit mental health symptoms, they are quickly assessed and moved out of the SHU.***

4. Please provide a breakdown of inmates & detainees referred to mental health after being moved to SHU, considering: demographics, cell number, any diagnoses, any prescribed medication, follow-up appointment dates, time & date of referral, time & date of certified mental health professional attention, date of SHU admission, date of symptom presentation, and any other relevant categories as collected by ECCF

   RESPONSE: ***.We do not collect this information.***

5. Please provide a floor plan of SHU.

RESPONSE: ***While we would allow the task force to tour the SHU, diagrams of the building cannot be shared.***

6. What are the most prevalent mental health diagnoses among inmates in SHU?

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

7. What are current trends of diagnoses among the SHU population, as identified by ECCF? Please describe for both inmates & ICE detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

8. What are current trends of mental health treatment among the SHU population, as identified by ECCF? Please describe for both inmates & detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

9. What are the current trends of successfully controlled diagnoses, as identified by ECCF?Please describe for both inmates & detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

10. Any other data regarding SHU as collected by ECCF.

    RESPONSE: No.

Essex County Civilian Task Force Questions
Dr. Szerbo
December, 2020

General

1) The National Institute of Health declared that the following personality disorders are frequent in prison: Narcissistic, antisocial and paranoid. Does ECCF document these conditions?

   RESPONSE: ***Personality disorders are documented in the "Problems" section of the Electronic Health Record (EHR) if the patient meets all the necessary diagnostic criteria in accordance to standards set in the DSM-5. If the patient has those traits, but does not meet the full criteria, the traits are documented in the individual contact notes.***

   How are they handled at the Jail?

   RESPONSE: ***People with these disorders typically have clinical symptoms that are treated with medication and therapy contacts. Clear, open, respectful and consistent communication is the best way to handle these patients.***

2) What is the state of ECCF infrastructure dedicated to handling mental health cases?

   RESPONSE: ***Mental health issues are first documented in the initial nurse screening intake. The patient is asked questions for suicide prevention and to determine the need for a mental health referral, based on the screening. If the patient is in urgent need, mental health staff will be called immediately to the intake area to assess the patient. If the referral acuity level is minimum to moderate, the patient is referred to mental health for later screening by a masters level counselor. Based on the outcome of that patient encounter, the patient may be referred to the psychologist or psychiatrist.***

   Staffing consists of 4.6 mental health counselor FTEs, a full-time psychologist, full-time psychiatrist and 1.4 psychiatric nurse practitioner FTEs.

   The ECCF has a forensic unit consisting of 16 beds and 2 cells in the Infirmary which can be used for suicide prevention.

   Does ECCF need investments in this area? If yes, please describe.

   RESPONSE: ***Investments in the area of mental health would be advantageous. First, the ECCF medical department is looking for more linkages to enhance care in the community. Another way to enhance services would be to add forensic beds for long term placement. Finally, it would be helpful for patients to obtain long acting psychotropics upon discharge***.

3) What is the time frame of requesting a mental health visit to the time of being attended by a licensed mental health professional?

RESPONSE: ***Patients referred to mental health on an urgent/emergent basis are seen immediately. The less acute referrals are seen according to policy and procedure.***

4) What mental health services are available for those who while incarcerated may have had family members pass from COVID?

RESPONSE: ***As with anyone who lose someone while incarcerated, referrals are made to the mental health department by medical staff, social workers, officers, or administration since they often first receive the communication. Patients are seen regularly by mental health to help them process their grief while confined. Social services and administrative staff arrange for funeral visits/viewings, where possible.***

5) What are general COVID mental health services available?

RESPONSE: ***Anyone directly exposed to COVID-19 is quarantined for14 days. They can request mental health services via tablets.***

What relevant services are available 24 hours a day at a 24-hour facility?

