

**Academic and Health Policy Conference on
Correctional Health – Quincy, Massachusetts
Strategic Planning Meeting: March 29, 2007 1:30-4:30
Primary Care Session**

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Attendees

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Objectives

By the end of the meeting, participants will:

- **Consider the opportunities, barriers and next steps for expanding research in their field(s) within correctional health settings**
- **Consider the importance, opportunities, competencies and next steps to expanding workforce training in their field within correctional health settings**

RESEARCH DISCUSSION

Opportunities

Hot Topics based on policy need and opportunity to build on current research base

1. Harm reduction strategies

- The efforts of Canada, Western Europe etc. in terms of needle and condom provisions were cited. Why can't we do the same in the U.S. We could limit the spread of diseases in corrections and thereby limit the spread out to the public.
- What's known to be effective would be to study in CH related to outcomes, i.e., needle use and condom use. DC jail is already using condoms but no one is looking at them. Mississippi also provides condoms under certain circumstances....but not being looked at systematically.

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- Condoms are used in Philadelphia..(not PA) but none are being looked at in an organized way.
2. A malaria study done in Illinois??...in the 60s??? phlebotomist injected inmates with malaria and watched the natural history.
 3. PA has one harm reduction study intervention occurs prior to discharge.
 1. Challenges are to find and follow people after discharge/release. Suggested using Parolee's as a population
Vermont's sex offender group in Vermont have been closely monitored/followed.
 2. Categorizing chronic diseases based on controlled approach. Intent to collect data and spread...more data use than research (Ron Shansky ☺)
- hypothesis: A well organized correctional health system can achieve equal to or better outcomes than a good managed care program.
Set up a national center for NCCHC
- 1) Multidisciplinary teams have better outcomes
 - 2) Clinicians using Guidelines improve outcomes
 - 3) Single or multiple nurses managing the chronic care outcomes.
- These 3 together improve outcomes, no research to support, but he has just anecdotal data.
6. What are the factors that can predict progression of hep C? California has a lot of data that has never been studied - 500 liver biopsies.
 7. In what states is there a uniform identifier, like fingerprint to assist with the search for inmates.
 8. Patient education in prison, San Quentin is piloting groups for diabetics to manage their own DM. As it is in most settings "We" (CH providers) manage it for them in prison.
 9. Look at the reduction of recidivism through the hand off upon discharge
 - Similar to discharge from hospitals to decrease re-admission
 10. The focus of residency/fellowship should be re-entry.
 11. What is the cause of the *disease* of incarceration and why do they keep coming back? Prison is an industry...It creates jobs for communities.

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12. Incarceration is a public health issue. For the majority it's temporary housing...for very few it is permanent housing.

13. Study of attitudes of health care professionals and custody

Inventory of current status of funded research include topics and funding agencies

- There's a lot we want to do, not a lot of money.

1. Betsy Chang Ha from CA Receivership suggested that we look at what NIH, foundations, etc. are seeking to fund and fit our efforts into their needs/goals. What are their hot topics...and then fit ours into what they want studied. For example, RWJ..hot topics of IT – electronic med records, chronic care, look at the national priority agenda and create a study to fit i.e., IHI....Patient Safety. Re-Entry

2. Proposals to DOCs for the contracts should include program evaluation. This way the contractor would pay for it. Why don't they already ask for it; they should be paying it for it to get meaningful evaluation. Contract proposal should support a few PhDs and Fellows to facilitate the evaluations...to ultimately save money

3. Do research that impacts cost.

4. UTMB has it built into full time epidemiologist and pay stipends to the School of Public Health for students

Suggestions to entice funders to want to support correctional health research

- Testing research from previous populations (such as the VA) in correctional health might be a good way to sell the research to funders and to the various DOCs
- Disease Registry system would be feasible because of the closed system..electronic medical records...to make attractive to funders.
- Impact of good patient education and supportive care in outcomes. (changing life, to keep them engaged in self care and keep them in the health care system when released) Determine a creative way to keep in contact, facilitate their access to care .
- Emphasize that correctional health is a continuum of the public health of state.
 - We share our overlapping population with the county health dept.
 - Alignment of public interests and funds... ex. Detox beds in MA....3 day delay so when they enter the system they are floridly detoxing...and need acute hospital care....huge increase in the costs.

