

**December 9, 2014**

**NYS Correctional Medical and Behavioral Healthcare Workshop**

**Keynote: The Present and Future of Correctional Health and Mental Health Care**

**Steven Rosenberg, President, Community Oriented Correctional Health Services**

On Thanksgiving Day, the lead editorial in the New York Times was entitled “Mass Imprisonment and Public Health.” The fact that the Times chose this topic as its lead editorial speaks to the extent to which the society at large is recognizing something that all of us in this room already know: One cannot separate the issues that cause individuals to become engaged with the criminal justice system from their underlying behavioral health disorders.

COCHS has been fortunate to be at the forefront of shaping this awareness through our many national and local partnerships. The March issue of Health Affairs was dedicated to examining this relationship between behavioral health and corrections. We now have the leading journal of health policy and the leading newspaper in the United States recognizing the connection that we in this room are so familiar with.

COCHS was privileged to work with Mayor DeBlasio on his Task Force on Behavioral Health and the Criminal Justice System. Right now, I’d like to cite a piece of data from that report that speaks more eloquently to the connection between behavioral health and criminal justice than I could:

In New York City, 400 individuals make up the population that most frequently ends up on Rikers Island. On average, these individuals have been in the jail more than 18 times in the previous 5 years. 67 percent of these individuals have mental health needs, and over 99 percent report substance use disorders. These individuals account for 10,000 jail stays and 300,000 days in jail over the last 5 years. Yet 85% of their charges were misdemeanors or violations.

So while the recognition that the correctional system is not the best place to treat these individual's behavioral health disorders is long overdue, our behavioral health care systems and correctional systems must be reengineered to more appropriately respond to the needs of these offenders. As with any large-scale change, there are likely to be both opportunities and challenges.

Perhaps the biggest challenge will be managed care's entrance into the correctional space. This poses a challenge because up until now, the foundations of managed care and of population health, like Big Data, Analytic Heuristics, and technology, have not been part of correctional health care management.

One can see this best with the entrance of the Centene Corporation into the correctional space. Centene, which has been a Medicaid managed care provider for the last thirty years, recently joined forces with MHM Services, a provider of correctional mental health services, to create Centurion Managed Care. Centurion is now the health care provider in

correctional facilities in Tennessee, Minnesota, and across the border in Massachusetts and Vermont.

The power of Big Data becomes evident when you recognize that the tools developed to manage care in the Medicaid space that Centurion is now taking into the correctional space. One simple example is a tool called Impact Pro. By analyzing certain risk factors, correctional clinicians are able to use Impact Pro to anticipate when an individual behind bars may experience a behavioral health crisis and need an intervention. This tool allows correctional clinicians to prevent crises before they occur which ultimately saves the jail money, while simultaneously improving the quality of patient care. Tools like Impact Pro exemplify a future when Risk Assessments within a correctional setting take on a different meaning.

Now, I am not pointing out Centurion as an exemplary correctional health care provider, rather, Centurion's existence, and the partnership between MHM and Centene, ought to be a clarion call that alerts you to the fact that correctional health care is in the midst of a great change. The combination of behavioral and physical health in correctional facilities under the incentive structure of a managed care system is bound to require a new understanding of how health care is delivered inside and outside the jail. This change to managed care means new ways of understanding the needs of the criminal justice population, and the nuances between treatment of behavioral health needs and recidivism. A managed health care provider in correctional facilities will have a different set of incentives, and properly managing care will require a bit more sophistication than

the previous fee-for-service methods of health care financing. Understanding how to serve justice-involved individuals will require new tools and methods of analysis that will benefit correctional health staff, correctional administration and behavioral health providers in the community.

As you all obviously know, because you registered for this conference, we are here to discuss the present and future of medical and behavioral health care for corrections here in New York State. As you understand, this is a complicated task for you because you are facing a rapidly shifting environment.

But for me, this is a difficult task too, because the present is quickly becoming to future as my staff and I at COCHS are trying to pin the present down. So, in order to make this easier for all of us, I'm going to describe the future we are moving towards first and then say what we should look for in the present to make sure that we reach the picture of the future that I'm painting.

