

COCHS and Inmate Re-entry

Community Health Clinics as Providers of Jail Health
Care Facilitating Continuous Care at Re-entry

Academic and Health Policy Conference on Correctional
Health Care

March 30, 2007

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What does COCHS do?

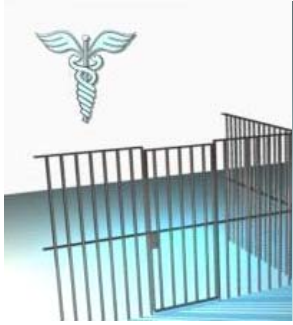
COCHS provides TA and consulting services:

1. Developing satellite health center sites within jails
2. Organizing inmate health and post-release services around health centers in the community of the inmate's residence
3. Extending health screening beyond jails to pre-arraignment
4. Advise on installing, at a health center's request, an electronic medical record system that links the correctional and health center



What does COCHS do?

5. Legal and marketing assistance to allow for development of competitive bids
6. Assistance in developing policies and procedures
7. Performance standards and targeted clinical quality improvement
8. Training and technical assistance



COCHS Staff

Keith Barton

Staff Physician

Ben Butler

Chief Technology Officer

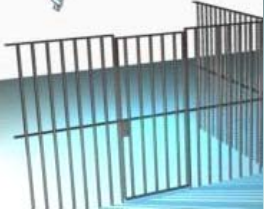
Steve Scheibel

Medical Director

Paul Sheehan

Chief Operating Officer

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Jail Demographics

- 87% male
 - (Female Population has increased 10% annually over the last 10 years)
- Most are poor and are unemployed/underemployed at time of arrest
- 60% lack a high school diploma
- 63.7% from minority populations
 - 38.9% African American
 - 15% Hispanic
 - 1.7% Other Races
- 82.2% have used illicit drugs
 - 68.7% used illicit drugs regularly
- 30% will be homeless after incarceration (2004 NY City Survey)
 - 40% of the females are homeless
- 60 to 90% of the females have been victims of physical/sexual abuse
- 67% of the female inmates have children under age 18
- Most are returning to the same community, which typically is resource limited for re-entry programs



History

- **Hampden County**
 - *A patient at the Brightwood Clinic missed his appointment*
- **Evaluation and Notoriety**
- **Community Corrections**
 - *A little different legally, but the same medically*
- **Letter to the Robert Wood Johnson Foundation**
 - *What do we do with this?*
- **Site Visits – to Hampden County and others**
- **\$7.4 million grant and the birth of COCHS**



Results

Community Health Model of Correctional Health Care is considered a national model by numerous health, hospital, and justice agencies.

Assessment by ABT Associates indicates:

- Improved Inmate Health
- Improved Public Safety
- Improved Public Health
- Protection of Correctional Staff
- Cost Savings
- Better Use of the Health Care System



Jail Population

- In last decade, U.S. jail population increased 31% per capita
 - *193 incarcerated in jail per 100,000 residents; 1995*
 - *252 incarcerated in jail per 100,000 residents; 2005*
- At mid-year 2005, 800,000+ people in local jails
- 12 million people released from the over 3,300 jail systems every year, (nearly 9 million unique individuals)

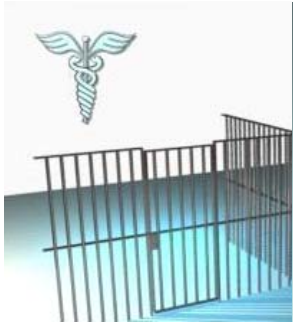


“Corrections, Community and Public Health: Connecting the Dots.”

Title of the Speech delivered by Acting Surgeon General Kenneth P. Moritsugu to the American Correctional Association, January 22, 2007, Tampa, FL,

He encouraged attendees to build bridges between correctional custody, correctional health care and the community to ensure the health and safety of all Americans.

“For inmates, incarceration is an opportunity to access the support they need for their longstanding health conditions, including substance abuse problems, chronic diseases and infections.”



Merging Community and Correctional Health

“...a partnership between health care providers in the community and the local jail dramatically increases the odds that people will have clear access to necessary health services after release. Continuity of care is critical for their health, for their chances of success after release, and for the health and safety of the public.”

Confronting Confinement, A Report on Safety and Abuse in America’s Prisons, June 2006. Page 41.