RESPONSE: ***Mental health services are available 24x7.***

6) There exist public concerns that individuals with mental health challenges are not receiving proper treatment, particularly regarding detainees receiving the same diagnosis of adjustment disorder and being simply prescribed sedatives. Please comment on how you plan to address and change mental health practices at ECCF?

RESPONSE: ***The mental health department does not subscribe to the practice of using sedatives or any type of chemical restraints. This is against policy and procedures. Patients that receive a mental health diagnosis are treated with counseling and clinically indicated psychotropic medications, which are consistent with community standards.***

7) There exist public concerns regarding curtailment of programs due to COVID-19, some of which are important for mental health reasons and/or for individuals' legal cases [e.g., anger management classes]. How does ECCF plan to address this issue moving forward?

RESPONSE: ***Mental health, social services and Medication for Opioid Use Disorder (MOUD) - Mediation-Assisted Therapy (MAT) staff have outlined a comprehensive plan for re-establishing anger management, conflict resolution and a number of other therapeutic classes.***

When will these programs resume?

RESPONSE: ***As restrictions are eased, this multi disciplinary team is prepared to re-launch programs. In the meantime, they are creating avenues to integrate tele health courses into their programming.***

8) How is accessing external partner services impacted by the COVID-19 pandemic, if, for example, an inmate is in crisis and the Facility cannot treat them on site?

RESPONSE: ***Referrals to crisis services has not been impacted by the pandemic. Arrangements have been made for psychiatric screeners meet with individuals in crisis at the Facility. Other patients are transported to Newark Beth Israel Medical Center or University Hospital for assessments.***

Is ECCF finding timely community partner help difficult with COVID-19?

RESPONSE: ***For psychiatric crises, it has not been difficult finding community partners.***

9) Some individuals have recent experience with patients who are released from the Facility, but are not guided in continuing treatment. Has this protocol been reviewed and changed?

RESPONSE: ***For known releases, patients are provided with a list of community health professionals, medications or prescriptions, as clinically appropriate and referrals to community providers. At the same time, there are built in challenges for patients who are released without the knowledge of the medical staff. For example, inmates/detainees may be released directly from court. This is an area of concern which is actively being discussed in special needs meetings. The ECCF is always reconciling to identify any unanticipated release.***

How and how recently?

RESPONSE: ***Review of the discharge policies and all policies occur at least once/year. The last formal review of policies was on and around October 1, 2020. The discharge policy is reviewed at weekly meetings as patient cases are discussed. In addition, the Record Room custody staff reviews for any unexpected court releases on a daily basis***

10) What training do officers receive regarding safe interaction with inmates suffering from a mental health issue?

RESPONSE: ***Officers are trained every year during quarterly in-service training for signs of mental health symptoms, among other issues.***

What is the extent of an officer's individual authority?

RESPONSE: ***Officers may refer an inmate/detainee to the mental health department if the inmate exhibits concerning characteristics observed by the officer. Officers CANNOT determine if an inmate has mental health issues. Diagnoses and assessments are determined solely by the mental health department.***

11) Are their additional mental health services regarding the impact of COVID-19, for example if an inmate's family member has passed?

RESPONSE: ***Referrals are made to the mental health department by medical staff, social workers, officers, or administration since they often first receive the communication. Patients are seen regularly by mental health to help them process their grief while confined. Social services and administrative staff arrange for funeral visits/viewings, where possible.***

12) Is ECCF paying for tablets or are they donated by GTL?

RESPONSE***: Tablets are provided by GTL.***

13) How does ECCF proactively evaluate persons who cannot describe or otherwise self-report what mental health issues they may be experiencing in private or isolation?

RESPONSE: ***Mental health staff review EHR records to see if there is a history. In addition, other healthcare staff and officers who see the person daily will report their observations to mental health staff. Social work staff will also inform mental health of any phone calls made by family members. Mental health staff use their counseling skills to elicit information.***

14) Is there a capacity to use telecommunication for necessary mental health and addiction programs?