This future is one where the jail can be viewed much like any other health care provider in the community, as one that treats the individuals coming into its walls as consumers of health care. Including the jail in this continuous chain of health care providers requires an assessment of the tools and practices that are currently used in corrections and health. In order to paint this picture, I will begin by describing the broader landscape of health care financing across the country through both a policy lens and a business lens. Then I will describe the future of behavioral health in New York State and how this fits into the

broader picture of federal changes in health care delivery and financing. Then, we will look at policy changes in neighboring states that are bound to impact the country. Finally, I will ask you to look for signs of these changes in the present, and to consider how you can begin using the foundations of data sharing and technology to meet your public safety and public health needs.

You in New York State are not alone. Because of the Patient Protection and Affordable Care Act, millions of individuals who did not have access to health insurance are now eligible for Medicaid or commercial plans. While New York State had already expanded Medicaid eligibility to many justice-involved individuals, we know that there have been challenges particular to enrolling this population.

The ACA and the HITECH Act are gamechangers because of the wealth of data that everyone will be able to collect across the country. The expanded population eligible for health insurance creates a landscape where health needs for individuals who had been left out of the health care system now can be studied more closely. For the first time, populations that never had access to health care systems are being included. This inclusion creates a new terrain for research and investment in the health of populations that desperately need it.

The ACA, however, is only one part of the changing terrain. The entire health care financing system across this country is changing. Many states are moving away from the former transactional payment method toward more accountable methods of health care

financing. Previously, many payers were not held financially accountable for patient outcomes, and fee-for-service models incentivized overtreatment in order to raise reimbursements from insurers. The future will consist of a health care financing system that is inclusive of all of our citizens and focuses on accountability and measurable outcomes. For the 400 frequent fliers at Rikers Island, this change means that their profound behavioral health needs will no longer remain hidden. And over time, this means correctional health care providers will no longer be able to remain siloed.

Meeting benchmarks and achieving better health outcomes, however, means that we need new ways of collecting and analyzing data; Managed care is wholly dependent upon the lessons that can be learned from Big Data. A system dependent on accountability and outcomes is premised on understanding of what types of outcomes can be delivered, and Big Data provides the statistical pool that care providers can finally use to understand the clinical needs of a jail's patients.

This understanding depends on how and who we count. For too long, individuals in the justice-involved population had not been considered consumers of health care. This meant that the populations that interacted with the correctional system remained hidden and their unique health needs were rarely studied and almost never fully met. The justice-involved population and the communities in which they live have, for too long, been relegated to the shadows and left out of health care planning efforts. From a health care planning perspective, 400 individuals, of which only 15 percent were even accused of a felony, speaks to the extent to which this sub-population has remained hidden. With the

increased access to health care that comes from the ACA, this population will no longer remain hidden, but can come out of the shadows and be counted with everyone else. The line distinguishing “consumers of “correctional health care” and “consumers of health care” will begin to dissolve.

As this line begins to disappear, the jail will need to communicate better with providers inside and outside the jail. A means of doing this could be by sharing patient data to the State Health Information Network of New York, or SHIN-NY, to coordinate care and effectively create reentry programs. By communicating to community providers through health exchange alerts that an individual has entered the jail, community providers can adjust their treatment regimes appropriately and even continue their treatment while an individual is in jail. This will require correctional facilities to invest in technology programs that will enhance communication outside the jail. Rikers Island is leading the way in both data connectivity and the claiming of federal funds under the Medicaid Meaningful Use Incentive Program. For more information about this, Homer Venters is in the audience, and I am certain he can help you learn more.

Managed care will not just eliminate the line between community and correctional consumers of health care. Managed care also removes the barriers between community health and individual health. An individual’s health condition is indicative of broader, underlying issues that may plague an entire population. We are all familiar with the work of the Justice Mapping Center and its documentation of “million-dollar blocks” in Brooklyn.

In order to create a framework for addressing the broader population needs, the Institute for Healthcare Improvement, under the leadership of the former CMS administrator Don Berwick, developed the Triple Aim to capture this new phenomenon. The Triple Aim consists of three prongs. These prongs are improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

This new framework shifts us from our previous model of care, which focused solely on treatment for an individual. The individual now must be viewed in relation to the health of the community from which he comes and the community into which he will return. The Triple Aim captures a complicated relationship between the individual and his broader community that should not be lost on those providing health care in a correctional facility. As we know, those entering the jail do not stay long, and when they return to the community from the jail, they bring their communicable diseases, behavioral health problems, and substance use disorders along with them. The health of the individuals in the jail correlates to the health of individuals outside the jail. Those 400 frequent fliers are interacting with far more people than just the providers in the jail. The health of these individuals directly correlates to the broader health of the community. And, once released to the community as insured members of a Managed Care Plan, the burden of treating the underlying behavioral health disorders must be acknowledge and not simply ignored until their next incident of incarceration.



