Heads and Tails of Jail Healthcare: ATI and Reentry

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Code: **AJA2021**

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ACOJA Consulting – Who We Are

ACOJA Consulting LLC is a NYC-certified M/WBE and internationally recognized team skilled in strategic planning and guidance for health and human services, public health research, and government programs.

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Don Kern MD MPH CCHP

Dr. Don Kern, Corporate Medical Director of Quality Correctional Health Care since 2014 has over 40 years of experience practicing medicine and over 20 years of experience in correctional medicine. Dr. Kern loves any opportunity to educate and explain correctional medicine to healthcare professionals and lay people. Dr. Kern provides oversight for continuous quality improvement, utilization management, and other clinical matters. He serves as site medical director for several clients and participates in the clinical on-call schedule.

Past Medical Director for Massachusetts state prisons and former Medical Director of NYC Correctional Health Services; Chief Medical Officer in Birmingham, Alabama correctional facility; and Utilization Management (UM) Medical Director for Pittsburgh, Pennsylvania based, national correctional healthcare company/

Dr. Kern is Board Certified in Internal Medicine and licensed in over 14 states. He is a Certified Correctional Health Professional (CCHP) by the National Commission on Correctional Health Care (NCCHC), where he is a past Board member and senior physician surveyor. He serves as a Senior Physician Surveyor for accreditation audits of correctional facilities. He is a Past President and member of the American College of Correctional Physicians and member of the American College of Preventive Medicine.

Graduate of Haverford College (BA), Tufts University (MD) and BU (MPH)

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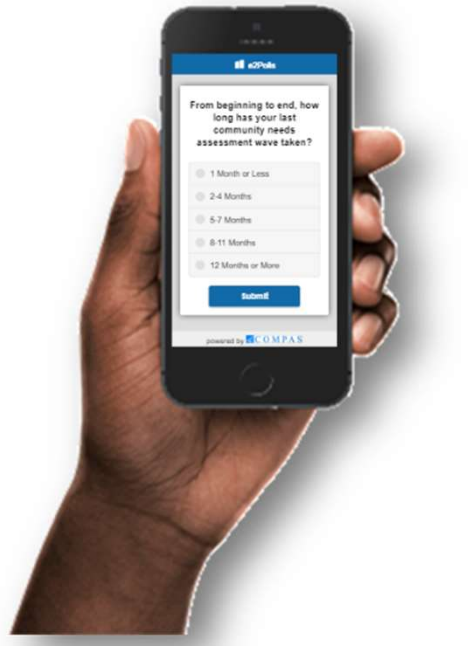
Interactive Poll



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Abstract

The beginning and end periods of incarceration are key to efficiency, quality, and improved health outcomes. Two areas that can have a significant impact on correctional health operations are alternatives to incarceration and reentry planning. Collaborative approaches can identify high risk high need patients with medically-risky and complex care needs and address health and social service needs toward improved health outcomes.

Lectures on jail healthcare tend to focus on the middle period of incarceration: chronic care, mental-health prescribing, opiate overdose, etc. Often neglected but also important to efficiency, quality, and improved health outcomes are the beginning and end periods of incarceration.

This correctional colloquium addresses two areas that can have a significant impact on jail health operations: alternatives to incarceration and reentry planning.

Building robust community and jail collaborative programs can identify medically-unstable patients (e.g., serious mental illness, etc.), as well as potentially reduce incarceration for medically-risky and complex patients (e.g., HIV, substance-use disorder, unstably housed, etc.).

Presenters include the creator of the evidence-informed Transitional Care Coordination Intervention for one of the largest U.S. jail systems, as well as a seasoned jail physician experienced in a variety of facilities.

Audience interaction is encouraged.

Moderator: Aaron Arreola, CJO, Sergeant, Imperial County Sheriff's Office, aarreola@icso.org

Presenters: Alison O. Jordan, LCSW, Principal, ACOJA Consulting, Ali@ACOJAconsulting.com Don Kern, CCHP, Corporate Medical Director, Quality Correctional Health Care, donald.kern@qchcweb.net

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Traditional Jail Health Talks

e2Polls Question 1:

What topics do you associate with traditional jail health talks?

[chronic care, mental-health prescribing, opiate overdose, etc.]

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What topics do you associate with traditional jail health talks? [chronic care, mental health prescribing, opiate overdose, etc.]

- technology use in treatment re: telehealth?
- mental health, liability, screening
- Suicide Prevention, Mental Health Care, Alcohol Withdrawal, Overdose
- Mental health
- Infectious disease screening
- Sick call, mental health, suicide watches, labs

Heads: Key Health Considerations at Jail Admission

e2Polls Question 2:

What areas might be important to efficiency, quality, and improved health outcomes at the beginning of incarceration?