RESPONSE: ***Telehealth services are actively being discussed for implementation in the near future. Essex County's 2021 contract for medical services provided at the ECCF requires the medical provider to implement telemedicine.***

15) The previously issued Health Service Report (Attachment B) shows no on-site inmate health services utilizations. Is this accurate?

RESPONSE: ***A sample Health Services Report is attached here.***

Medical Health

1. In the view of ECCF, what are current trends and prevalence rates across all diagnoses among the total inmate population?

RESPONSE: ***The top 5 medical diagnoses are diabetes, hypertension, COPD, HIV and substance abuse.***

2. Please provide a breakdown of co-occurring mental health and substance use disorder diagnoses among the total inmate and detainee population

RESPONSE: ***ECCF's current system does not provide the ability to parse such details. However, it is estimated that 1/3 of current MAT cases are also receiving mental health services.***

Mental Health

3. What is the total number of inmates& ICE detainees receiving mental health services? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***Readily available data includes the following:***

Type of Encounter	May 2020	June 2020	July 2020	August 2020	Sept 2020	Oct 2020
Face to Face contact with Forensic	25	169	135	134	55	137
Mental Health Clinician Encounters	431	682	713	655	641	688
Face to Face contacts with Watches	89	175	211	225	153	137
Psychiatrist Encounters	195	229	206	221	213	180
Psych APN Encounters	236	293	315	330	272	308
Psychologist Encounter	105	140	84	79	56	27

4. What is the number of inmates and ICE detainees referred to mental health, who do not present with mental health symptoms during intake, but later make mental health complaints or display mental health symptoms? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***While all patients who receive mental services have such documentation in their charts, ECCF's current system does not provide the ability to parse such details.***

5. Please provide a comprehensive list of the medications prescribed to treat mental health diagnoses?

RESPONSE: ***Please see the following list:***

- CholinesteraseInhibitors

Aricept (Donepezil) 5mg, 10mg, 23mg

- Benzodiazepine-Anxiolytics

Ativan (Lorazepam) 0.5mg, 1mg, 2mg tab

Librium (Chlordiazepoxide) 10mg, 25mg cap

- Non-Benzodiazepine-anxiolytics

Buspar (Buspirone HCL) 5mg, 15mg tab

Vistaril (Hydroxyzine–pamoate) 25mg, 50mg cap

Vistaril (Hydroxyzine) HCL vial 25mg/mL

Mood Stabilizers (anticonvulsant)

Depakene (Valproic Acid) 250mg cap

Depakene Liquid Valproic Acid Liquid)

Depakote (Divalproex) 125mg, 250mg, 500mg tab

Depakote Sprinkle (Divalproex SOD Sprinkle) 125mg tab

Lamictal (Lamotrigine) 25mg, 100mg, 150mg, 200mg tab

Tegretol (Carbamazepine) chew tab 100mg

Tegretol (Carbamazepine) 100mg, 200mg tab

Tegretol XR (Carbamazepine ER) 100mg cap, 200mg, 400mg tab

Topomax Topiramate) 25mg, 50mg, 100mg, 200mg tab

Trileptal (Oxcarbazapine) 150mg, 300mg, 600mg tab

Mood Stabilizers (non-anticonvulsant)

Eskalith (Lithium carbonate) 300mg tab

Eskalith (Lithium citrate) (473mL) 300mg/5mL syrup

Anticonvulsants

Dilantin (Phenytoin sod ext) 100mg, 200mg, 300mg cap
Keppra (Levetiracetam) 250mg, 500mg, 750mg tab