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- CTSA grants focus on pediatrics and community—use corrections as a community to help to get the additional million in these grants. Money is to be used to set up the research infrastructure within those settings.
K awards to set up young researchers with a mentor for a number of years.

NIJ as a source of funding? UCONN for mental health

NIC history of focusing on technical assistance grant to a closed shop of former directors; consulting on operational issues???? I have no idea where we were going with this one.....

HIV and mental health and sometimes substance abuse are the only ones with some sense of follow-up after release.

Where are we now regarding evaluation and monitoring of correctional health systems?

- Basically NOT outcomes driven...
State of the industry in terms of the evaluation of 1)structure, 2)process, 3)outcomes? Most correctional health systems are stuck in either one or two (mandated)? Which systems are in three? No one seems to know of any.

Where are the gaps between the two?

DOCs are in stages 1 or 2 (structure and process) while we are interested in outcomes.

Potential areas for collaboration

1) Ron's chronic disease initiative

2) UTMB and Texas Tech have the same electronic medical record..”*emerald*”..they now have the license and can modify it any way they want to. They have had it for 6 years. Their advantage is that their partnership between UTMB and Texas Tech are legislated and therefore the funding follows. For others:

Medical School involvement (unless legislated...)

- Partnership has to be a money maker
- Must find a champion in the school

- Are any groups already in place?

3) UTMB and TT would be a logical collaboration, however there is no formal relationship between UTMB and TT

- UTMB w/ California shared some data and published
- UTMB has some NIH monies predominantly in infectious disease.

Current collaboration

- 1) Uconn does work some with Yale
- 2) Health transfer summary between and among jails and prisons. Wisconsin.
- 3) RWJ is funding jails to replicate Hampden County model by zip codes. Coaches?? from Oakland have been funded.
- 4) Transitions clinics to help releases with medications, connections to health care. Primary care clinic based in one of the other clinics.

Interdisciplinary strategies that would add value and improve competitiveness

Not addressed ☹ Sorry.

UMCH has 1-2 undergraduate students per year from Worcester Polytechnical Institute (WPI) who do their senior project with a GSN researcher who is studying the Hepatitis C population within the MA DOC. These students input and analyze the data for UMCH.

Each year 2-3 UMass Graduate School of Nursing advanced practice nursing students choose to complete a 45 hour community service learning project within the MA DOC Health Service Units. Examples include: 1) a comprehensive literature review of national initiatives to address the aging populations within Departments of Correction throughout the United States, 2) an education program for inmate workers regarding personal hygiene and institutional cleaning processes to decrease the spread of MRSA. 3) Another group is currently completing a “white paper” regarding the analysis of access to care issues and recommendations for the highest maximum security male facility within the MA DOC.

Barriers

Challenges to expanding research and strategies to overcome these?

1. No one to do it. “If we had a graduate student.”
2. We are dealing with “symptomless diseases” – minimal “felt impact” from doing it right versus doing it wrong (HTN, DM, etc..)

What’s being done currently to facilitate research

1. UMass Correctional Health through Commonwealth Medicine offers grants to tie researchers to our correctional health populations.
2. San Quentin using peer educator models
3. Most DOCs are structure and process focused..not concerned about the outcomes.

ACA to communicate to wardens regarding collaboration with health care. Reach out to them.

Who's not here that should be?

- Custody folks...maybe later
- Med College of Georgia
- People working with parolees.
- Health Departments
- Look at the people that study prisons...sociologists...socio political aspect of incarceration...prison culture.
 - University of Arizona...Indian reservations, DOC, and they do an annual teleconference

Where else should we be?

Training Discussion

Importance and Opportunities

What added value does training in correctional settings provide for your discipline?

- UTMB is a separate department and building for 120 prisons with approximately 150 thousand inmates. UTMB provides for their orientation, CME, They provide the curriculum for all their staff at all facilities. A lot of it is on-line training. They have a fellowship in correctional medicine, usually 2 residents (often family practice, sometimes internal medicine) Exposed to all aspects of care: they provide care, experiencing how challenging it is to deal with the specialty programs from the "outside" 12-18 months expanded fellowship. Go on to federal prisons, they retain a significant number of them..some to public sector. They work in prisons and prison hospitals. Owen is the Director.
 - Maintaining the skill level of the nurses..rotate them out to traditional hospitals.
 - Mobile skills training center converted motor home.

