2013-06-18 14.01 BRIDGING CRIMINAL JUSTICE SYSTEMS AND COMMUNITY HEALTHCARE_ INTEGRATION%E2%80%99S ROLE IN REENTRY

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BEGIN TRANSCRIPT:

LAURA GALBREATH: …Community Healthcare: Integration's Role in Reentry. My name is Laura Galbreath. I serve as the Director for the SAMHSA-HRSA Center for Integrated Health Solutions, housed at the National Council for Community Behavioral Healthcare, and I will serve as your moderator for today's webinar.

Today's webinar is being recorded, and all participants are in a listen-only mode. You can find the call-in number for the webinar on the right-hand screen. Questions may be submitted throughout the webinar by either typing in your question in the dialog box, or raising your hands, and when we get to the Q&A I'll open your phone line.

We'll answer as many of your questions as times allows. And at any point if you have technical difficulties, please call Citrix at 888-259-8414. Today's slides are currently posted online on the CIHS website, integration.samhsa.gov, if you'd like to go there and print those off. You can take notes as you go along.

And lastly, just please make sure to provide your feedback by pulling up the short survey at the end of the webinar. We do review that to inform future webinar topics, so it's very important to us. [0:01:23]

We're very happy at CIHS to be working with Community-Oriented Correctional Health Services, based out of California, for today's webinar on this topic. And with other 1500 individuals registered for today's webinar, it really, to me, highlights the interest and attention needed to bridge the integration of primary behavioral health and local criminal justice systems.

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In today's webinar you'll hear from Marsha about a public health approach to this issue, and then you'll hear for two examples of integrated care to show how different public health departments have approached this issue. We'll have ample time for questions and a discussion, but again, we may not be able to get you every single question at the end of today's webinar. [0:02:08]

With that, we'd like to start off with a poll question to get a little better sense of your engagement in this area. So the question should be coming up. It is a simple yes/no question where we're going to ask you: Do you currently have a clinical or administrative relationship with your local jail system? Please take just a moment to type in your answer. We'll leave the poll open.

While the poll is going on, I just want to remind folks that today's webinar is kind of focused on a primary care audience with a focus on even how do we work with public health and across the systems to really serve the need of this emerging population in reentry. And, you know, there's a lot of different stakeholders who have registered, and we'll do our best to get to your different questions. But note that this was planned with a primary care focus in mind for today's webinar. [0:03:12]

Thank you for your voting. At 80 percent, and we'll go ahead and close off the poll question; then we'll show you the results. The results should be shown on your screen with 81 percent of you voting. Fifty-eight percent of you have a current existing clinical or administrative relationship with your local jail system, and 40 percent, 42 percent, said that no, that you do not currently have a relationship. Our hope is that by the end of today's webinar, whether you currently have one or not, that you'll be able to take the next step and have some ideas from the different presenters that we have joining us, with us today. [0:04:00]

So thank you for that, and again, typing your questions at all during - any point during the webinar, and we'll make sure to break at several points to answer those after different presenters. And with that, I'm going to turn it over to Marsha Regenstein, who is a professor with the Department of Health Policy, School of Public Health and Health Services at George Washington University, to get us started. Marsha?

MARSHA REGENSTEIN: Thanks so much, Laura. Let me begin first by underscoring the importance of today's topic. Two critically important changes have occurred over the last decade that should bring enormous benefits to correctional health and support efforts to facilitate integration of the jail-involved population into communities all across the country. One of these changes involves the advanced technical knowledge associated with electronic systems to help create seamless health records for individuals who interact at various places within our entire healthcare system. [0:04:57]

Advances in HIT are really a game-changer in transforming a wish list of care coordination and integration activities into real everyday best practices. And of course, the second game-changer is the Affordable Care Act which expands health insurance for poor and near-poor individuals, in part by eliminating certain categorical requirements in the Medicaid program that effectively left most poor adults completely out of coverage. People who spend some time in jail - and the

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majority of jail populations actually spend relatively little time in jail and rejoin their communities within a month or two. These people are exactly the group that can benefit the most from health insurance and benefit expansions and mechanisms to create continuous care, more coordinated and integrated primary care, specialty care, mental health treatment, and substance abuse services. So with that, please, next slide, please.

I'd like to provide a bit of background on what the jail population looks like in this country to frame the issue and really emphasize the size of the population and its importance in terms of the goals of the ACA, which are to improve healthcare, provide better health, and reduce costs. [0:06:17]

Let's look at estimates for our current year, 2013. Over the course of the year, we estimate that ten million people will spend some time in jail. In terms of number of jail stays, that's about 11.8 million separate jail stays, and on any given day there are about 736,000 people in jail.

Let me step back now just a moment and talk about the entire incarcerated population. Today on this call we're concentrating on the jail population because it's very large and it's a population that moves quickly between jail and the community with opportunities for the jail to serve as a bridge or liaison to critically important primary care health services, as well as really desperately needed mental health and substance abuse care. [0:07:04]

As you know, people can be incarcerated in jails or prisons. Jails tend to be local facilities owned and operated by county officials and county employees. Prisons are state or federal correctional facilities. If we look at a day count of everyone in the country who's incarcerated, the number is about 2.2 million. I already mentioned that about 736,000 of these are jail inmates. The rest, about 1.5 million, are prisoners in state or federal prisoners (sic). Prisoners tend to be incarcerated for longer periods of time, whereas jail inmates are in jail, on average, less than 30 days. Over the course of the year, many more people are in jail than in prison, and they spend a lot less time there. This creates some challenges for jail and community programs to create partnerships to help jail-involved individuals determine eligibility for health insurance and other social service programs, enroll in these programs, and engage providers to support their needs, especially for mental health and substance abuse services, as they reenter the community. [0:08:12]

It's also important to note that the majority of people in jail are unconvicted. This group is also referred to as those individuals who are pending disposition. We're going to talk about coverage in a few minutes, but it's important to note that health reform distinguishes between this group of unconvicted individuals who are pending disposition and other inmates.

Over the past couple of years, there's been a decrease in the total number of individuals in jails. It's not clear whether this trend will continue, and certainly, there are many, many counties around the country that are experiencing serious crowding problems in their jails. But overall, there's some good news in terms of the potentially shrinking jail population. Yet, the dip in total people incarcerated won't come close to toppling our world record as the country with the highest incarceration rates. The U.S. incarcerates, in both jails and prisons, about 937 of every

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100,000 adults. Only Russia comes close with the world's second highest rate, a rate that's still only about 82 percent of our rate. You'd expect Canada maybe, that rate, to be low, right? It's about one-sixth the U.S. rate, but China's rate is also much lower, exactly the same rate as Canada, about one-sixth of the U.S. Next slide, please. [0:09:31]

So really, if anyone cares about health policy or health practices for vulnerable individuals, efforts to improve care coordination and access to critically important services for jail populations should be at the top of their priority list. The characteristics of people in jail - I'm talking about adults, ages 18 and above - are very different than those of the general population. Jail inmates are much more likely to be male, but 13 percent of jail inmates are women. And while this number had been growing for a while, the percentage has stayed pretty flat over the past several years. Statistics on income of jail inmates is old, it's from the early 2000s, but it's probably still correct. We know that the majority of inmates are poor or near poor. Black men are represented in disproportionately high numbers among jail populations. While 1 in 106 white men in the U.S. are in jail, the rate for black men is 1 in 15, and for young black men, the rate is even higher. One in every nine black men between the ages of 20 to 34 is behind bars. [0:10:42]

Jail inmates have lower rates of education, are much more likely to be never married, are 14 times more likely the general population to have been homeless in the year prior to arrest. And half of all jail inmates indicate that they have a family member, most often a parent or sibling, who's been incarcerated. Next slide, please. [0:11:05]

The rates of mental illness and substance abuse is staggeringly high among jail populations. Jails are in fact the single largest residence for people with behavioral health needs, and their isolation can create serious siloing in terms of care delivery and coordination across primary care, prevention, and mental health and substance abuse treatments while in jail, and also on reentry into the community.