Neurontin (Gabapentin) all formulations

Phenytoin Infatab
Zonegran (Zonisamide) 25mg, 50mg, 100mg cap

- Barbituates

Patient Specific Phenobarbital (Phenobarbital) 32.4mg, 64.8mg, 97.2mg tab

- Anticholinergics

Artane (Trihexyphenidyl) tab 2mg, 5mg

Cogentin (5x2mL) 2mg/2mL inj

Cogentin (Benztropine) tab 1mg, 2mg

- Antiparkinson

Requip (Ropinirole) .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg tab

Sinemet (Carbidopa/Levodopa) 10/100mg, 25/100mg, 25/250mg tab

Stalevo (Carbidopa/Levodopa Entacopone)

Antipsychotic (typical)

Haldol (Haoperidol) 0.5mg, 1mg, 2mg, 5mg, 10mg, 20mg tab

Haldol (Haloperidol) 5mg/mL vial

- Antipsychotic medications (atypical)

Risperdal (Risperdone) tabs 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg

Zyprexa (Olanzapine) 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg tab

SSRI - Antidepressant

Celexa (Citalopram HBR) 10mg, 20mg tab

Paxil (Paroxetine) 10mg, 20mg, 30mg, 40mg tab

Prozac (Fluoxetine) 10mg, 20mg cap

Zoloft (Sertraline) 25mg, 50mg, 100mg tab

SNRI - Antidepressant

Cymbalta (Duloxetine) 20mg, 30mg, 40mg, 60mg cap

Effexor (Venlafaxine) 25mg, 37.5mg, 50mg, 75mg, 100mg tab

Effexor XR (Venlafaxine Extended Release) 37.5mg, 75mg, 150mg cap

Other - Antidepressant

Remeron (Mirtazapin) 15mg, 30mg, 45mg tab

Wellbutrin (NDRI) (Bupropion HCL)75mg, 100mg tab

Wellbutrin SR (NDRI) (Bupropion HCL SR) 100mg, 150mg, 200mg tab

Wellbutrin XL (NDRI) (Bupropion HCL XL) 150mg, 300mg tab

Antiemetic and Antivertigo medications

Antivert (Meclizine) 12.5mg, 25mg tab

Zofran (Ondansetron) 4mg, 8mg tab

Among these, what are the most common medications prescribed to treat mental health diagnoses?

RESPONSE: ***Librium, Risperdal, Zoloft and Benadryl***

6. Please provide the frequency these medications are prescribed accompanied by corresponding diagnoses for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

a. Please provide stratified data breakdown that considers, inmates vs. detainees, diagnoses, length of stay, demographics, housing area, additional inmate prescriptions, and any other categories as available to ECCF.

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

7. In the view of ECCF, what are current trends in mental health treatment among the total inmate and ICE detainee population?

   RESPONSE: ***The overall trends in mental health treatment have been trauma informed, cognitive-behavioral and supportive counseling to help people cope with the stress of the criminal justice system and the restrictions that come with incarceration. An additional trend is to monitor for the presence of substance use disorder and make referrals as needed to the MAT/MOUD program.***

   What are the non-pharmacological treatments/interventions used in the care of persons with mental health diagnoses and symptoms?

   RESPONSE: ***Interventions used include individual and group treatment and crisis intervention. Group treatment has been limited due to the pandemic, but will resume when public health concerns are lifted.***

8. Describe the current trends, i.e. using data, on whether inmates with mental health diagnoses have well-controlled symptoms.

   RESPONSE: ***The majority of patients are stabilized within 24-48 hours. Patients who are not stabilized in that time frame are sent to hospitals for further care, based on clinical direction.***

   Please explain how the facility, inclusive of the medical and mental health departments, determines "well-controlled."

   RESPONSE: The definition of ***"well-controlled" is based on the guidelines of the U.S. Preventative Task Force.***

9. What are the different types of Suicide Watch procedures followed by ECCF?

   RESPONSE: ***In order to protect the patient, actively suicidal patients are placed on constant observation, while those with potential risk are closely monitored on a regular schedule at 15 minute intervals. Suicidal patients receive preventive supervision, treatment and therapeutic follow up.***

   Please explain the medical department's and mental health department's logic behind these levels.