“By coordinating institution-based efforts with those of community-based service providers, jurisdictions across the country could not only realize a better return on their investment, but also begin to build capacity in communities currently unable to meet the health care needs of their residents.”

Report of the Re-entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community – Co-funded by the Dept. of Justice, Labor, Health and Human Services, 2004. Recommendations Page 158.



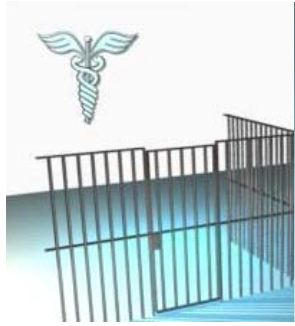
Jail Administration and Health Services

- Jails' budget and administration separate from other community health and social services.
- Correctional health care (jails and prisons) is required and protected by U.S. constitution. U.S. Supreme Court in 1976 (Estelle vs. Gamble) articulated the government's constitutional obligation to provide medical care to people it has incarcerated.
- \$67.2 billion spent on corrections in 2006.
- \$6-10 billion (est.) correctional health care expenditures in 2006.



COCHS Principles

- Early Detection
- Prompt effective primary care
- Education and prevention services
- Ongoing care



COCHS

Reframes Thinking

Jail inmates → People temporarily displaced from their community.

Jail → Site with the greatest leverage to find/create medical homes for temporarily displaced residents.

Connectivity is the key: connecting jail and community services.



Inmate Health Care Models

Traditional Model

COCHS Model

Inmates entering jail receive basic health screening.	Screening for medical conditions at intake – HIV, gonorrhea / Chlamydia, diabetes.
Inmates see doctors that work only in the jail.	Inmates see providers who work in both in the jail and the CHC
Medical records for inmates in jail are separate from any outside of jail.	Medical records kept by Jail/CHC are mutually accessible at intake and post-release.
Inmates receive short-term treatment for mental illness, tuberculosis, Hep C, STD's and other conditions.	Inmates receive ongoing treatment and continuity of treatments initiated in jail.
Emphasis on controlling behavior of inmates with mental illness while in jail.	Emphasis on keeping <u>former</u> inmates with mental illness on their medications and engaged in case management.



During/After Release

Traditional Model

COCHS Model

Inmates often leave jail with no medication for chronic conditions.	Inmates leave jail with medications and/or prescriptions that can be filled through the CHC.
Inmates may spread infectious diseases after they return to the community.	Inmates are screened and treated. Because the CHC cares for families, the family also receives education/treatment for contacts.
Benefits of previous health care received in jail are lost because care did not continue upon release.	Care is the same in and out of jail because inmates are seeing the same CHC caregivers in both locations.
No case management upon release.	Case managers set appointments for inmates to visit their CHC upon release.