But the so-called isolation of this large group of individuals while in jail with these kinds of substantial, costly, and treatable health conditions can also create an opportunity to screen, identify, develop a care plan, partner with community organizations, share health information, and create discharge plans for better access to care for the full complement of health needs. [0:12:00]

People in jail are more likely than not to have a mental health problem. Sixty-four percent have a mental health problem when they're in jail or in the year leading up to arrest. And an even higher percentage, 68 percent, have some sort of drug dependence or abuse. They also have higher rates of infectious diseases, such as TB and HIV/AIDS, and also high rates of other conditions like arthritis, hypertension, asthma. Next slide, please.

So what does healthcare look like now for jail inmates? Some jails have developed excellent health programs both to care for inmates while incarcerated and address their physical and behavioral health needs. But the average jail is really, honestly, not in the healthcare business. Health services are limited and fragmented at best. The facilities and logistics are not designed

for comprehensive health screens or services, let alone enrollment in reentry programs for insurance coverage and links to community-based care. [0:13:01]

Inmates have difficulty accessing care once out of jail, and community agencies face barriers reaching into jails to begin the process of integrating a soon-to-be-released inmate into the community. Right now, communities across the country face real shortages in terms of health services and health professionals, especially in the areas of primary care, mental health care, and substance abuse treatment. Medicaid has traditionally not covered substance abuse treatment for adults, a situation that will change with the requirement to provide essential benefits that include substance abuse treatment in expansion states. But exactly how these benefits or programs play out in the next years remains to be seen. The opportunity exists though for agencies to shape these programs early on so that they provide the right mix of care management and treatment to people facing reentry and use information across sites of care to increase the efficient use of resources. [0:14:00]

Getting back to my earlier point about the game-changers, health reform, both from an expansion and also from an essential benefits perspective, may finally result in millions of people who desperately need highly coordinated health services that include substantial mental health and substance abuse treatment, getting the care they need.

Jails may not want to be in the healthcare business, but their inmates so desperately need these services that they need to partner with local agencies and help bridge the gap between incarceration and care. Next slide, please.

Many of you may be familiar with this slide. It's from the Kaiser Family Foundation, and it illustrates what groups will benefit from the Medicaid expansions. As you know, in states that choose to expand, individuals would be eligible for Medicaid if they're in households with incomes below 138 percent of poverty; that's that 133 percent of poverty line, and then there's the five percent income set aside, or disregard. So it's essentially incomes below 138 percent of poverty. [0:15:10]

Children and pregnant women are already covered at levels that are higher than this floor, and they'll continue to be covered at these higher levels; they won't be part of the expansion population. The Medicaid expansion is all about bringing poor and near-poor adult men and women into coverage, and this targets precisely jail-involved individuals. Next slide, please.

So who will be covered under the Medicaid expansion? In May 2013, the Congressional Budget Office revised its estimates of the impact of health reform to reflect the Supreme Court's decision that states may choose not to expand Medicaid. The latest estimate is that there will be about nine million new Medicaid-enrollees in 2014, a number that will rise to about 12 or 13 million over the next decade. [0:16:00]

Given how many jail inmates are poor, we estimate that about six to seven million jail inmates could qualify for Medicaid based on their income, but that assumes that all states take the expansion, which is clearly not happening. Adjusting for some states expanding and some not,

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we believe that about three to four million new enrollees will be people who have been in jail at some point during the year, which means that about 20 to 30 percent of new Medicaid enrollees are likely to come from the jail population. Next slide, please.

What about jail inmates in the Health Insurance Exchanges? We believe some new exchange enrollees will come from the jail population as well. CBO also revised its estimates about the numbers of Americans who would enroll in these new health insurance markets. The latest estimates put enrollment at about seven million in 2014, and then with that number growing to 24 or 25 million towards the end of the decade. [0:17:03]

It's a bit harder to estimate the jail population who will be in this group. It's possible that about two to three million inmates could get subsidized coverage through the exchanges. Again, requirements related to essential benefits that include a comprehensive set of benefits with mental health and substance abuse services could improve access and quality of care for jail populations through this coverage vehicle as well.

One additional note: The ACA includes an interesting provision related to Health Insurance Exchanges and jail inmates. The ACA includes language that explicitly allows incarcerated individuals pending disposition of charges, to enroll in health plans participating in state health insurance exchanges, if they otherwise qualify. It will be interesting to see how this provision plays out over the next several years. Next slide, please. [0:18:03]

What can we expect as a result of these policy changes? Many of you may be familiar with the notion of the triple aim. It's a concept that Dr. Don Berwick, former Acting Administrator of CMS, developed with colleagues that sets a three-part goal for improvement in the healthcare system. These three goals are better health, better healthcare, and lower costs.

If you think about the jail population and their need for effective primary care, behavioral health, and care coordination, and the costs that are borne by all of us, including communities, jails, and the individuals themselves who are incarcerated there, this may be the opportunity to harness new coverage, new benefits, and new information technology to really advance population health for an extremely high-risk group of people. Evidence shows that when people are connected to a source of health insurance upon reentry to a community, recidivism rates go down. This truly could be a triple win. And with that, thank you. I'm going to turn the mike back over to Laura. [0:19:13]

LAURA GALBREATH: Great. Thank you so much. We appreciate that context. It will really help us as we dive in now into hearing from two examples of work that's being done in communities across the country. Vanetta, are you there?

VANETTA ABDELLATIF: I'm here.

LAURA GALBREATH: Great, welcome. This is Vanetta Abdellatif, Director at Integrated Clinical Services, and turn this over to you to share what you guys have been able to do in the Portland, Oregon area.

VANETTA ABDELLATIF: Sounds good, thank you very much. I'm going to do a brief overview of just generally how corrections health is organized in Multnomah County, and then I'll highlight what we've done with implementation of electronic health records. Next slide. [0:20:00]

So Multnomah County is within Portland, Oregon. Our community is a mid-sized city, about 735,000 people, and I am responsible for personal health services within the department, so anything that is individualized delivery. So I have responsibility for the community health center as well as jail health. And so within my service area we have 35 sites which include three jail sites and about $160 million budget for the overall department and about a thousand FTEs in the overall department. Next slide.

The Multnomah County Health Department, as with any public health department, our overall goals are to assure, promote, and protect the health of Multnomah County residents. Go ahead, next slide, Laura. [0:21:00]

And Integrated Clinical Services is the unit within the health department in which jail corrections health is housed. Under our individualized client services we have eight primary care sites and six dental sites throughout the city, and those are collocated; 13 school-based health center sites throughout the city; and four different school districts; seven pharmacy sites, which are collocated with community health centers; an HIV services center; and three corrections health sites. We provide clinical support within electronic health records and electronic dental records and practice management systems that go throughout integrated clinical services and our quality assurance. We're joint commission accredited, M2-THC (ph) accredited, and we have eligibility screening to get people enrolled in the Oregon health plan or our Medicaid program. Next slide. [0:22:00]

This slide just gives you an overview on our virtual tours, some of the sites throughout the city. On the bottom right is the main site, which is the adult jail and the booking center for Multnomah County. Next slide.