   RESPONSE: ***The main purposes of constant and close watches is to keep people safe, and to give them a way to gradually transition to watch levels of less supervision, and ultimately be removed from watch. Individuals on constant or close watch are seen every day by mental health staff***

Constant Watch is for acutely suicidal individuals who are actively voicing suicidal ideation with a plan. There is an officer placed at the door of the cell, who watches the person constantly. The patient is provided a safety mattress, safety blanket, and safety gown. Any other possessions in the cell are determined by mental health staff. This level of supervision ensures that if the person engages in any self-injurious behavior, healthcare staff can be notified by the officer and arrangements made to send the person to crisis.

Close watch has two levels, with a safety gown and with clothing. Close watch is for individuals who are not acutely suicidal, who have feelings of suicide with no specific intent or plan. For close watch with a safety gown, the person has a safety blanket and mattress, as well as other possessions authorized by mental health. The officers make cell checks on these watches at staggered intervals no greater than 15 minutes. This level of watch allows for less supervision, with limited possessions, to determine if the person can be safe and then moved to the next level of close watch with clothes. These individuals are seen daily by mental health.

Close watch with clothing and other possessions is for patients who have progressed through the levels of watch, cooperated with treatment efforts, but still pose a potential risk of suicide. As mentioned, officers make cell checks at staggered intervals no greater than 15 minutes. A good response on this level of watch suggests the person can be cleared off watch altogether and moved to a regular housing unit. Individuals on this level of watch are seen daily by mental health. When they are clear off watch are seen for a follow-up at either 24, 48, or 72 hours based on the individual needs of the person. Individuals off watch are maintained on the mental health caseload and followed regularly for the remainder of their stay.

Intake

1. What do the medical and mental health departments designate as serious mental health conditions warranting refusal for incarceration?

RESPONSE*: Reasons for refusal for incarceration includes active psychosis or suicidality.*

Please provide the internal guidance and training provided to staff on the proper identification of such conditions.

RESPONSE: *Medical vendor follows clinical guidelines set by the National Commission on Correctional Health Care (NCCHC) and the N.J. Department of Health and Mental Hygiene.*

How many individuals are referred offsite each year for serious mental health conditions?

RESPONSE*: Individuals sent to the ER for crisis include:*

May 2020	June 2020	July 2020	August 2020	Sept 2020	Oct 2020

2	2	5	4	2	3

Offsite transfers to psychiatric hospitals can be provided.

2. How do nurses at nurse intake assess where an individual should be housed?

RESPONSE: ***The intake nurses do not assess where an individual should be housed. The determination for forensic or infirmary placement is made by providers and carried out by custodial authority, based on the medical department's recommendations.***

Please provide the internal guidance and training provided to staff on how to make appropriate referrals on where to house inmates

RESPONSE: ***Medical vendor follows clinical guidelines set by NCCHC and Department of Health and Mental Hygiene.***

Suicide Watch

1. Please provide the internal guidance and trainings provided to staff on distinguishing the necessary levels of Suicide Watch.

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   a. Please provide a breakdown of all inmates placed on a form of Suicide Watch over the past 6 months, including: number of inmates, demographics, type of Suicide Watch, any mental health diagnoses, any medical diagnoses, and any other relevant categories as collected by ECCF.

   RESPONSE: ***This would need to be compiled, so need more time to work on a comprehensive response.***

2. Regarding mental health: Please provide a list of community partners& FQHCs CFG has utilized in the last 2 years

RESPONSE: Community partners include ***NJCRI, , Newark Community Health, MHA of Essex County, Collaborative Justice System, Ann Klein, Trenton Psychiatric Hospital, Essex County Hospital Center, as well as others.***

a. How often each partner is contacted per month**

RESPONSE: ***ECCF's current system does not provide the ability to parse such details.***

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   June - 24
   May - 5

   **** Please be advised that these numbers are greatly affected by the limitations of the pandemic.***

2. **How many of those identified as having substance abuse disorders have co-occurring mental health diagnoses**?