(i.e. Infectious disease screening, HIV testing, Medicaid screening / facilitated enrollment, Health Liaison to the courts, ATI / ATS / Nursing home applications / eviction prevention / visitor outreach)

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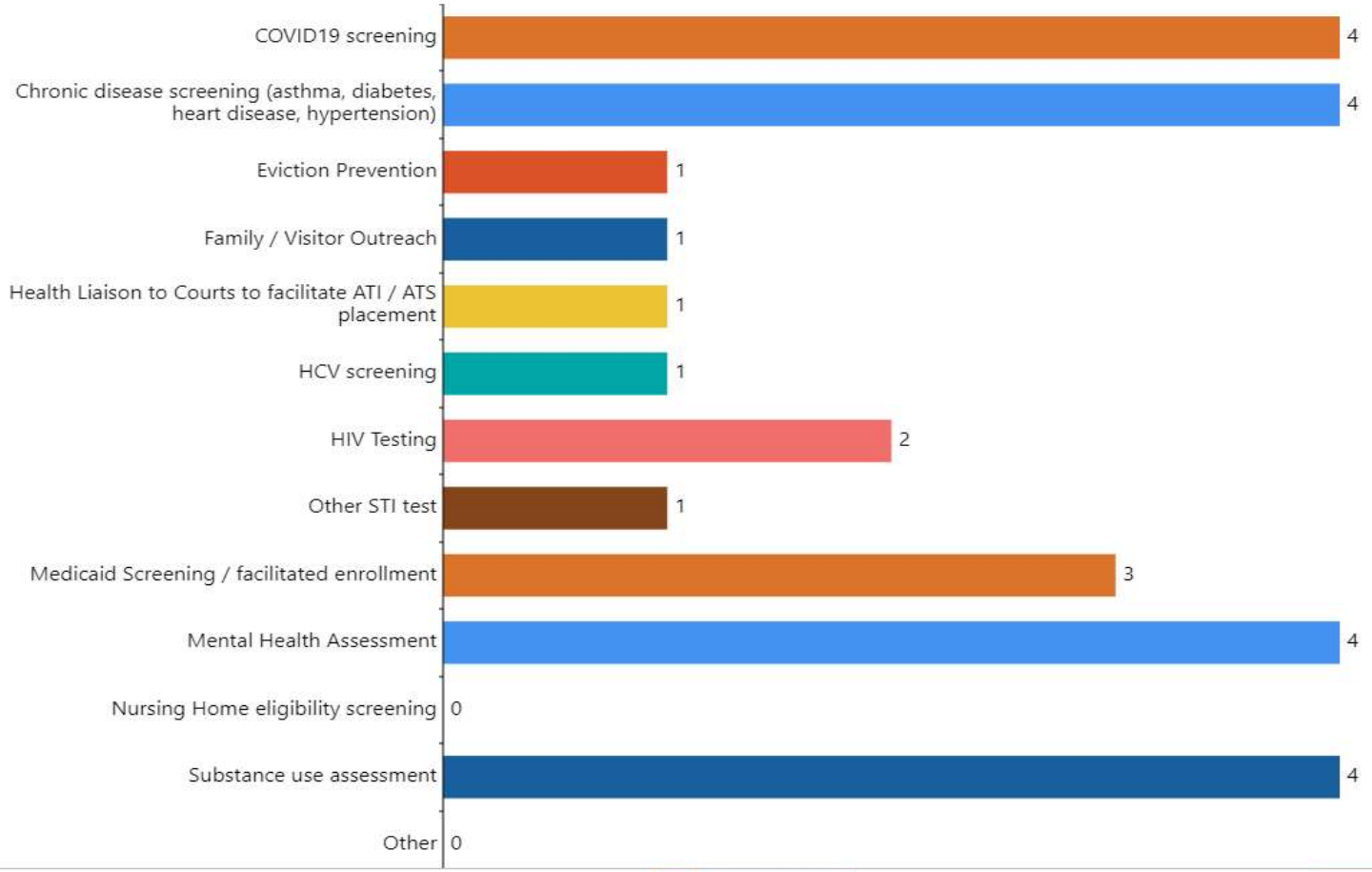
What areas might be important to efficiency, quality, and improved health outcomes at the beginning of incarceration?



Participants: 6/0

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Tails: Preparing for Community Return

e2Polls Question 3:

What areas might be important to efficiency, quality, and improved health outcomes at the end incarceration?

(i.e. Linkages to primary care, transportation arrangement, continuity of medication, community housing, employment, income assistance, accompaniment, supports)