Overall within the community health center, we are a large community health center. Last year we provided about 70,000 individuals with 240,000 visits in primary care and dental services. The majority of our clients are poor at 100 percent or below of FPL, and at 200 percent or above FPL covers the rest of our clients. Next slide.

Corrections health; we've touched bases on this. We provide services through three facilities: At the detention center, Inverness Jail, and Donald E. Long, which is the juvenile detention center. And we have over 100 employees, a couple of physicians, nurse practitioners, and the nurse practitioners are our psych NPs. And also nursing care and certified medical, medication aides to do medication disbursements. Next slide, please. [0:23:34]

In 2012, corrections booked about 35,000 clients, and the average daily sentence is around 1280. We have approximately 1370 beds in our three jail sites. Our length of stay is fairly short, around

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13 days, and percentage of females who are being booked in our jails is around between 18 and 25 percent, and the males, of course, are the majority. Next slide. [0:24:10]

This slide just gives an overview of the services that we provide in corrections health. Next slide.

So we're going to talk a little bit about electronic health records. About four years ago, the jail services were reviewed by the county auditor. And in that review, there was a recommendation made that the cost of moving physical records from site to site was very inefficient and extremely costly, and at that time there was a recommendation to move forward on electronic health records. We had to implement electronic health records in the primary care sites as early as 2006. But in the jail, the funding source for electronic health records was nonexistent. Once the county auditor made that recommendation to go with electronic health record, the county chair at that time had created an innovation fund to fund ideas and investments that were going to save money down the line, and that's where we were able to get resources to look at electronic health records. [0:25:21]

So, you know, some of the problems that we had before those records were really trying to move from - kind of joining the 21st Century and moving from having to actually look around for all of these notes, having a ton of - [fill the space] (ph) set aside for physical records. And also we had problems with accessing and gathering of data and connecting with community providers because of having to look through voluminous notes.

Now that we have the EHR and we implemented it in October of 2012, we are connected within our whole system. We're able to access records simultaneously throughout the system. And then this was some of the other benefits that we have found since we implemented in the fall. Next slide please. [0:26:16]

One of the points that Marsha made that we have found and went into the decision of organizing corrections health under a leader for community health centers is that we know that the clients that we serve in corrections are coming from our community. And so we've structured our program so that we are sharing some resources that are going to be the same whether or not you're in jail or outside of jail. So how we oversee the medical delivery pieces in the health department and provide that kind of support and oversight to corrections.

The dental services and the dental director is within the health department and provides 0versight to policies and delivery within the jail, and we know people are going in and out. So we have a public health perspective in the types of services that we provide and how we approach clients that we're serving in the jail. [0:27:17]

Our record is shared among the community providers here in the Portland Metro area, so we have access to care everywhere. And if our clients have been seen outside of the jail, let's say, in an emergency department in one of our local hospitals, we're able to access that and it keeps us from having to duplicate some of those tests.

There is a mission within Multnomah County to really look at integrating those clinical services. So, you know, part of our belief is that if we are able to not duplicate services, understand what types of touches our clients have had... And, you know, the majority of our clients are uninsured, so, you know, it's limited in the number of kind of medical or behavioral health touches they've had outside of the jail. But if they've had those, we want to be connected to that so that we're not repeating and we can kind of support community providers in the care of the folks that we're seeing. Next slide, please. [0:28:20]

This kind of describes our early foray into looking at an electronic health record. We had one false start. We went with a - we had looked at a product that we thought we could take something off the shelf and use that. And our thought at that time was that it would save us money in not having to make a lot of modifications to an electronic health record.

What we found when we were pretty far down that pathway is that it siloed our records. We were not able to actually meet the clinical needs and the documentation needs of the providers. And we evaluated that it was going to be more costly for us to take something off a shelf that seemed that it would be less expensive. But the amount of cost and the inability to connect with our providers within Multnomah County, but along the community, were much higher than what it would appear in just the actual maintenance and implementation costs of that record. [0:29:29]

So we took a pause in our project, and we started to evaluate looking at the Epic product to move forward. The other piece is Epic had developed further in the time that we had gone the pathway of looking at another product, and the Epic leadership had made a decision that they were open to providing electronic health records to a correctional facility; when we first looked at the product in 2009, they weren't open to those conversations. But once they were, we were able to take advantage of some of the modules and smart sets that we'd already built for primary care and utilize that in our corrections health program. And so that is part of why we chose the Epic product to use in the jail. [0:30:17]

The other piece is Epic, in our region, is the dominant provider. About 80 percent of the health systems in our community and other providers are using the Epic product, which makes connectivity and coordination much easier in this region. Next slide.

I'm kind of touching on the expectations. We wanted to improve the management of our healthcare information. We have one clinical systems management group that works across the apartment to provide support to Epic within the health department, and they do that for both the community health centers as well as jail health, so we're able to leverage existing resources.

We wanted to improve access to appropriate healthcare information during clinical encounters and had some really good success even on the first days in pulling out the information from our local emergency departments, which was great. We also were looking at improving overall clinical care for our client by connecting to community providers, and I touched bases on that previously. [0:31:18]

We are still in the process of streamlining our own work processes. The implementation is new, and I anticipate it will take us at least a year to really look at all of our workloads and to make them work with this new tool. Next slide.

These pieces we've talked about before. We anticipate improvements to quality and timeliness, appropriateness of care. We're looking at developing and utilizing current clinical reports to measure on population-based types of challenges that we're finding in the jail, like diabetic care, for instance, or how many of our clients are receiving the PHQ9 screenings, and what kind of treatment plans are in place for those folks, and seeing whether or not it makes the difference in their care. So we're starting to look at that and bring that across into the jail. [0:32:14]

Reducing duplication, which has been really good. We were able to eliminate the transportation of these charts from jail to jail and actually have the records where they need to be. Patient and client movement within the two jails was a real problem for us, and we didn't have the data where we needed to have the data. And that has made a huge difference for our clients' quality of care, but also the staff's ability to do a better job, and of course, the clinical outcomes and litigation.

And we spent quite a bit of time during the implementation, working with the county attorney's office, as well as our IT people, to look at how our staff document in this new record. And we're on a shared server with other community providers. And so how do we actually put things in the record that are going to provide adequate information to the clients, but also - and prior to the staff that are working with clients. But also being mindful of how, on these records, are discoverable, and what information needs to be shared with the correction staff versus the corrections health staff. And we're able to come up with some good approaches that were going to be helpful to all of those different stakeholders. Next slide, please. [0:33:34]

So some of the early successes, we had some improvement around productivity, and we're looking at reductions and kind of future expenditures. When that comes, it comes with the redundancies and doing stuff that we don't need to do. And there's some metrics around the amount of time to look for charts which has been great, and the ability to locate our charts, which has actually been a really nice win. Next slide. [0:34:04]

And this gives an overview on some other kinds of benefits that we have then experienced. Next slide, and it's self-explanatory.