   RESPONSE: ***ECCF's current system does not provide the ability to parse such details. However, it is estimated that 1/3 of current MAT cases are also receiving mental health services.***

3. What is the number of inmates & detainees receiving substance abuse treatment, who do not present substance abuse disorder symptoms during intake, but are later discovered?

   RESPONSE: ***We do not currently track this data.***

Please provide this number and date of discovery for the following months in 2020: November, October, September, August, July, June, and May.

RESPONSE: ***We do not currently track this data.***

4. What is the total number of inmates & detainees identified as experiencing withdrawal upon pre-booking?

   RESPONSE: ***We do not currently track this data.***

   Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***We do not currently track this data.***

5. What are the most common medications prescribed to treat withdrawal?

   RESPONSE: ***Librium, Suboxone, Ativan, Clonodine***

6. What are the total medications prescribed to assist substance abuse disorder detox?

   RESPONSE***: Please refer to previously provided ECCF's withdrawal protocol*****.**

7. Which medications are currently utilized in ECCF's Medication-Assisted Treatment program?

   RESPONSE: ***Suboxone, Vivitrol, Methadone***

8. How often is each of these medications prescribed? Please provide for the following months in 2020: November, October, September, August, July, June, and May

   RESPONSE: ***We do not currently track this data.***

   a. Please provide stratified data breakdown that considers, inmates vs. detainees, length of stay, demographics, housing area, additional inmate prescriptions, and any other categories as available to ECCF.

   RESPONSE: ***We do not currently track this data.***

9. In the view of ECCF, what are current trends regarding substance abuse disorder treatment among the total inmate population?

RESPONSE: ***The current substance use disorders that are trending in the ECCF are Opiate, Benzodiazepine, Alcohol disorder..***

10. What are the current trends of successfully controlled substance abuse disorders, as identified by ECCF?

    RESPONSE: ***The following substance use disorders are successfully treated at ECCF with Opiate, Benzodazipine , Alcohol***

    Please explain how the facility, inclusive of the medical and mental health departments define "well-controlled."

    RESPONSE: ***The Medical and mental health department define "Well-Controlled" as patients scoring mild in the CIWA and/or COWS.***

11. Regarding substance abuse treatment: Please provide a list of community partners CFG has utilized in the last 2 years

    RESPONSE: ***Greater Essex Counseling Services, Cope Center, Center of Excellence (UBHC), Bethel, Suburban Clinic, New Pathways, People Helping People in Need, East Orange Substance Abuse, Kaleidoscope Health Care, Team Management 2000,Crossroads Treatment Center, Eva's Village, Turning Point, Integrity House, Cura, Damian House, Straight and Narrow***

    in addition to the following:

    a. How often each partner is contacted

       RESPONSE: ***The service providers are contacted based on the clients need and if they reside in that municipality.***

    b. Service each partner is contacted for

       RESPONSE: ***The services are based on client's needs, i.e. co-occurring, housing, Outpatient substance use program, inpatient substance use program, half-way house, family counseling, DVR services, grants services for treatment (prior to the 999 or 9998 code being lifted), case management services. These are some of the services the community partners provide and based on the client's needs and where they will be residing upon release determines which community partner will be contacted.***

Special Housing Unit (SHU)& Segregated Housing

Please provide all statistics and data regarding SHU's use as collected by ECCF.

Some specific inquiries:

1. Please provide a breakdown of inmates& detainees in SHU over the past 6 months diagnosed with mental health issues, including: number of inmates, rate of release from SHU, demographics, prescribed medication, time of presentation, time of SHU admission, and any other relevant categories as collected by ECCF.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

2. How many inmates & detainees are admitted to SHU with mental health diagnoses?

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

3. How many individuals are currently in SHU?

   RESPONSE: Approximately 163 individuals

   Please provide this number for both inmates and ICE detainees for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***More time is needed to provide these details.***

   How many SHU inmates have mental health diagnoses after being admitted to SHU? Please provide this number for the following months in 2020: November, October, September, August, July, June, and May.