By reframing the delivery of correctional health care through the Triple Aim, we must begin viewing the individual being treated in the jail as part of a broader community and remain cognizant of the impact his condition can have on the community that he returns to. This means that quality care will include conversations about the client's reengagement with the community. By helping him understand that his illness is not his alone, public health can be improved through treating an individual. And, given that 85% of the incarcerations of those 400 individuals were for misdemeanors or violations, it is self-evident that we are describing a public health issue, not a public safety issue.

But for those in impoverished areas, behavioral health treatment is rarely available. This, however, is changing. In March of this year, Congress passed the Excellence Act, which creates Certified Community Behavioral Health Clinics, or CCBHCs. This change is sure to affect the delivery of behavioral health services to individuals who had been previously excluded from reaping any of the benefits of evidence-based behavioral health care interventions or been subjects of behavioral health studies. The CCBHC pilot program will begin in eight states, but this process will be competitive. In Missouri, stakeholders are already coming together to figure out how they could ensure Missouri's role as an Excellence Act pilot site. This means that right now, New York State should be creating a coordinating council to prepare to become one of the eight CCBHC pilot sites. Developing CCBHCs that truly meet the needs of impacted communities will also require capital. Leveraging New York State's long history of credit enhancement and the local availability of lenders such as the Non-profit Finance Fund should become an essential component of any plan to become one of the pilot states.

Preparation for becoming a CCBHC pilot state requires major action on the part of New York State, but I want to alert you to the ways that New York State has already begun adapting to the new, managed-care future. Many of you may already be participating in Health Homes. And I'm sure many of you can't stop thinking about how you are moving to a managed care program for behavioral health. As a part of this change, you will be creating specialized Health and Recovery Plans, or HARPs, that will fully integrate behavioral and physical health programs for individuals with significant health needs.

HARPs will be available for high utilizers of health care resources. These are individuals with co-occurring medical and behavioral health conditions. These are the individuals with diabetes, or HIV, or High Blood Pressure, who do not take their meds, or who may be unable to care for themselves because of severe cognitive limitations, or who may have difficulties finding employment or housing. This population overlaps with the individuals that are very difficult to treat inside the jail. As you know, the people who are often the most expensive to house in the jail are the same individuals who are unable to care for themselves outside of the jail. HARPs could be a first line of defense to assess that an individual may be on the verge of a psychotic episode, or that an individual does not have stable housing. A HARP allows for an intervention on the medical and behavioral side before correctional interventions are necessary. And if I wagered a guess, all 400 of the frequent fliers would be eligible to participate in a HARP.

HARPs will join the strong tradition of case management efforts that New York established through its Health Homes Pilot Program. Health Homes have been an important component of managing the health needs of individuals with some of the riskiest combinations of health factors. Health Homes provide an excellent example of aligning incentives to increase community providers' responsibility for justice-involved individuals. One of the Health Homes pilot sites seeks to include metrics aimed at managing justice-involved individuals. By holding the Health Home responsible when an individual enters a correctional facility, the Health Home providers can be motivated to keep their clients out of a correctional facility, and to get them out as soon as possible.

If that change weren't enough, your new Medicaid waiver has many more changes in store for you. New York's Medicaid program has created the new Delivery System Reform Incentive Payment program, or DSRIP. DSRIP is a means of restructuring the health care delivery system in order to reduce costly and avoidable hospital use by 25% in the next 5 years. This goal is a noble one: New York ranks 36th among states in the country in potentially preventable readmissions-with over 36,000 potentially preventable emergency room visits per 100,000 visits.

DSRIP restructures the way that providers interact with one another. In a DSRIP, several providers must join together to form a single Performing Provider System, or PPS. So what we see across the states are that hospital systems are reaching out to providers in the community on both the physical health side and the behavioral health side in order to create systems that will allow individuals who do not need to be in the hospital to access

care in the community. In order to draw down funds from the state, each PPS will need to communicate about clients and coordinate care in order to improve outcomes and save money. If a PPS does not achieve the benchmarks it set out to achieve, then it will not be able to reap the financial benefits available from the state.