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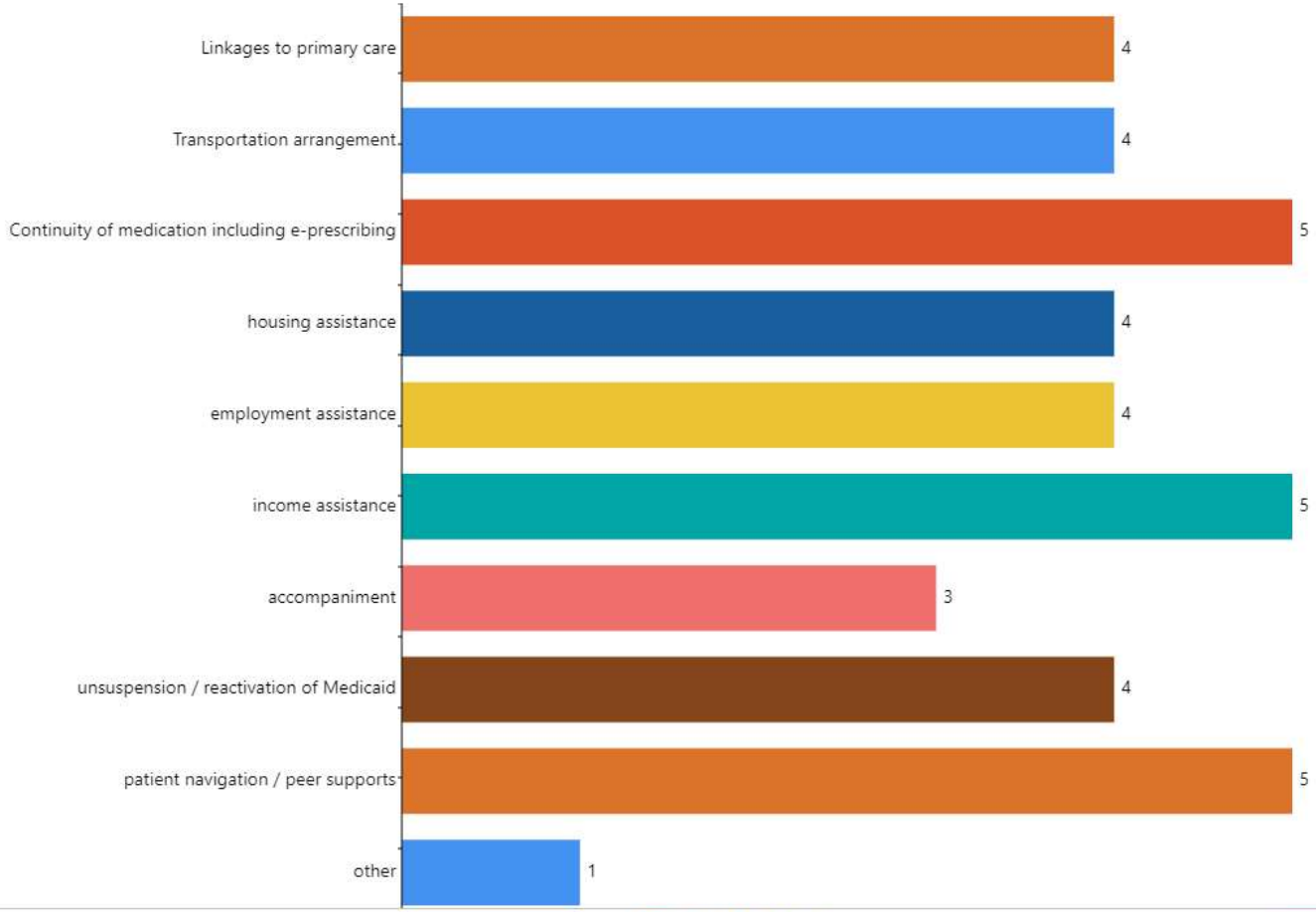
What areas might be important to efficiency, quality, and improved health outcomes at the end of incarceration?



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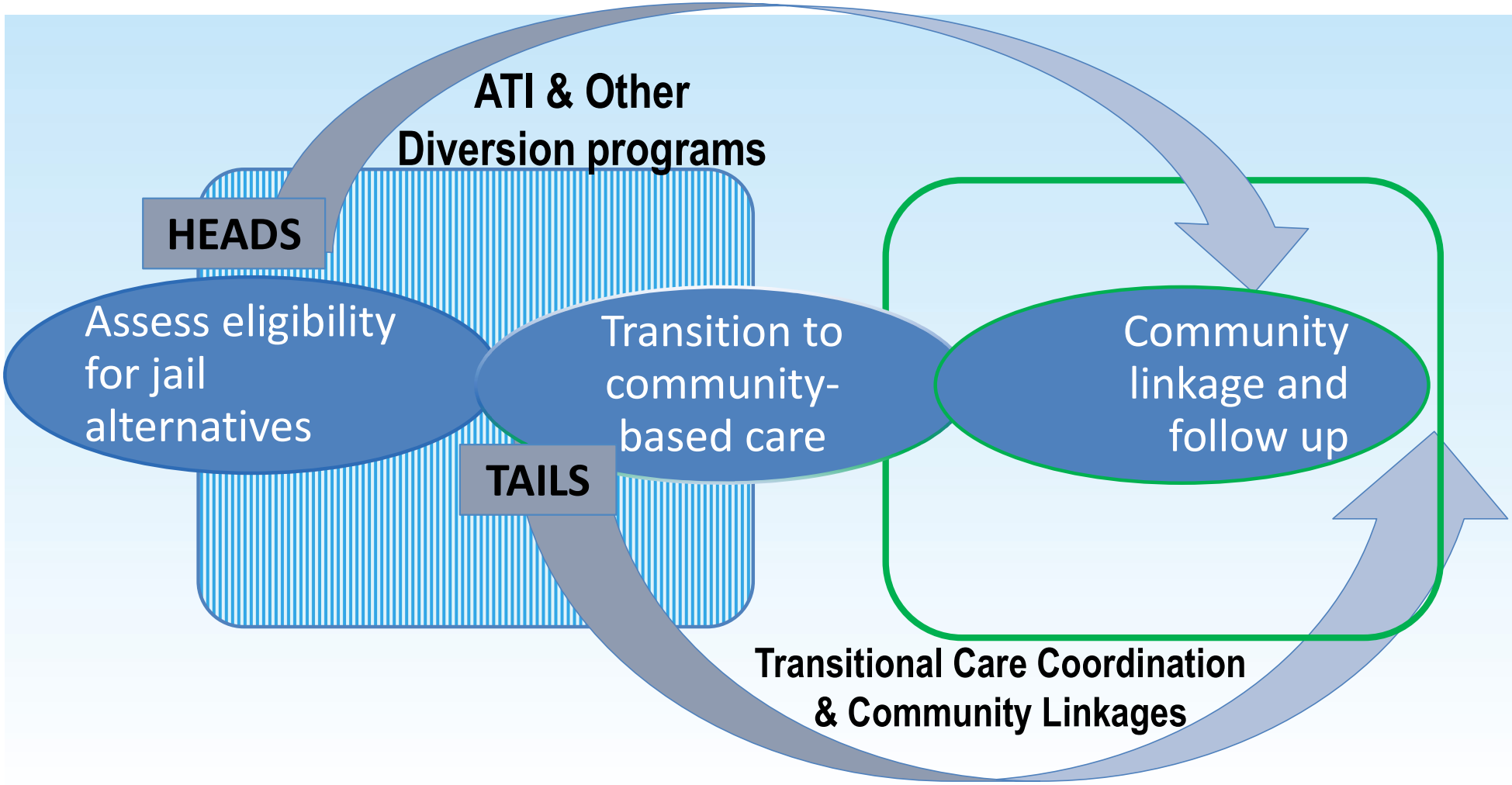
Heads & Tails of Jail Healthcare