   RESPONSE: ***If patients have underlying mental health issues, they cannot be placed in the SHU. Therefore, we do not collect this information. If they exhibit mental health symptoms, they are quickly assessed and moved out of the SHU.***

4. Please provide a breakdown of inmates & detainees referred to mental health after being moved to SHU, considering: demographics, cell number, any diagnoses, any prescribed medication, follow-up appointment dates, time & date of referral, time & date of certified mental health professional attention, date of SHU admission, date of symptom presentation, and any other relevant categories as collected by ECCF

   RESPONSE: .***We do not collect this information.***

5. Please provide a floor plan of SHU.

RESPONSE: ***While we would allow the task force to tour the SHU, diagrams of the building cannot be shared.***

6. What are the most prevalent mental health diagnoses among inmates in SHU?

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

7. What are current trends of diagnoses among the SHU population, as identified by ECCF? Please describe for both inmates & ICE detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

8. What are current trends of mental health treatment among the SHU population, as identified by ECCF? Please describe for both inmates & detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

9. What are the current trends of successfully controlled diagnoses, as identified by ECCF?Please describe for both inmates & detainees.

   RESPONSE: ***Inmates and detainees are not housed in the SHU for mental health reasons. Therefore, we do not collect this information.***

10. Any other data regarding SHU as collected by ECCF.

    RESPONSE: No.

For Mental Health:

1. When is a mental health screen conducted for newly admitted inmates?
    a. Who performs the screen? (level of training, credentials)
    b. Is it conducted in a space in which the inmate has privacy?
    c. What are the screening questions?
    d. For a positive screen, what are the next steps? How soon is the inmate assessed and by what level of provider?
2. What training is provided for jail staff regarding recognizing and identifying mental health issues? Do any trainings address stigma?
3. If an inmate is suicidal, what is the protocol?
    a. If they are kept in the isolation unit, what does the isolation look like? Do they have windows/view of the hallway? Are they confined to a cell and for how many hours? How often are in person assessments made and by what staff members? Are these assessments done in the presence of correctional officers or other staff members, or can the inmate speak privately with the mental health staff?
    b. How do inmates indicate they wish to speak to a provider? Does it have to go through a CO or another staff member, or do they have a direct way to indicate their request? How are such requests triaged and what is the timeframe for response?
4. For inmates in the general population:
    a. How can an inmate request a mental health assessment? Are they able to do so without involving a CO or other staff member? Is there a confidential way to make a request and does the inmate feel that this information is kept confidential, or does it appear to be public?
    b. In what timeframe is an assessment completed? What level of provider performs the assessment? Does the inmate have a private space in which to discuss their concerns?
    c. Do inmates have a confidential way to report abuse or neglect by staff members? How are these complaints addressed and what kind of investigation is performed? How many such complaints have been filed in the last 5 years?
    d. What kind of therapy or counseling services are offered (both group and individual)? How are inmates aware of these services and in what ways are they advertised? Can an inmate request psychotherapy for emotional support without having a mental health diagnosis? Is there any collaboration with family or loved ones for the inmate's treatment? Are there any time limits on treatment?
    e. What is the process for establishing aftercare? Is there a warm hand-off? Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?
5. Medications
    a. How are medications chosen for the mental health formulary? Is there a possibility to provide non-formulary medications when needed or requested by the inmate? Are medication regimens for inmates automatically changed upon admission if their medications aren't on the formulary? What kind of assessment process is performed to ensure that medication changes are tolerated?
    b. How frequently do inmates taking mental health medications see a prescriber? How often do they have their labs checked and what is the process for this?

c. Do they receive actual medication supply on discharge from the jail, or just a prescription? How long is the prescription for? What recourse do inmates have if their insurance is not reactivated in a timely manner?