Overview

Traditional Model

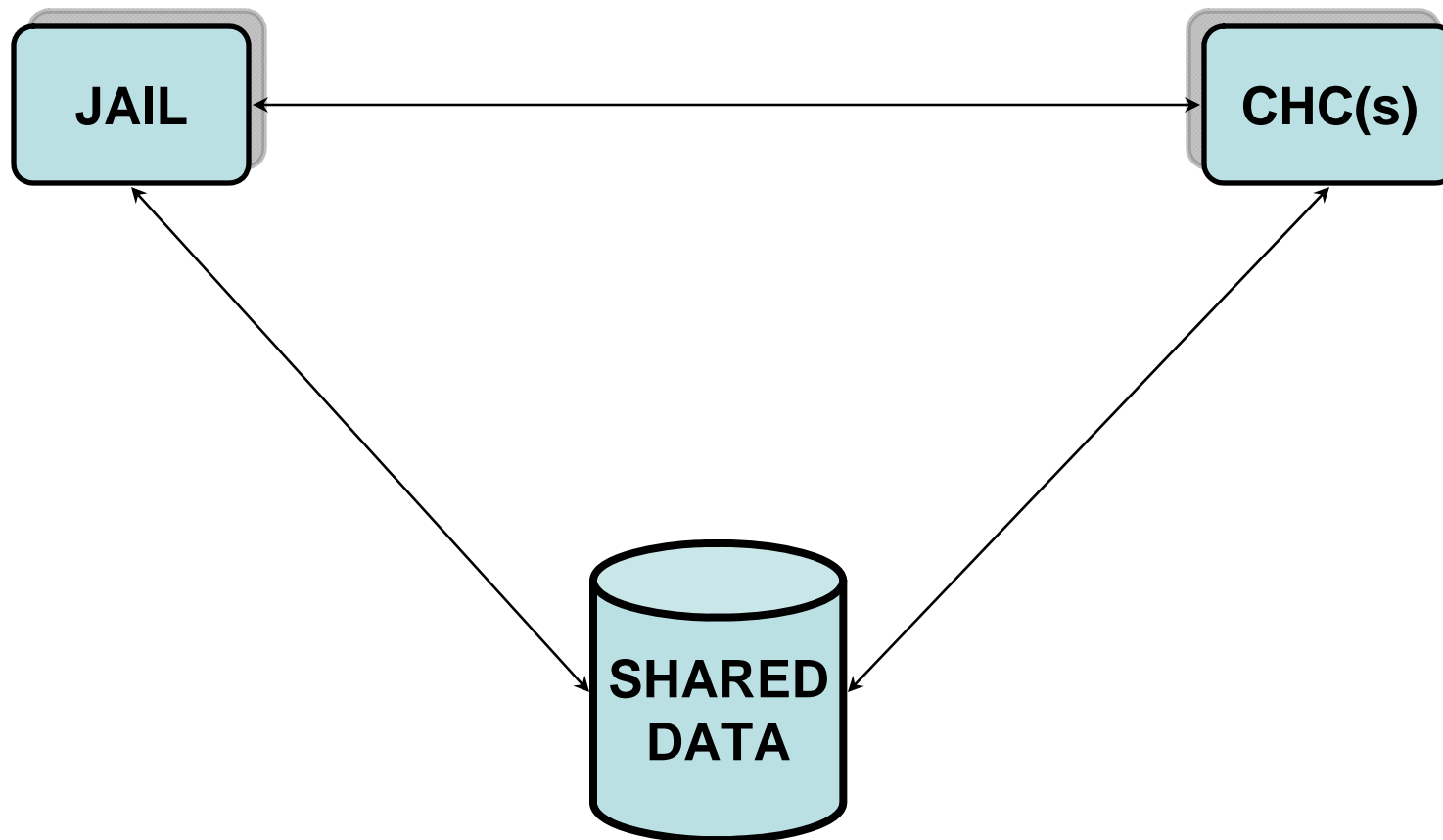
COCHS Model

Inmates unlikely to receive care upon release.	Inmates likely to receive care upon release through their CHC.
Jails pay contract private companies to provide pharmacy services.	Significant discounts may be available to CHCs through the federal drug pricing program (“340B”).
Inmates leave jail and use the emergency room for treatment of illness or chronic conditions.	Inmates leave jail and use CHCs for treatment of illness and chronic conditions, reducing unnecessary ER visits.



RHIO

Regional Health Information Organization

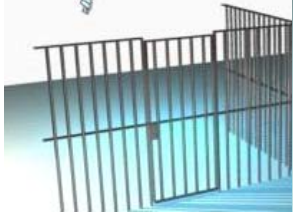


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Jurisdictional Readiness Criteria

- CHCs willing/able to take responsibility for inmate health care
- Local government needs a commitment to re-entry efforts and public health
- Understand importance of record transfer between correctional and community health care settings
- Inmate health care spending at least at national median (currently \$10/inmate/day)



Washington D.C.

Expanded Public Health Screening

Dept. of Health

- Orasure HIV
- Urine GC - Chlamydia



Link to Health Insurance Enrollment

Income Maintenance Dept.

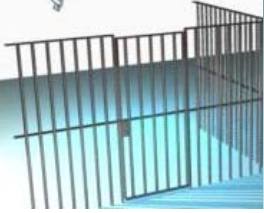
- Alliance cards issued upon discharge

Contract with Unity Health

- \$60 million → \$82 million
- 165 FTEs → 202 FTEs
- Discharge planning / Case Mgmt.
- Continuity of care
 - Jail
 - Health Center
 - Hospitalization

Create a RHIO Regional Health Info Org

- Past (history intake)
- Present (EMR)
- Future (discharge planning / case management)



Connectivity

Key to Post Release System of Care

Current COCHS activity

Primary Care Redesign & Linkage

Future COCHS opportunities

- HIV Services
- Behavioral Health
- Substance Abuse
- Juveniles
- Community Corrections