

## Prison Commission Testimony

### The Burden of Infectious Diseases during Jail Confinement: Screening, Treatment, and Future Directions

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The care of inmates in jails should be of central concern to all citizens. Well-designed protocols and opportunities for follow-up are available in prisons, but less so in jails, with more rapid turnover of inmates and greater challenges to make an accurate diagnosis or initiate appropriate treatment.

One of our great challenges has been identification of infectious diseases in our jail. There is a rich literature on the prevalence of infectious diseases in prisons, but not nearly as much in jail settings. It has been suggested that infectious diseases are even more prevalent in jails than in prisons as the rapid turnover makes diagnosis challenging. Further, there is a natural tendency to deal with acute “crisis” type medical problems, such as drug withdrawal, uncontrolled diabetes, and the risk of tuberculosis.

This winter and spring many jails and prisons focused their attention on an outbreak of community-acquired resistant staphylococcus aureus (MRSA), a relatively “new” infectious disease that was at risk of rising to epidemic proportions in these institutionalized settings. It was through the superb oversight and communication between our staff and the state and county Department of Health that this potential epidemic was halted. Here are some examples of the steps that were taken to control this

infection in our facility. Because of our close working relationship with our state DOC, as well as our county Department of Health and dissemination of new information at the Medical School, we became aware of the increasing number of cases of community-acquired MRSA. Memos were crafted to our staff (medical, nursing, correctional) and inmates regarding surveillance and prevention. We obtained resource material from the Bureau of Prisons and worked with the administrative leadership in the jail regarding putting into place enhanced infection control strategies. A specific skin infection log was initiated using New Jersey Department of Health and Senior Services Data Collection Forms, which would allow pooling of data from many sites and early recognition of infection trends. Procedures were implanted for identification of suspected skin infection – wound culturing, isolation, and treatment recommendations. Infection information sheets were posted in housing units for inmates to read (this information was written at appropriate literacy levels in English and Spanish). Custodial, administrative, and visitor bathrooms had proper handwashing technique posters placed in them. Nurses and physicians spoke to inmates during their intake examinations and during all sick call visits, answering questions and reviewing good hygiene practices. We also found that education was crucial for officers who assist in first recognition of hygiene issues and referral of inmates to the medical unit. Certainly this was a challenging process, but ultimately it was successful. I can say with confidence that the number of confirmed cases were few, and that officers, inmates, visitors, and staff were comforted by the degree of education and attention that this problem received. Frankly, no stone was left unturned. The health of the public was secured through this close oversight of this infectious process. It was encouraging to me to realize that education of inmates was a

strategy that could change behavior regarding hygiene and risk, and that bodes well when they are released.

At our institution the average duration of incarceration is about 8 days, but this is misleading. About 10 percent of inmates are state inmates with prolonged stays; the remainder turn over much more quickly, thus the inmate that one is most likely to randomly encounter is gone in 3 or 4 days. These statistics speak to the challenge of routine identification of high risk inmates, initiation of screening, treatment if necessary, and follow up.

I don't want to use all of my time reciting statistics on infectious diseases in jails; suffice it to say that the published rates of syphilis, gonorrhea, Chlamydia, and herpes have all been increasing in the last decade. Like many facilities, we are overrepresented with inmates of color, who have higher rates of these diseases than other inmates. Like many facilities, there is a recognition in our setting of the increased prevalence of these conditions in women, many of whom are asymptomatic. A separate women's clinic has been established to screen women for STDs.

Clearly, strategies to increase diagnosis of STDs – or for that matter other infectious diseases – could be put into place, but at what cost? Routine testing of all inmates, with the use of rapid screening tests, would place a significant burden on laboratory and pharmaceutical costs. And, as suggested, this increase in diagnosis would not necessarily be translated into increased rates of treatment due to rapid turnover. A practical

consideration that we face with this population beyond cost – perhaps this is a sad reality of our times – is managing expectations in a litigious environment. Making a diagnosis when an inmate is walking out the door places a burden on the facility to track that inmate down – certified and registered letters and other outreach, for example. This places an additional burden on facilities that are often understaffed from an administrative standpoint. Several correctional centers – such as Hampden County Correctional Center in Massachusetts - have been effective in putting public health services into practice in jail settings. Their model includes not only early detection and a comprehensive assessment of health problems, treatment, disease prevention programs, and health education, but also continuity of care in the community with collaboration between the County Health Services Department, community health centers, and other local health care providers.

Could we develop such a model in Somerset County or in the other counties in our state where jails are present? If so, who would staff such health centers? Are local providers really “out there” who are willing to accept inmates as patients? These are all practical problems, and ones that I have faced in the last 7 years. The value of hearings such as this is to give us the opportunity to speculate on best practice models, with a clear eye toward cost and practical processes. Most jail populations are extremely transient. The expectation that inmates will follow up in a local (to that jail) community is, I believe, unrealistic. When we request release of medical records from our inmates to verify prior treatment and current medications, they are addressed across the state and beyond. Local

physicians are often anxious about having inmates as patients, not just from the standpoint of image to their other patients, but also related to reimbursement concerns.

As I conclude, let me speculate on the future, and the role of medical schools to potentially advance the cause of improving care in jails. There are an increasing number of medical schools partnering with state departments of corrections to provide or oversee all or part of correctional health care. In 2004 our university partnered with our state DOC to provide mental health services, and we are planning a national conference to address such partnerships. As schools develop “Correctional Health Institutes” or “Departments of Correctional Health,” there will be a framework for expanding this mission to local jails. Medical schools – or for that matter schools of public health - are not always the perfect partners; we tend to be inefficient and thus costly, have missions that are competing, and are overly bureaucratic compared with a private practice or in-house providers. However, we have a steady stream of enthusiastic future health care professionals eager to work in a variety of health care settings. As a medical student in Buffalo, New York, in the early 1980s, I remember working on the ward where inmates from Attica Prison were transferred. With appropriate supervision, this was a superb opportunity to provide direct patient care and learn about infectious diseases – at that time, the beginning of the AIDS epidemic. Medical, nursing, and public health students take on community based projects. In the city of New Brunswick, our students have begun a clinic providing care, free of charge, to citizens who have nowhere else to receive care. Social services are also available. These examples exist in every school in the country. Why couldn’t this model be expanded to counties for inmates, or could such

centers be sites of continuity care when inmates, many of whom have no insurance, are released?

Let me again thank the Commission for this opportunity to express my views on this important subject. To summarize, protocol driven care; attention to regional, state, and national trends for existing and emerging infectious diseases; chart audits and other monitoring to ensure that polices are being followed; education of staff and inmates; and close linkage with county health departments — assuring that all of these elements are in place would go a long way to reducing the burden and risk of infectious disease in inmates and in the general population.