Jail Health Care

- Constitutional right
- Begins at entry into custody
- Care costs not evenly distributed across population – a small number of patients consume the majority of health care delivery and costs
- Greatest variability in cost from:
  - Hospitalization
  - Emergency room and other off-site trips (e.g., dialysis, cancer, etc.)
  - Expensive pharmaceuticals

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Costs

- "In Multnomah County, corrections healthcare tops $24 million annually, which is paid for out of the county's general fund. It covers everything from x-rays to gynecological care." – Oregon Public Broadcasting, 24 October 2019.
- "Medical and mental health care costs for Cowlitz County Jail and juvenile center inmates will increase 13% this year." – The Daily News, Longview, WA, 26 February 2020.

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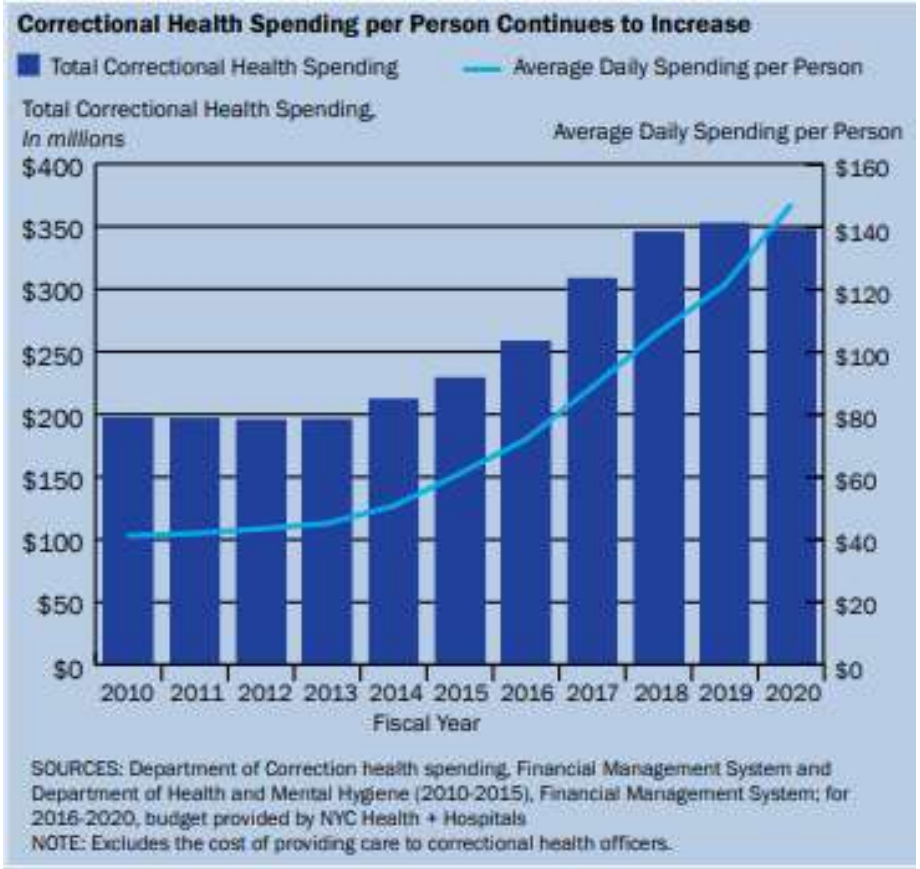
NYC Correctional Health Costs



https://ibo.nyc.ny.us/iboreports/why-has-the-cost-of-correctional-health-services-increased-in-the-last-decade-btn-september-2020.pdf

2015: Public hospital system took over (formerly Corizon with local health agency)

Cost increase from:
2010: $41 p/p per day; 13,000 ADP
2020: $247 p/p per day; 6,500 ADP