The following is partially in response to Janet's question regarding DOC training requirements for students to be in the systems.

- UCONN: some psychiatry residents rotate a day a week for about 4 months. They have 6 weeks of training pre-HSU...and they train with custody part of the time. **Does this help the relationship between custody and care?** Sometimes....but worry about the health folks become jaundiced toward the inmates in the process.
- In PA, students go through same training as volunteers which is two days.

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➤ **What venues and methods are possible?**

Departments provide their objectives and their own attendings (TX).

Residents really like it for the most part because of the pathology.

Distance Learning for training:

UTMB in particular uses Distance Learning. See above.

UConn distance learning with a lot of automation and tracking system for DOC and Health.

Programs in Place

UMCH provides an interdisciplinary Clerkship every October. Eight Medical students and two-three Graduate Nursing Students are provided an immersion experience into most of the DOC Health Service Units to assess the population of the system and to shadow providers of each of the disciplines (physician, nurse practitioner, physician assistant).

Prelicensure graduate nursing students experience their psychiatric nursing rotation at the Bridgewater State Hospital.

Prelicensure undergraduate nursing students from Boston College experience a portion of their community health nursing experience at MCI-Framingham women's prison.

Graduate adult and family nurse practitioner students from UMass Worcester Graduate School of Nursing and the Massachusetts General Hospital Institute of Health Professions perform clinical preceptorships within the MA DOC. Some for one semester, some for two semesters.

UMMS has one student in his second year with a physician in MA DOC for LPP experience. Currently there are two first year students experiencing the LPP in two MA DOC facilities.

Department of Family Medicine and Community Health is developing a fellowship for Correctional Health in partnership with Infectious Disease fellow?????? Is this correct.

- **Who are the learner groups that should be targeted?**
- **What accredited programs exist?**
- **What are the institutions known for their training programs? UTMB**

Curriculum Planning

What learning objectives/core competencies are essential to working in this discipline in corrections?

- Tracking what you order for your patients to advocate to make sure it happens. Ie. Being accountable for the outcomes of your patients
- Develop the attitude that I am the one who has to make sure that things get done.
- If you are used to making sure things happen you do well in the system.
- If you don't feel responsible for the "list" that you need to see and what happened that they didn't show up, then it won't work in corrections.
- Morbidity around substance abuse and trauma and it affects interaction.
- 23 % of inmates have a hx of a gunshot wound.
- Many abused as children.
- Patient advocates against an authoritarian system that may use health care as a punishment or reward.
- Ethics of, are we teaching folks to work in a use of force environment?
- How to work in a chain of command environment with reporting relationships as well as command relationships.
- Do we understand how our security colleagues view situations and events compared to how we might.
- Use of classical drugs versus the newer more well known now thanks to drug companies etc...
- Treatment plan has to be different than it would be in the free world.
- Patients may choose not to comply, because if they do improve, ie.e, they have to go back to general population.
- Ethics should be imbedded...seem to lose site of pt advocacy role.
- Not becoming numb to the situations you are facing.
- Biggest jeopardy is in female prisons with female nurses. Female inmates have tremendous needs and nurses may just eventually shut off.
- Investigate how people feel regarding the various crimes??? Equated to abortion for rape, terminated pregnancy.

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- Clinical practice in Correctional Medicine..several chapters that could be helpful.
- UMCH focus group poster was hanging on the wall during the session. Some of the findings of these groups were explained. Can augment more for the article.

What are the ideal methods imparting this knowledge and skill?

Barriers

Next Steps

Product for end of meeting

- **8 bulleted summary points that follow from the outlines for research and/or training**
 - Harm reduction
 - Re-entry
 - Health disparities
 - Patient education for prevention of risky activities that might cause them to re-offend.
 - Long term outcomes
 - Natural history of incarceration
 - Pts who stay in longer, do better..those people being released are dying 3.5 times faster/sooner??
- Ethical considerations for research in corrections from IOM

Completed sign in sheet with contact info: (separate file) and also at beginning of this document.

Individuals identified who are seriously interested in writing up proceedings

Allison Hart Smith
Ralph Spada
Nick Scharff
Janet Fraser Hale
Arthur Brewer

Follow –up e mail summarizing meetings 2 to 3 weeks after conference by co-facilitators

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Plan conference call in May to follow up on action items and article(s)

Plan web page in CWM to include info from meeting and links