So, you know, one of the pieces that I think has been a real benefit that we have found is when you are going to an electronic system, we had an opportunity to look at some of our really poor workloads and making some of those improvements, particularly on the intake. And so we have spent - we don't have to repeat some of those early booking questions that are happening, especially for some of the frequent flyers. And we're starting to explore working with emergency medical services here in the health department to see how we can connect some of the records that we're finding and some of the frequent flyers that are coming in out of the jail and sharing some of that with the ambulance drivers. And so we know what kinds of problems actually need to - require ambulance pickup and those that don't. [0:35:21]

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And as we spend more time with the record, we anticipate that we're going to have a lot more of a history and that it will be a lot more valuable. We're having those conversations about what's the most important thing to collect booking in, and how can we share that information with key programs that are going to be in service to the clients that we both are seeing. Next slide.

So these are further examples of how electronic health records have helped support us with compliance and measuring and reporting pieces. Next slide. [0:36:00]

So this slide really shares - gives you an overview of all of the inputs that we are including in our electronic health record. So we are looking at how to further develop an integrated health record. We have Epic, which has the physician and the nursing notes. We have information that it's coming across on an interface from the eSWIS program that will provide information about the inmate's name and compare aliases and help us to kind of look at duplicates. And then we also are contracted with Diamond Pharmacy and we're using their electronic medication administration on record, Sapphire, to do the med passes with our CMAs. And that interface about meds that are ordered and given, there's an interface that is going into Epic, and through all of these sources that's where we're connecting all of these different data sources to really look at what we need to provide for, for the staff to provide care to the clients in correcting health. Next slide. [0:37:20]

There was a real need for a culture change in going with electronic health record in our system. They found that there was some basic things, like providers and staff that didn't type, who were scared of computer systems, and also trying to provide that kind of support in a 24-hour setting, which we don't have to do in the community health center. And now that we've gone on it live, staff has really enjoyed it and don't want to go back.

Now, of course, we're going to have some of the grumbling because there are some things that are a little slower in electronic health records just as far as the input and trying to get a laptop and things like that on the floors. But overall, staff has found that this has really helped to improve their ability to manage the patients. And even on the very first day that we went live, them being able to access the EKG of a client who had gone into the emergency department the night before, showing up and finding out what meds they'd been given, what the results were, helped them avoid having to repeat those tests, so they are really finding the power in the tool. Next slide, please. [0:38:43]

So this a reiteration of some of the wins that we've had with electronic health records in our system, and I've talked about all of those. Next slide.

So this provides my contact information, and thank you for listening.

LAURA GALBREATH: And we will provide it at the back-end of the webinar as well for all the presenters, so you have that available to contact them if you have any question. We do have a lot of questions that folks have typed in. Please feel free to continue to type those. I'll start with there were a couple around behavioral health. Can you say a little bit more in terms of the

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correctional health site, kind of the levels or types of treatment, and then two, what level or credentialing is the behavioral health specialist doing that work in that setting?

VANETTA ABDELLATIF: Okay. So within our jails we've got a couple of psych nurse practitioners, and they can be independent providers here in Oregon, and they have prescribing capacity. And then we have a qualified mental health professionals, which are LCSWs. And in my understanding of how that piece is happening, that would come through in either the screening, booking, and they may want to have someone evaluated and then they would make a referral to the QMHP to do a further screening. And then depending on what they're seeing, they'll go to the QMHP or the psych NP to do follow-up. [0:40:26]

We are very, very thin in the behavioral health professionals that we have in both of our jail settings, and it's one of the areas that we're working to further resource. We've been working closely with the corrections staff and with the probation staff to do some more targeted work around kind of identifying people who may be at risk for suicide, and trying to do some training with those non-health staff to be able to identify that so that we can really kind of target it, reach out to those clients early on. But I think that it's one of the areas that personally I think we're thinner than I would like us to be, but that's kind of the structure right now is through a referral piece. Not everyone will get a screening. They have to be screened in to be evaluated. [0:41:27]

LAURA GALBREATH: Before I go to a couple of technical questions about the EHR, still on the behavioral health front, what are some of those - community connections look like in terms of both referral to behavioral health services, but then also thinking about primary care and behavioral health integration? How are they - are they looped in? And you talked about a system that you used to share information across community providers. Would you say a little bit more about that system, but then specifically about your coordination with local mental health and/or addiction providers? [0:42:05]

VANETTA ABDELLATIF: So I can speak a little bit more about the primary care providers, and so I'll tell you a little bit about that. And then on the mental health piece, I'll have to get some more specifics on those individuals. Within the primary care system, we have structured a way to refer out those folks who are coming out of our jails into our primary care clinics if they want to establish a primary care home. We do focus on our patient-centered medical home, and so only those folks who want to get kind of long-term care or get primary care, a relationship would get referred in. If they're looking for urgent care, we would make referrals to community providers for them. Within the community health centers, we do kind of short-term behavioral health interventions. But if they are severely mentally ill, we'll make referrals to community mental health providers, which, in the jail, the QMHPs will partner with what they call kind of like a discharge planner on the jail side. And they will make phone calls and connect and beg, borrow, and steal to try to find slots for folks. [0:43:31]

Our challenge are those people who are uninsured, like in every other community. If they have coverage, it's easier to find a provider for them. If they don't have coverage, the discharge planning piece takes a very long time and they have to be in really high need to find a slot for them. And there are still people who we know would benefit from being connected to a service

provider, but if they're not severely mentally ill, it is difficult to find them a place in the community. [0:44:01]

LAURA GALBREATH: Right. Regarding this system, how do you handle in terms of the confidentiality and patients with especially - there's questions around people that are incarcerated in jail that may have substance abuse conditions. How do you get that relief or how do you engage with - let them know that that information is going to be shared across your - within your organization, but also in the community among providers?

VANETTA ABDELLATIF: Right. They are signing an informed consent to release the records. The AMD records are segregated within Epic. We have a medical records department with accredited records technicians, and so when it comes to releasing the information outside of our network, they do that sort. [0:45:07]

Internally, within our informed consent, we identify there and disclose that we are on a shared record. And so we made a decision to lean towards not limiting who we share the record within our network because we want to be able to coordinate chairs, and so that's part of that release.

It's more of an informed consent; this is how we provide care. And then that releases also in our primary care sites because we're on a shared network. So if they went to another provider that's on an OCHEN (ph) here, that's how we release those records. They could access what services they got at the jail or any of our community health centers if they had a need to do it, to provide care. And we're protected under OCHEN to do that, this organized - healthcare organization agreements, so if we're doing this to coordinate care, we're protected. Laura, did I answer that question? [0:46:21]

LAURA GALBREATH: Yes, sorry. I was on mute (chuckling). Yes, no, thank you very much. And the last question before we go to the next presenter is just about the health information exchange. Are you utilizing a health information exchange for that information sharing, or is it a separate system that you were discussing?