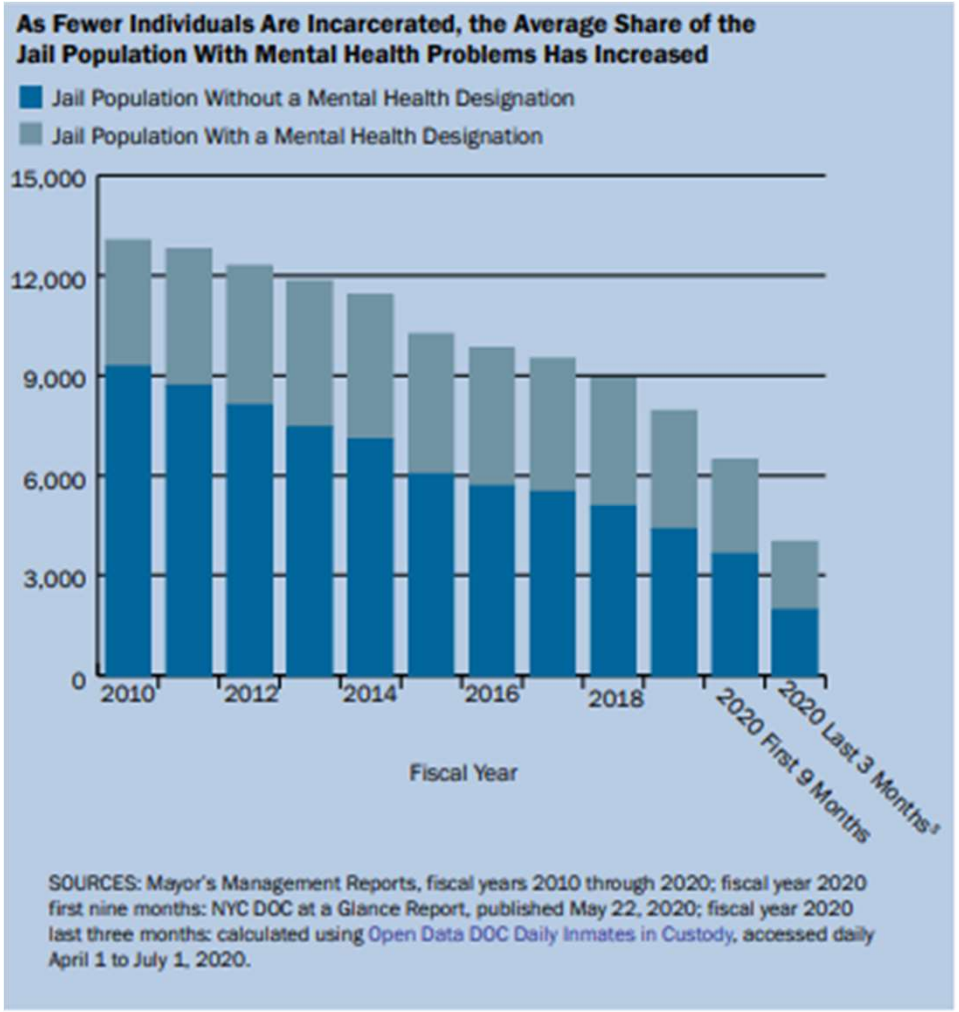
175% increase (after inflation) to
Expand and enhance services:

- Hep C and SUD
- Mental Health program housing
- Substance Use Reentry Services

Increasing Mental Health Population

"As the average daily population decreased by 60 percent from 2010 through 2020, the share of the population with a mental health diagnosis increased from 29 percent to 48 percent, suggesting the population remaining in jails, although fewer in number, may be costlier to treat."

NYC Independent Budget Office, 2020



Emergency Room

- “Texas Association of Counties made estimations for the entire state based on data gathered from respondents and concluded about $40.5 million was spent last fiscal year for emergency room visits by jail inmates, up about 53 percent from 2017 and triple that of fiscal year 2011.” – The Odessa American, 2019.
- “The average emergency room visit cost $1,389 in 2017, up 176% over the decade. “ – USA Today, 4 June 2019.

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The best way to minimize a health care cost is:

To prevent the cost in the first place.

President Reagan Shooting

- Thomas J. Baker, head of criminal division, Washington Field Office, Federal Bureau of Investigation
- “Law-enforcement cooperation is a force multiplier: That is the most important lesson of that day.”
- The same applies here: Custody and medical cooperation is a force multiplier.

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COVID-19 Silver Lining

- CUNY Institute for State & Local Governance
- Data from 26 mostly large urban jurisdictions
- For all sites comparing February 2020 to October 2020

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COVID-19 Silver Lining

- ADP in February 2020 = 68,055
- ADP in October 2020 = 58,490 (-14%)
- Bookings in February 2020 = 61,756
- Bookings in October 2020 = 44,459 (-28%)
- ALOS in February 2020 = 33 days
- ALOS in October 2020 = 35 days (+4%)

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Who is likely to be (more) expensive:

- Medically unstable at arrival at jail
- Mentally unstable at arrival at jail
- Already injured at arrival at jail
- High blood alcohol at arrival at jail
- Pregnant at arrival at jail
- Elderly at arrival at jail

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Options in pre-booking

- Set rules for situations that require hospital clearance prior to booking – make sure hospital staff understand jail health capabilities.
- Assign medical staff to pre-booking.
- Direct access to DA, Public Defender, Judiciary.
- Rapid verification of detainee story.

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Longer term approaches

- Drug Court
- Mental Health Court
- Community Corrections – Community Policing
- “Credible Messengers”
- Training, training, and more training
- County government mandating cooperation among county agencies
- Sequential Intercept Model

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Law Enforcement Assisted Diversion

- "Law Enforcement Assisted Diversion (LEAD) is a pre-booking diversion pilot program developed with the community to address low-level drug and prostitution crimes … The program allows law enforcement officers to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution. By diverting eligible individuals to services, LEAD is committed to improving public safety and public order, and reducing the criminal behavior of people who participate in the program."
- Supported by National Institute of Corrections

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LEAD Results

Compared to people in the comparison group of individuals from non-LEAD neighborhoods. LEAD program participants were:

- more than twice as likely to be sheltered,
- more than 46% more likely to be employed, and
- 33% more likely to have an income through earned wages or benefits
- 60% less likely to be arrested over the four years of the evaluation.