The benchmarks built into the DSRIP can help PPSes pay particular attention to justice-involved populations. Just like the HARPs, many of the people who might be frequent fliers in the hospital are the same individuals that are coming through the justice system. While there are no specific benchmarks that relate directly to justice-involved populations, meeting the health needs of individuals in the community is bound to have impacts on the behavioral health needs that lead to any sort of institutionalization. And with accountable health care providers, correctional staff are much better positioned to treat community providers as allies in the quest for public safety. Instead of taking an individual to the jail, a PPS might have a financial incentive to make sure that their patient does not go to jail in the first place.

Programs like DSRIP and HARPs, which require helping a client connect with the services planned for him, will rely more and more on peer mentors to achieve the benchmarks set for them. Peer support programs provide culturally competent case managers who can help an individual work through his recovery. These peer supporters are often consumers of behavioral health services themselves. Using the expertise and experience from their own recovery process allows peers to use their own path to recovery as a lesson for those they mentor.

This movement to benchmarks and managed care in the health world will necessarily affect everyone in the correctional world. While the present status of correctional health may be tumultuous, the future is a bit clearer: correctional institutions must recognize that because an individual enters into a correctional institution, he does not leave the community. This means that the jail can no longer be viewed as a silo apart from the rest of the health care providers in the community.

The Legislature in New York recognizes this connection between the individual and the community and is working on legislation that will make this transition between jail and the community much smoother. A bill, which is currently in the hands of social services, would allow the jail to presume that an individual coming from the jail is eligible for Medicaid—granting the individual access to Medicaid services as soon as he leaves the jail. Bills like this that focus on protecting individuals during their transitions of care are essential for facing the difficulties inherent in meeting the needs of this population.

Other states are trying to address these issues in other ways. You don't have to look far to see the use of benchmarks and managed care in correctional health. Right across the border in Vermont, the first pay-for-performance contract for correctional health was just granted to Centurion. Vermont's health provider in the combined jail-prison system will now be required to meet quality and health benchmarks in order to receive the incentive payments. These pay-for-performance contracts are only possible because our understanding of how population health works and because of the complex heuristics that

allow providers to provide the right kind of care at the right time. We will see more and more of these pay-for-performance contracts. And while there will be bumps along the road due to a lack of knowledge and treatment plans due to years of research neglect, as we begin to experiment more and more with providers that are held accountable for the care they offer, we will see how the heuristics developed there can save money and improve care in the long run.

Before we get fooled into thinking that this is all just idealistic policy-think, we should look to the evidence that the walls of the jail cannot bind the future of correctional health.

Again, I want to remind you that the very existence of Centurion suggests that Wall Street has read the tea leaves and recognizes that the future of correctional health care will evolve through a system of managed care. If major players like Centene and MHM have joined together to create Centurion and risked a lot of money to make it successful, then we should not be surprised to see other entities following suit. If Wall Street recognizes that the barriers between jail and community health care systems are crumbling, it is time for us to pay attention, too. For those of you that were at the annual meeting of the National Council for Behavioral Health Care earlier this year, you may have noticed that there were more than 25 private equity companies seeking opportunities in this space.

Framed differently, universal health insurance monetizes individuals who, up until now, have been the dispossessed and the cast offs in our society. As long as those 400 frequent users at Rikers had no economic value while they were in the community, no one had a vested interest in responding differently to their needs other than providing round

trip tickets to Rikers. The presence of Wall Street and monetization are likely, over time, to radically reconceptualize how the needs of those 400 individuals will be met in the future.

HARPs, DSRIP, and all these new ways of thinking about the overlap between health of the individual and health in the community, as well as the continuum of care on both sides of the jail, are all premised on understanding the folks we are trying to reach. As I stated earlier, justice-involved individuals, and the communities from which they come, have been rarely studied and were not monetized. Most of what we know about insurance utilization and quality assurance are premised upon studies that were created without criminal justice folks in mind. Now that access is open to all, we will need to study and understand the best way to deliver health care and meet the special needs of these communities.

So far, I've tried to paint a picture of the future: managed care, near-universal access to health insurance, a shift in the perception of the jail away from its siloed past and into an understanding that being booked into jail is a transition of care, and using the Triple Aim to frame the goals of care delivery. But what does this mean for us here and now? What sorts of things should we look for and do as harbingers of the future that I'm describing?