VANETTA ABDELLATIF: There's two ways that we're doing that. So Epic has something called Care Everywhere. So if there is an Epic provider out there, our providers are able to go into Care Everywhere and they can see a line that says, "Oh, this person has received care at X hospital, and then they can go in and pull that record. And, you know, it's mostly things like tests that have been taken or medications that were provided or that sort of thing, so that they can look at that. [0:47:08]

See, health exchanges are still being developed in our community, so that I don't think that there is enough info there that providers are able to access. And then the other way - so that Care Everywhere is like they're not in our system. And then the other way is we are within a group called OCHEN. And OCHEN has organized all of the master patient indexed on a single server. I'm getting outside of my scope because I'm not an IT person, but basically it's all on one server. And so if we pull up a patient name and they've been seen anywhere on any of these providers and there are about 35 organizations that are on OCHEN, they can identify that they've been

seen somewhere else. And they can pull that record in and see whether or not they are still engaged in care with another provider, see what kind of services that they have, and be able to document in that record so that there is a single record for that patient, if they've been seen at any organizations or clinics that are within the OCHEN system, so that's kind of internal. It's almost like looking at, you know, just another site within a large organization. [0:48:18]

LAURA GALBREATH: Great. Thank you for that clarification and understanding, you know, what's unique to your community. So we're going to go on to our next speaker. When we get to the discussion point, two topics that have kind of come up in different questions that we'll dive back into is around care coordination, and also further discussion about eligibility for Medicaid. So we'll glide back into those after we hear from our next presenter, which is Homer Venters, who's the Doctor and the Assistant Commissioner for the Correctional Health Services for the New York Department of Health and Human Hygiene. And so we're glad to have you with us to talk about another case study looking at a different model in New York. And with that, Homer, is your line open?

HOMER VENTERS: Thank you very much. Thanks very much, Laura. I appreciate the opportunity to chat and get feedback from everybody, so hello. [0:49:10]

So my name is Homer Venters, and I'm responsible for healthcare in the jail system of New York City. So as you can see from this pretty ugly picture, Rikers Island, which is where most of the jails… There's a large complex. It's an island that has nine jails on it and lots of other buildings as well. And then besides the nine jails that are on Rikers Island, there are three what are called borough houses or other jails outside the - off the island. One is a boat which sits off of the Hunts Point in the upper right-hand corner of VCBC, has 800 men in it. The middle one is the Brooklyn House, and then there's a jail in Manhattan at the bottom right there known as the Tombs, or formerly the Bernard Kerik Center.

So all of these 12 places represent the jail system for people arrested in New York City. It's, as with most jails, predominantly people who are pretrial. There's a small like 10, 12 percent of folks who are serving a sentence of a year or less. And then there are also quite a few people, maybe a thousand or a little bit less, who are state sentenced, but who are coming through New York City for their cases. So people who are down on appeals or other features of that case. [0:50:28]

Within these 12 jails, some of the specialty areas, we have one jail just for adolescent males, and so in New York City that's people who are 16, 17, or 18 years old. We have a women's facility which is on the island. And then there are for - of interest for our discussion today, there are also places with higher levels of mental healthcare, mental observation units.

So it's a large operation. There's about 1400 people who work in the healthcare operation either for a contract provider… We have a contract provider, Corizon, that provides much of the staffing, and then also with the DOHMH we have several hundred people. All told, approximately 200 million a year goes into healthcare for people who are in the New York City jail system. And like a few places around the country, we have a division of responsibility where

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the City Charter of New York identifies us and the DOH as responsible for the healthcare, and our colleagues in the Department of Correction are identified as being responsible for the custody and security, the other aspects of incarceration. We can go to the next slide. [0:51:42]

LAURA GALBREATH: I can do that. If you could, the volume seems to be a little bit low for listeners. If you could move the microphone closer…

HOMER VENTERS: Sure.

LAURA GALBREATH: Or speak up a little bit; that might help. Thank you.

HOMER VENTERS: Sure. So tell me if this is better at all, or just give me a message as I'm going along.

So just to give you an overview of how our health service is set up in New York City, and then get into some of the particular issues around the nexus between primary care and mental health. So we have about 80,000 admissions a year in our system. And unlike a lot of jail systems, we have a very extensive intake process. So the whole medical intake into the jail takes about four hours and looks a lot like a hospital admission. It involves a physician or physician's assistants and multiple contacts with nurses and PCAs or, like, med techs. [0:52:42]

And so people come into the jail, and before they're ever housed into their housing area, they go through this medical intake. Well, from that medical intake flows many of our referral to mental health, and some of them are staff referrals where, you know, the person doing the intake thinks mental health services are needed immediately. But most of them are routine, so they occur within 72 hours. And then the mental health service has an intake and sets about its work of assessing the level of symptoms, the level of care, the level of provider, and whether or not special housing is needed. [0:53:21]

And so as the mental health service is doing its work of, you know, doing the original intake, several days into the jail admission and then follow-ups, they're also engaged in discharge planning for everybody who's in the mental health service, which I'll get into a little bit later.

And then, as I mentioned, the medical intake generates, you know, many medical follow-up visits, and there's some medical discharge files, but not so much. You know, everybody - one of the reasons we have a pre-heavy interaction with people on the intake is because of the jail, you know, as others have mentioned. Many people are leaving early, and so we want to do - since we're the health department, we do, for instance, gonorrhea, chlamydia screening, everybody under the age of 35 who's male, and all the women. We do HIV, offer, so we do about 40,000 HIV tests a year. And so there's a lot of - we do immunizations. So a lot of this work both generates more visits, but also information that, just like the mental health service, is relevant as people return to the community. We can go to the next slide. [0:54:29]

So this circle is a central conundrum for us just inside the jail. So just keeping with the notion that these two services, medical and mental health, need to be able to work together inside the

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jail. We've put a lot of effort into this and it is - it continues to be vexing, although we certainly have made great strides with the integration of an EHR. But, you know, just looking at the early days of jail admission, if you imagine somebody coming in to jail who, you know, raises a flag for some mental health issue, many of those people that are picked up by a primary care provider… Like I'm an internist, so I consider myself kind of a layperson when it comes to certainly the more sophisticated mental health assessments. You know, to a primary care provider, there are a lot of substance abuse concerns that look a lot like mental health concerns. There's also just a lot of kind of adjustment to jail, 72 hours after you got arrested, that looks like pretty acute mental health concerns. [0:55:35]

So for the medical providers who are doing the intake, their one trigger generally is to refer to mental health. And they might do it routinely, or they might do it in a stat fashion. But, you know, then that referral may trigger many things. We kind of fold the substance abuse service into the mental health service, so we refer to it as one even though they're obviously quite different endeavors of different providers and different interventions. So we can take a look at that next slide. [0:56:06]

Okay, so as far as this issue of keeping the primary care and mental health services working together inside the jail, I just wanted to mention three aspects of this. So there's the EHR in the jail. There's our efforts to put nursing in the mental health units, which is just going in one direction that I recognize, but it's really important in corrections. And then the third is the mental health training for primary care providers. We can go to the next slide.