(Collins, Lonczak, and Clifasefi, 2015a)

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Facilitators

- Medicaid prescreening
- Discharge Planning
- Electronic health record

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Barriers

Lack of:

- Housing
- Employment
- Transportation
- Social Supports

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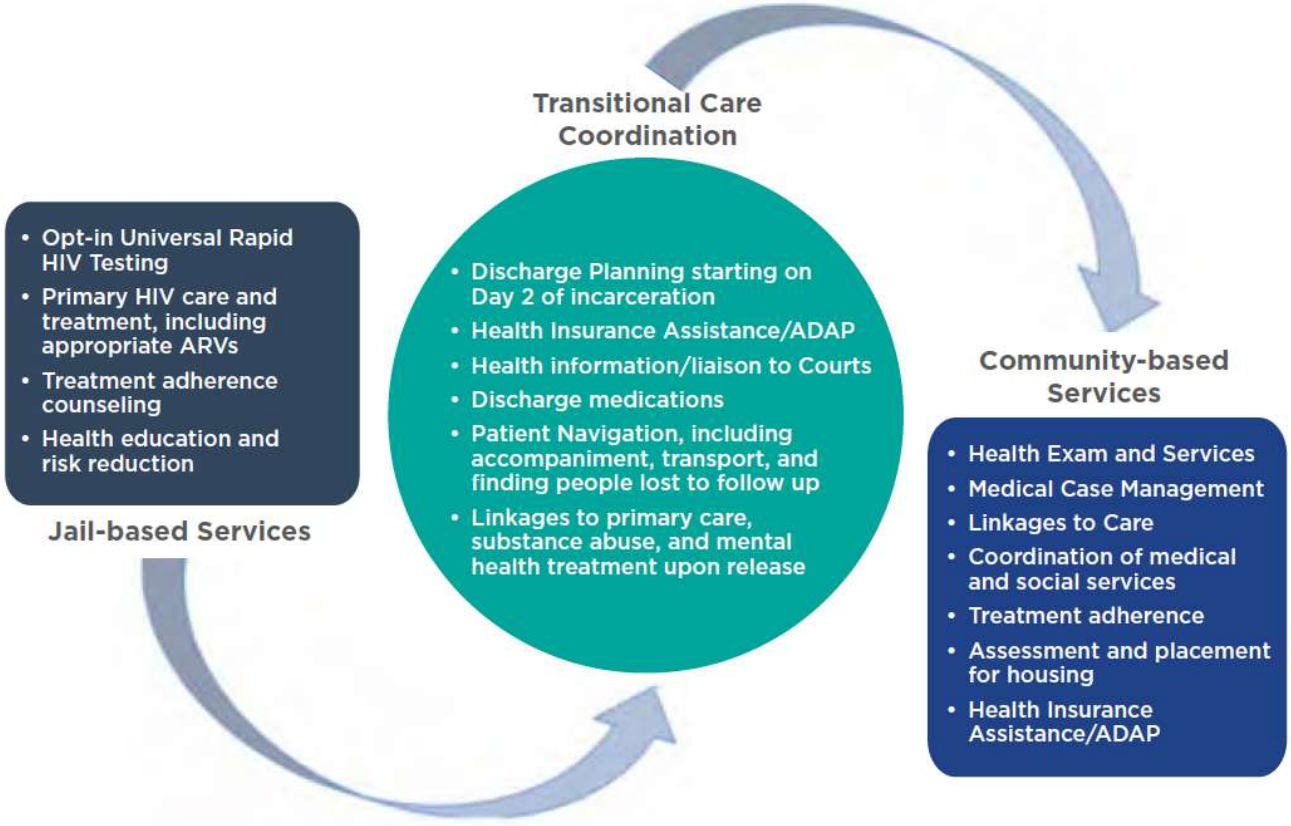
Transitional Care Coordination



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Transitional care coordination in New York City jails: facilitating linkages to care for people with HIV returning home after incarceration. PMID: 23128979 DOI: 10.1007/s10461-012-0352-5

It can take just one individual to initiate improvement and one team to sustain it.

https://www.acojaconsulting.com/providing-transitional-care-coordination-handbook

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Remove Barriers

- Address basic needs (food, clothes, housing)
- Focus on linkage to primary care post release
- Create single point of accountability
- Use eHR / Health Information Exchange

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Establish Relationships

- Smile
- Listen first - then ask good questions
- Begin where you can
- Set realistic goals
- Build trust
  - Start with winnable battles
  - Deliver

Expect to give more than you receive!

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Core Elements of TCC

Five Core Elements of the Intervention

1) Establish initial contact with the client in jail.
2) Create a transitional care plan alongside the client.
3) Facilitate a warm transition during and after incarceration.
4) Design approaches to follow -up after linkage to care to support maintenance in care.
5) Design protocols to transition clients to the standard of care 90 days post-release and close client cases.

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Transitional Care Services

- Identify population – use electronic health records
- Engage client – access to housing areas
- Conduct assessment – universal tool
- Coordinate post-release plan – Primary care, social service, treatment
- Screen for Health Insurance / Benefits – facilitate Medicaid enrollment
- Continuity of medications – eprescribing / discharge meds 7 days + Rx
- Facilitate continuity of care
  - Transfer summary Make appointments / walk-in arrangements
  - Arrange transportation / accompaniment

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Linkages & Maintenance in Care

- Document linkages to care
- Hold community partners accountable
- Culturally responsive care
- 90-day follow-up as a benchmark

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More than Primary Care

- Medical case management
- Substance use treatment
- Housing & employment services
- Court health liaison
- Community outreach to reengagement

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Health Liaison to the Courts

Facilitates

- Community alternatives to incarceration (ATI)
- Medical-informed placements in lieu of continued incarceration, such as
  - Program placement (e.g., substance use treatment)
  - Compassionate release (e.g., skilled nursing/hospice care)