For SUD:

1. Is a substance use/withdrawal screen completed for newly admitted inmates?
    a. Who performs the screen? (level of training, credentials)
    b. Is it conducted in a space in which the inmate has privacy?
    c. What are the screening questions?
2. Withdrawal symptoms can present hours to days after initial assessment. What protocols are in place to identify inmates who are experiencing withdrawal symptoms? What type of staff are monitoring them and how are they trained to identify such symptoms? What is the next step once a withdrawal syndrome is identified and how soon is the inmate seen by medical staff?
3. Do inmates have a direct and confidential way to report substance use issues such as withdrawal? Do they have to go through a CO or other staff member? Is there a confidential way to make a request and does the inmate feel that this information is kept confidential, or does it appear to be public?
4. What is the protocol for treating intoxication and withdrawal? When are inmates kept on site versus being referred out to a hospital? What kind of follow up assessments are performed if they come back from a hospital admission?
5. Are all jail staff trained to use Narcan? Is Narcan available in all areas of the jail? How many overdoses happened in the last 5 years in the facility and what were the staff response times and the clinical outcomes?
6. What training is provided for jail staff regarding addiction, intoxication and withdrawal? Do any trainings address stigma?
7. Medications for tobacco and alcohol use disorder
    a. Are medications provided for smoking cessation? Nicotine replacement (in what forms), varenicline, or other options? What is the method for inmates to be identified for this treatment and/or how can they refer themselves?
    b. Are mediations provided for anti-craving for alcohol use disorder (acamprosate, naltrexone, gabapentin, etc)? If so, when is this assessment done?
    c. If available, how are these services advertised to the inmates or how are they made aware?
    d. What is the process for establishing aftercare? Is there a warm hand-off? Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?
8. Medications for Opioid Use Disorder (MOUD)
    a. Out of the 3 MOUD options (buprenorphine, methadone, naltrexone), which are available for inmates at Essex County?
    b. What opportunities do inmates have to report substance withdrawal after an initial negative screen? Are they regular staff assessments? Can inmates privately request to discuss MOUD with a provider at any time, and does that require other staff involvement such as a CO?

c. How is opioid withdrawal treated? Are all inmates detoxed entirely and then offered MOUD, or can be they be immediately started on maintenance MOUD and avoid detox?
d. If an inmate is identified as having an opioid use disorder, is MOUD offered? What kind of education are they provided about it and what kind of staff does this education? Are all inmates offered all options for MOUD, or is a specific MOUD chosen for them?
e. If methadone is available – what is the protocol? Is there a local opioid treatment program who is involved? How are dose adjustments made?
f. If naltrexone is available – is it only the oral form or is the injection available? Is it administered for the entire stay or only prior to discharge?
g. If buprenorphine is available – are there any dosing guidelines? How do providers respond to reports of craving but no objective withdrawal symptoms? How is dosing performed (mouth checks, etc)? Are any inmates denied buprenorphine due to lack of insurance or issues with finding an aftercare appointment?
h. What happens if an inmate is found to be diverting MOUD? Are they able to continue on MOUD themselves or is it discontinued? If it is discontinued, is there a process for re-assessment in the future?
i. Are there any restrictions placed on inmates who are on MOUD? I.e., changes in privileges, moving to a new location in the jail, etc. Are there any jail-specific incentives or disincentives for inmates to go on MOUD?
j. What is the process for establishing aftercare? Is there a warm hand-off? Does jail staff provide any follow up calls afterward to determine if an ex-inmate was successfully connected to treatment?
k. Do they receive actual medication supply on discharge from the jail, or just a prescription? How long is the prescription for? What recourse do inmates have if their insurance is not reactivated in a timely manner?
l. Is Narcan provided on discharge from the jail?