So I'll get to this, what this graphic represents or this picture. This is just a screenshot from our EHR. But in 2008, we decided that we needed to implement an electronic health record. And so at the time, it was kind of the Wild West of EHRs for people who were around or in the business of thinking about this at that point. There were lots of new EHRs. There was a lot of promise out there. You know, the thought was that we would get EHRs in jails and they would magically talk to the EHRs in the community and all would be right in the world. [0:57:16]

We selected an EHR that was actually being used in the community, rolled out in a community, Eclinicalworks. Another part of the Department of Health was actually working quite aggressively to get this into the hands of smaller providers, small groups of providers; it's an ambulatory care product. We got it off the shelf, and then we started the job of trying to adapt it to the jail system. And so for those of you who are familiar with jails, you know, probably half or two-thirds of the work looks kind of like ambulatory care. But then you have maybe a third or maybe a little bit more of your work that is very, very different from ambulatory care. You have infirmaries, medical infirmaries. You have, you know, detox going on. You have mental health services. You have all sorts of rounds that don't - would never exist in the communities that go into solitary confinements. That aims (ph) at rounding up people; they'll see if they're basically still alive or if they're decompensating. All these types of work, emergency responses that are hard to adapt a community ambulatory care EHR to, but that's the job we started in 2008. And it took us actually three years to roll out. We stopped while we were doing it twice; once for hardware issues, once for training issues. [0:58:34]

But it was a difficult rollout, but one of the things that was most helpful is, you know, where we were at is we had two different paper charts. We had a medical chart and a mental health chart, and they were almost never in the same place at the same time. The clinical staff almost never had the knowledge of the other chart, the other services chart, when they were seeing a patient, and so it was really an untenable position for dealing with sick patients. And certainly as everybody knows on the call, the patients with lots of mental health concerns also are very sick medically. And so it was just not at all ideal. [0:59:14]

So one of the biggest areas of adaptation for us was in creating the space and the tools in this ambulatory care, this primary care EHR, to allow us to do good mental health. And so in thinking about some of the different mental health encounters, we have a mental health intake, which was our first initial encounter with somebody that's been referred over. We have follow-up visits. We have treatment plan reviews. We have the psychosocial and we have suicide watch. If you look at the box, the dropdown box that's white, the white background in the upper right, you can see some of the, you know, different - it's hard to read, I apologize - but some of the different types of encounters: Mental health clinic; TPR is treatment plan review; medication check; those are all mental health encounters. [1:00:03]

But for us to build those encounters, build them then with structured data that is using templates as dropdowns and answers that you click on really has been very important for us not only in terms of tracking the care between the mental health and the primary care services. But obviously, when you build those structured data fields, then you can report on them and then your leadership can do a little bit better job of keeping track of who's sick and who's not.

I just want to point out the alternating - the striped box there that's blue and gray; that's the problem list, and so I'll refer back to it later. But one of the issues in jail is that we have almost no continuity of care. And so in a system like ours, we have 12 jails, let's say 11 jails for men. We have several hundred mental health providers, all levels from LCSWs to psychologists and psychiatrists. And so as we know, when people go from one mental health provider to the next, the kappa (ph) for diagnosis and even for treatment is not necessarily that great. And so what you end up with, particularly in the mental health setting, is lots and lots of problems entered into your problem list.

And when we talk about the HIE later on and continuity of care documents, this very long problem list that crops up in almost every patient can be a challenge. So we can go to the next slide. [1:01:28]

So that's, I just briefly mentioned, our EHR. One of the non-EHR or nontechnical things that we've done is we've dedicated nursing power into the mental observation units. And one of the real truisms of jail is that - and it's probably true of the community - but in jail, when you build a special place for one population, you end up falling down on your jobs for every other type of endeavor. So we have about 800 beds that are in mental observation units in our setting, so we like to think that these are close to inpatient level of care. I think they're probably not, because we still send quite a few people to the hospital, to Bellevue. But they're our highest level on island. [1:02:21]

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And so of everybody who comes into a jail, about a third of those people get a mental health diagnosis and come into the service. And of everybody in the service, about a third of them go into one of these dedicated units. These units, paradoxically, hold the sickest patients from a medical standpoint, but traditionally those patients have gotten some of the worst care or had some of the worst access to medical care. And it's because we load up all these services for mental health, we put them in special places, and then those special places make it hard for them to get to sick call, to medical follow-up, and especially visits outside of the jail.

And so putting dedicated medical nurses into these units has really been - well, we've been doing it for about three years. And because those patients, for many reasons that are probably self-evident, are hard to get connected with their medical care, this has been a really important move for us. [1:03:16]

I think also the thing this has done is correctional health is a nurse-driven endeavor. Even, I would say, we, in New York, have more resources than probably any other city in the country as far as dollars and staff, and still, with us, it's the nurses that make the difference in what kind of care the patients get.

As you go from our model to other models around the country that have fewer resources, the primacy or the importance of the nurses becomes even more absolute. And so having nurses that are in mental health settings that can serve as the ambassadors between the physician, the medical doctors, and the PAs and the mental health services is absolutely essential. And for us, that's just really crucial. So we can go to the next slide. [1:04:03]

So this has to do with getting our medical doctors up to speed on mental health issues. And so I'm mostly going to talk about the intake process. So as I mentioned earlier, all of our medical intakes are done by an MD or a PA, so that's, you know, 80,000 a year, give or take.

So we have integrated a mental status examination as part of this, and we have structured data fields that are in the HR that track this. And so if you look to the black, to the gray box to the right, the mental status exam, those are all things that each admission, each medical admission, the provider is clicking through that with the patient.

We also have recently begun a service about a year and a half ago where we get community medication fill history, and again, this is being done during the medical intake. But so we pay a private company to check every admission against known community databases for prescriptions. And so what that means is the medical doctor who's doing the second half of the intake - the first half is done primarily by nursing staff - is both assessing the mental status of the patient, but also has this information in front of her or him that shows which medications the person has been on in the community. Now, that community medication fill history is not perfect; there are limitations to it. Certainly if people are undocumented or if they're on medications like methadone that are not part of the standard prescribing regimens, then they may not be showing up there. [1:05:57]

One other area that I'll mention, where we've done a lot of training of the physicians and the primary care team, is in processing of injuries, so we have about 1500 injury encounters every month in our system. There's not good data about injury rates in other jail systems. We have recorded and published some data about injury rates in our jail system, and it's stunning how little is reported or mandated to be reported about injuries in other jail systems. [1:06:29]

But when people come, so that's 1500 times a month when patients are brought in front of our MDs or PAs, that is also a time where we want to do a quick mental health assessment. And so we have particular training. Some of it has been prompted by PREA, but a lot of it is just our own experience; that, you know, the people who are injured are more likely to be mentally ill. They're more likely to have had some prior friction with either staff or other inmates in the facility.

And so we have a structured template that we use, and part of the training and utilization of that encounter is not just to assess the level of injury, physical injury, but to assess whether or not there's a mental health exacerbation or whether or not the patient has been victimized. And that's again because we look for it, then we can make a structured data set out of it and report on it and track this as a vulnerable population. So we can go on to the next slide. [1:07:26]

So having talked a little bit about these connections between the medical and mental health services in the jail, I just wanted to mention a couple of things about how we return to the community. And before I get too much into detail, one feature of our service that I didn't talk too much about so far is the substance abuse program. So in our setting, we have a methadone maintenance program. Of our 80,000 admissions a year, probably about 20,000 of those get methadone either for maintenance or withdrawal - or for detox, sorry - and then we also give - obviously there's quite a few people that come in that are on detox for ETOH or for benzos. We also maintain people on bupe. And then we have a substance abuse program, some of which is from the courts, drug courts, and some of which is just people who are interested, that transitions people from a substance abuse programmed house. We have seven of these housing areas within the island, where people go through a DBT-based curriculum for substance abuse programming, back to the community. As they do that, we're getting them transitioned to substance abuse treatment in the community. We view that jail model as a pretreatment approach, and that kind of gets us up to speed with where we are now, which is the things we do for the mental health service in linking back to the community, and in particular, the primary care. So we can go to the next slide.