Service plans address

- Individual health and social support needs
- Public safety

Gathers health information, including

- Medical summary, labs, TB screening, and psycho-social Patient review instrument (PRI) for nursing home placement
- Patient care management needs (e.g., letter from MD)

Coordinates care plan with

- Defense attorney and jail health staff
- Community and jail providers

Advises courts/prosecutor with defender permission

Requires participant consent. FIRST contact defender for permission and to collaborate on the right first step.

https://apha.confex.com/apha/143am/webprogram/Session46024.html

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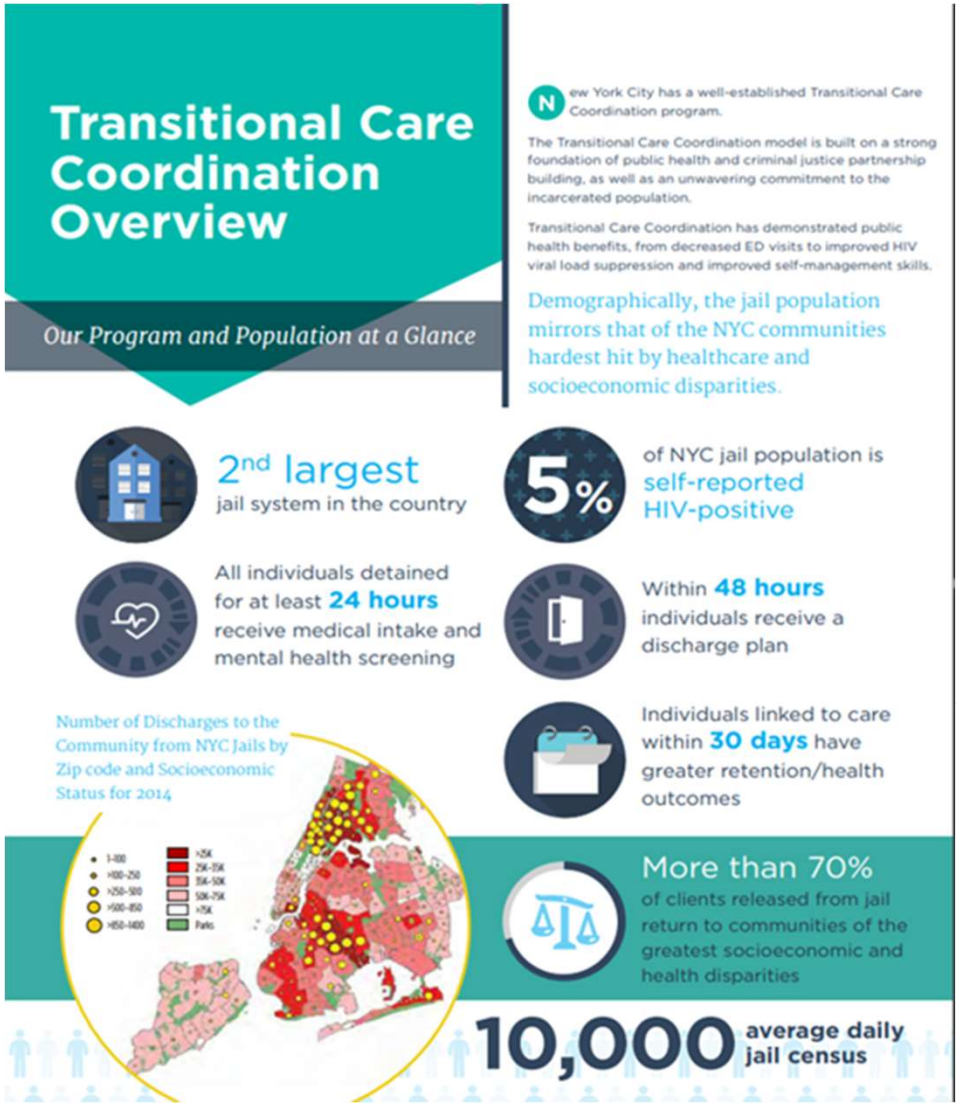
SPNS Correctional Health Linkages Initiative Outcomes

Fewer visits to the emergency department, from 0.60 per person in the 6 months prior to baseline to .20 visits at follow-up

Housing instability and food insecurity decreased from over 20% at baseline to less than 5% at follow-up.

Individuals also self-reported **feeling in better general health.**



Opiate Overdose Prevention Training

2014:
Piloted nation's first Opiate Overdose Prevention program for jail visitors.

4/14 to 1/19:
37,000 doses distributed to 29,000 NYC jail visitors.

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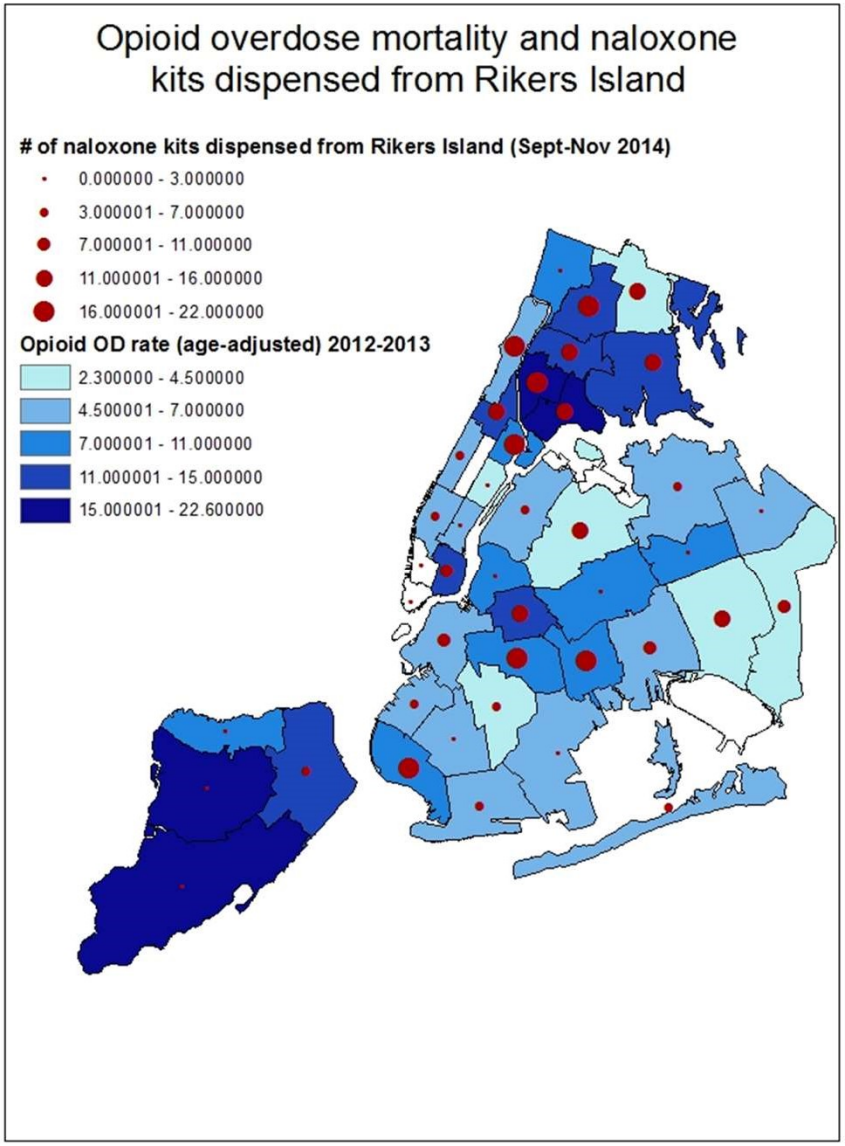

Community Outcomes:

Visitor Opiate Overdose Prevention Training

Witnessed overdoses and naloxone use among visitors to Rikers Island jails trained in overdose rescue

Zina Huxley-Reicher[a,*,1], Lara Maldjian[a], Emily Winkelstein[a], Anne Siegler[b], Denise Paone[a], Ellenie Tuazon[a], Michelle L. Nolan[a], Alison Jordan[b], Ross MacDonald[b], Hillary V. Kunins[a]

[a] *New York City Department of Health and Mental Hygiene, 42-09 28th Street, 19th Floor, Long Island City, NY 11101, United States*
[b] *New York City Health + Hospitals, 55 Water Street, 18th floor, New York, NY 10014, United States*

HIGHLIGHTS

- A 6-month prospective study of NYC jail visitors to Rikers Island trained in naloxone.
- Of the 283 participants enrolled, 14% witnessed at least one overdose.
- Of the 283 participants enrolled, 10% administered naloxone at least once.
- The naloxone use is comparable to similar interventions for high-risk populations.
- Training jail visitors is effective at reaching a population at risk of overdose.

https://doi.org/10.1016/j.addbeh.2017.11.029

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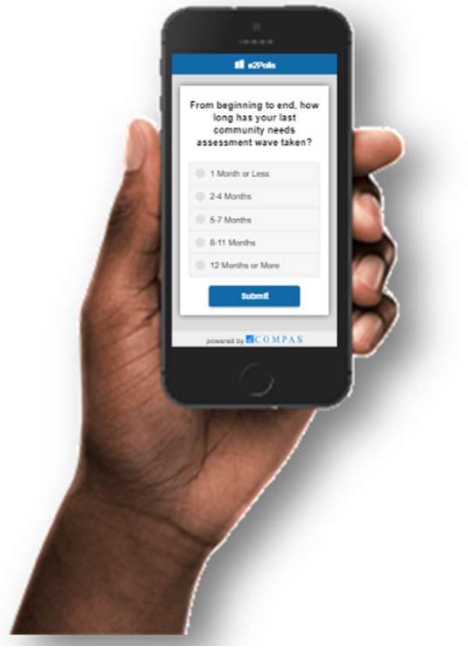
Interactive Poll Results

View full slideset with Poll Results at www.ACOJAconsulting.com



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[WHITEBOARD] Please list all your comments, reactions, questions, and ideas here as you participate in this workshop.

we have a triage worker who focuses on short-stay offenders. Short stays are frequently SPMI who are arrested with nuisance arrests. The worker has developed a trusting relationship, as they see them frequently, once the trust is built they are more amenable to working on some reentry planning

Checking in with friends

What's next? Please share what interested you in this session. What other information or resources would you like to know about at the intersection of corrections and community health? HIT Support? Discharge Planning? Transitional Care Management? Correctional / Community collaboratives? Other?

all of the above - I am happy to say our county does a lot of these things already

Healthcare provider

Mental Health and the reasons people in crisis are taken to jail instead of a facility to help them.

Continuing the dialogue

Hearing from Dr Kern

Let's stay in touch!

Request additional information, resources, Tools + Tips Handbook and more at:

www.ACOJAConsulting.com

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