So I'll just mention two looks at this. One is what do we do currently, and then what are some of the impending changes that we're in the middle of kind of hooking up or getting ready for? And, you know, you'll see the current planning. Most of our discharge planning has to do with people who are on the mental health service and people who have HIV. And then the new or impending changes really are a little bit more towards some of the things the other presenters have mentioned, which is the HIE and some of the health homes or the ACA features. So we can go to the next slide. [1:09:33]

So if you just go down to that third bullet, you can see that we have about half the people who come through our system each year are eligible for some sort of discharge planning. Only about half of those are eligible to get some services, and that really goes to how long people are with us.

So for example, everybody who comes in at a mental health service is eligible because of a court ordered stipulation. Everybody's eligible for discharge planning services. But the second the mental health clinician says "You're going to be in the mental health service," and the patient says "I agree," that starts many, many tasks for us to do in service of the stipulation, but in service of discharge planning. But, you know, because the median length of stay is about seven or eight days, you know, people are leaving in droves as we're just starting to have these first initial encounters related to discharge planning. [1:10:37]

So everybody in the mental health service, we start doing discharge planning as soon as they become patients of the mental health service. That really culminates ideally in a discharge plan that includes a connection to the care in the community, including transportation, including medications in hand, including housing, SSA. We do Medicaid work, all of these things, but all of that is predicated, I would say, on the patient being there. [1:11:06]

We also do similar work for people with HIV, patients with HIV, because we have a good amount of CDC and (inaudible at 1:11:14) money. We do pre-comprehensive discharge planning and Connection to Care for our patients there.

But even though we have an EHR, our discharge planning efforts currently are that we do all this work in our EHR. These are generally going to programs and health systems that receive paper from our EHR. And as I mentioned, a lot of the work certainly for mental health is driven by a court stipulation that has very, very, you know, precise parameters around how we deliver care, when we deliver it, time lines, things like that. So we can go to the next slide.

So the things that are really in the works for us: The HIE I think is - I'm going to try to stay away from any, like, annoying metaphors that get overused - but the HIE I think could significantly change our work flow. We're actually currently hooked up to the New York HIE, which is called the SHIN-NY and the Statewide Health Information Network of New York. I think I dropped an "N" out of there. [1:12:23]

But, you know, in theory, everybody who comes into our system, into our health system, we will be able to look them up on the statewide Health Information Exchange with their consent, and then we will also be sending data out as they leave. So right now, that is a pretty empty vessel in our state. I think we're probably one of the first large providers that's hooked up to it. We haven't actually started using it on intake, looking at the community information, because we're still figuring out what we're going to do with it.

So I think we need a dedicated - we need a new role or clinical information specialist, somebody who can look through all the information out there and assess what's important. I think if you put yourself in the shoes of the doctor or the PA doing the intake, you know, there's a lot of time

pressure there. So we want to know - for instance, if somebody's on Plavix, I'm not sure we want to know what their hepatitis genotype is, you know, or even if they were treated before. That's the kind of thing we can wait until the chronic care with it for. [1:13:27]

So we're still really working out how we're going to take all this information. The coin of the realm, the CCD, the continuity of care document, this little medical summary that all the EHRs can produce and trade back and forth, right now actually looks pretty poor for the two most common diagnoses that our patients have: Substance abuse and mental health.

And so, from the standpoint of primary care and general medical care, I think that just turning on the HIE will be of great benefit, but you know, if you're looking for a psycho-social, if you're looking for the last medication compliance report, things like that in the mental health realm or a substance abuse assessment, those things right now are poorly reflected in the continuity of care document. [1:14:12]

So and then the other thing is the other limitation is not many people are using the health information exchange. And while we will contribute lots of data to it, it will help us more if everybody is using it, and I think that that will take some time to figure out who is, you know, the large safety net systems around the state and the city for sure, who's getting involved.

And then we have a pilot - I'm just going to mention the two things together: Health homes and the Affordable Care Act. So I won't go into the Affordable Care Act because we've gotten some very good introduction from the other speakers. Health homes is a local iteration, although it does kind of exist in other states, even with the same name. But, you know, the State of New York has taken a look at everybody's who's on the Medicaid rolls and tried to come up with lists of people that have very high needs, they're very sick, and they've then asked local health systems to apply to become health homes. And that notion of the health home is they provide a high level of coordinated care for some reimbursement benefit over some short period of time, people enroll, and the health homes get up and running. And then the original money that goes to get the health homes up and running goes away because everything's happening more efficiently and somewhat magically. [1:15:35]

So we think that our patients - well, we know actually our patients - we looked and we ran a list of patients we had Medicaid numbers for, and over half of them were on the first health homes list; the people who are, you know, highest need for integrated services.

So we have started - we're exploring ways to work with local health homes. We already have one health home partner identified with whom we're going to try and find patients that are on their list but they have not yet found. Because we think that - and I think it's reasonable to assume - that some of the patients that health systems can't find are going to find their way into correctional settings. It's certainly… Because we have a large discharge planning staff, we can use that as a way to both - do a better job of the discharge planning ourselves, but also work together with the health homes. [1:16:24]

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I think that as we talk about the implications for the ACA and health homes more locally, one of the things we're discussing is how do we do a more broad assessment of people's health plan status, health insurance, health plan status, and view that information to direct discharge planning? And I think that we - you know, because we currently operate in this world where we have a court-ordered type of discharge planning for a mental health service and then we have another type that's for people with HIV, we want to think about, in the next year or two, moving toward the model where we have all of our discharge planning services meted out based on acuity and need rather than either diagnosis or program. Not that that obviously is a big challenge, but certainly our connection to the HIE will be a central feature of that. And I believe that those are all the slides I have so - oh, I may have one more, let's see. [1:17:31]

LAURA GALBREATH: One more.

HOMER VENTERS: One more, thank you, thank you. So I think that as we're talking about primary care and mental health integration, I think that, you know, for primary care providers, for community providers who are interacting with patients who have been in jail, thinking about how we succeed is important. Because, you know, traditionally jails - health services in jails traditionally have been there for some pretty stark reasons; it's to prevent people from killing themselves and prevent them from dying. And that is not, you know - the WHO definition of health hasn't traditionally applied in jails. And so as we, in correctional health settings, are looking to integrate the community health systems, and I think we should and we're certainly going to look forward to it - and we also want to be held to account in the same way - it's good for us to think about some common metrics for success. [1:18:28]

So the continuity of care, you know, we don't really have continuity of care even inside the jail. So we have cases where somebody is with us for two months and they might six or seven different mental health providers. And so we don't have internal continuity of care, but we do want to think about some very baseline - jails and other short-stay settings from a mental health standpoint; it's really about controlling symptoms. You know, it doesn't much matter - it's less important that the diagnosis be exact or consistent than it is that we move from having a high level of symptomatology to a lower level symptomatology, and that we're evaluating the safety and efficacy of what we're doing. And so that's - having a broad frame when assessing continuity I think is important as people return to the community. [1:19:14]

I think that the second bullet here, which is the source of data regarding health outcomes associated with jail, this is something I just want to put out there. And as Steve knows every time we meet, is that jail is not benign, and jail is not only full of good things for people who come through it from a health standpoint. We certainly, in correctional health, pat ourselves on the back a lot for taking people who are off their meds, or who have fallen away from care, and giving them good service and care. And I think that, generally speaking, people with chronic diseases, when they're in jail and prison, you know, they generally do better. Their A1Cs go down. In our system, their A1Cs go down over time. Their CD4s get better, things like that. But there are inherent health risks of jail to people. And so fellow primary care providers and mental health providers in the community should be aware that when people come through jail, they may get hurt in jail, or they may have a mental health exacerbation in jail. Then they go from a

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GAF of 70 to a GAF of 40. And so it's important to recognize that the passage through jail may confer a health risk to individuals. [1:20:18]

And then the other I think is, you know, are some outcomes that we want to think about, is everybody is probably familiar with the great work of Ingrid Binksmeier (sp?), and we've reproduced it here in New York to show that there's a huge bump in mortality as people come out of correctional settings, and how do we work together? You know, primary care providers may see somebody who is on the mental health service or the substance abuse service. They may be the first person to have contact with that person when they come back to the community. And so it's really important to be thinking about, you know, are they back on the streets, are they doing drugs, are they at risk for dying?

And then recidivism; I think there is good data to show that people with good health, continuity of health, are less likely to return to correctional health settings, and that certainly should be on our radar, too. So thank you, and I'll turn it back to Laura. [1:21:04]

LAURA GALBREATH: Thank you very much. We do have a few minutes for questions before we go over some resources and contact information for our presenters so you can type that in.

Someone did ask me, wanted to know what electronic medical records system you're using for your - in your system.

HOMER VENTERS: Sure. Eclinicalworks.

LAURA GALBREATH: Okay. And then the other question that I wanted to start us on in terms of just a quick discussion was some early questions around care coordination and eligibility, and I'm actually going to start with care coordination first. You know, given the different - you mentioned health homes, you know, the patients are in medical homes, and there are different aspects that are calling (ph) on the care coordination. What's one thing that, you know, folks that are on this webinar - and we do have like a sort of broad swathe in terms of different types of providers - can do to go back in their community? Maybe - you know, we felt that up to 60 percent have that relationship. What's one (inaudible at 1:22:16) can go back and talk about to improve that care coordination between these systems? And Homer, maybe we can start with you, and then have Venetta jump in as well. [1:22:25]

HOMER VENTERS: Well, that is quite a challenging question.

LAURA GALBREATH: (Chuckling)

HOMER VENTERS: I would say that, you know, there's a lot of promise out there about the integration with the ACA and for us with health homes. But I think that the best outcomes we have for patients are in situations where we're sending them back to a place we know. And so health systems that have been able to get people to come into the jail once in a while and meet us and for us to go to their setting and meet them is very low tech and it's very old-fashioned. But I think that those kind of bilateral relationships will continue to be very important even when

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people are on health plans and where moving people from, you know, back to their exchange or back to the health plan. I think that, in the end, there still will be a relatively small group of providers that are really open to taking care of our patients. And I think that we certainly want to grow that aggressively, but it's not going to change overnight. We're not going to wake up and have, like, three times more mental health providers and substance abuse providers. [1:23:37]

So the primary care settings that we know today are receptive to our patients, those are the ones we want to build relationships with. And I think that for people who are in safety net systems and who are, you know, interacting with patients that have been incarcerated, they are really critical to the success of whatever the kind of larger, sometimes a little bit confusing, policy plan is for their setting. [1:24:03]

VANETTA ABDELLATIF: Yeah, Homer, this is Vanetta. I really agree with you on that old-fashioned piece, and developing the relationships with community providers. Getting to know one another is really good. And one of the things we found in our system is that once we went live on the Epic product in corrections, we found that 40 percent of the folks that they were seeing in corrections already had a medical record in our Epic software on their Epic system, so either they were being seen by us or other community providers.

So I think being able to share that data with community providers about this overlap, and that people are really from the community, is really very powerful, because I think that community providers feel like they're not taking care of these patients, and some aren't, because they're uninsured. But they often are already their patients. So I think getting that kind of data and being able to share that and have those conversations if you're from a corrections setting would be really important. [1:25:02]

HOMER VENTERS: Right.

LAURA GALBREATH: Two more quick questions. Just quickly for both of you, is information being electronically shared right now between jails and state prisons, does that help assessment or that care coordination document go from where you're doing work in it, meaning the jail, to the prison system?

HOMER VENTERS: We're just building it now.

VANETTA ABDELLATIF: And this is Vanetta. I don't know for sure. I know that it isn't with Epic, so I'd have to check on that. We're so new I would imagine that if something is going to prisons, we're printing it, just like we would do a regular records release.

LAURA GALBREATH: And Marsha's line is also open, and this is a question along kind of eligibility. So as we think about healthcare reform, what are some tips or advice, you know, now that you're engaged in this population and you're having to do with eligibility for Medicaid? What are some - or, you know, obviously health exchange networks? Do you have any tips or

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advice around the coverage issue, and how do you help people from losing coverage or regaining coverage, kind of dealing with some of those pieces of care coordination and health? [1:26:23]

MARSHA REGENSTEIN: Well, of course, all of this is, you know, playing out right now; it's yet to be seen. But in the next several months, there should be the opportunity for people to log onto a website, whether it's at the state Health Insurance Exchange or a federal component, and determine whether those people are eligible for Medicaid. Their family member might be eligible for CHIP or the Health Insurance Exchange subsidies.

And so the Health Reform Act has a provision that's called sort of this notion of no wrong door; that people don't have to determine on their own whether they're eligible for Medicaid or they're eligible for an exchange or they get a subsidy, but that they can access this information, put in their own information about their income and their circumstances, and find out where they're eligible for. The goal is that people don't get bounced around on and off coverage the way that's so common right now because of the eligibility provisions in Medicaid. [1:27:32]

I would encourage all of the agencies to drive traffic to these websites to Health Insurance Exchanges because that's really what they're designed to do. There are positions that are funded by health reform for patient navigators to deal specifically with high-risk, hard-to-reach populations. Many of the people who are coming out of jails may be reluctant to interact with agencies that are asking for certain income-related information. But the best thing really is to drive traffic to these portals because they're designed to help people get health coverage regardless of the type of coverage it is. [1:28:14]

LAURA GALBREATH: Great, thank you. Any other tips or advice from our other presenters?

VANETTA ABDELLATIF: This is Vanetta. What I'll share is we are also trying to work on having some conversations with the state so that we can get some of that screening information early on when we get them into booking and starting to socialize the booking staff into screening for coverage which they've never done before. So we're starting to have those conversations with them now.

LAURA GALBREATH: Great. Thank you all so much for your time. Before we conclude, just wanted to share a few resources with the participants and remind you that these slides and this link will be available within the next 24 hours. But this does include some resources from the Community Oriented Correctional Health Services, a group that we worked with on today's webinar, in terms of identifying our faculty, obviously a SAMHSA resource, and also a white paper on some different community interventions from the Justice Department. [1:29:25]

And I'm here at the contact information if you need anything from CIHS in terms of how to integrate primary and behavioral healthcare; have other questions or ideas, you can contact us. We have e-mail addresses here for our three presenters, as well as Ben Butler from the Community Oriented Correctional Health Services, if you have further questions about these type of issues. So we encourage you to contact them with some of your follow-up questions that we may have not been able to get to because of time and details.

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But with that, I do just want to say that thank you so (audio gap) next webinar you will be asked to complete a short survey. Please be sure to offer your feedback. Your input is important and does inform the development of future webinars. Thank you all, and have a wonderful afternoon.

END TRANSCRIPT