Some of the things to be alert for are obvious. One of the biggest things that we could be aware of is how incentives can be aligned to improve outcomes for the individuals within the justice system. As I just described, there are many ways in which the incentive structures for health care is changing. These incentive structures between jail providers

and community providers must be intentionally aligned, which of course requires input and attention from all the stakeholders involved. In order to better align the correctional health providers and community providers, the financing infrastructure must be tweaked to make sure that outcome measurements are attuned to behavioral health outcomes. Like with some Health Homes pilots, managed care providers need to be held fiscally responsible for their client's outcomes. Physical health and behavioral health must recognize that they have to be able to work together to diagnose and treat clients whose needs overlap.

The next thing we need to do is pay attention to technology that can make it easier to collect data and understand population health better. Technology is shifting how we do everything in health and corrections. With the increased use of technology, we must pay attention to the data we collect, and how we can use this data to achieve the Triple Aim. Understanding population health can only happen through wise use of data. We must collect meaningful data so that they can be used in a way that effectively meets the needs of the individuals and populations that we are serving.

Much of the restructuring we are talking about is wholly dependent upon the ability to share information across providers. We must build an information architecture that allows for care to be coordinated between the community and the jail. We also must do more to understand the risk factors associated with an individual who comes from the jail, to the community, and back again.



Some of the steps we have to take will be less obvious, and will require creative use of technology and even inventing new technology to meet the evolving needs of the community. As I head into the final part of this talk, I want to describe some different ways technology is being deployed to reach far more individuals than ever before, while also providing evidence-based mechanisms for meeting the goals of both health and correctional staff.

One of greatest accomplishments that technology can achieve comes from using the power of telecommunications to multiply the distance specialists can cross. Telepsychiatry has allowed mental health providers to reach into underserved communities. Now, “meeting a patient where they are” means a whole lot more than simply making room for their condition, but it also means connecting with them in any way possible. Instead of traveling to a doctor, teleconferencing has made it possible for doctors to come to clients in a virtual world.

Centerstone of America, one of the nation’s largest behavioral health providers, has recognized the power of the technology for multiplying a workforce. Centerstone works in Tennessee, Kentucky, Indiana, and Illinois. Half of the states they work in have not expanded Medicaid, meaning that access to health insurance and services can be problematic. In Indiana, when the physical recovery center became too costly to run, Centerstone developed an online recovery site, called e-ROSC, that allowed Centerstone’s peer mentors to meet more clients at lower costs. Centerstone’s e-ROSC reveals a way that we can expect more work to be done in the future. By employing peer

mentors along with technological advances, Centerstone is able to do more with fewer resources,

Centerstone also recognizes that Big Data provides a means of better coordinating care and understanding how to align provider incentives. Centerstone has its own research wing that vigorously uses data and technology to bridge the divide between providers and patients. Centerstone analysts are using the Healthcare Effectiveness Data and Information Set, or HEDIS data, information used to rank and rate health plans, to leverage the incentives of payers and providers into better outcomes for their clients. When a Centerstone clinician realizes that one of his clients is missing appointments and followups, the clinician can intervene and help that individual get to their appointments—thereby improving performance on the HEDIS measures by connecting the individual with his treatment.

Centerstone is also piloting smartphone applications like Ginger.io. Ginger.io is a smartphone application that allows clinicians at Centerstone to know when a client has not moved from his home for the last several days, or whether they have been on their phone all night—suggesting that the individual is depressed or in the midst of a manic episode. By using these technologies, behavioral health providers are now able to pay attention to warning signs that an individual may need support to avert a crisis. Other piloted smartphone apps are also useful for telling whether or not a client has been smoking, traveling to areas in town that may trigger relapse, and providing virtual check-ins and assessments. Centerstone's relationship to technology and data provide an

excellent model for behavioral health providers who are hoping to deploy data in a way that leads to better outcomes for clients, patients, and care providers.

We at COCHS often hear of new applications that are being created that might be useful to both correctional staff and health care staff. Some of these applications help clinicians by providing push messaging to ask for an individual to rate how he is feeling at that moment. Other applications exist that will allow probation officers to directly message an individual or track where a client is at his time of check-in. These tools will allow practitioners to target check-ins and day reporting to the clients who especially need it, rather than creating a one-size-fits all recovery plan.

We can also see ways that technology and research is being deployed to provide therapeutic interventions through a software interface. In the United Kingdom, a cognitive-behavioral therapy program called Breaking Free Online has been achieving great success in connecting prisoners with online cognitive behavioral therapy both behind the walls of the prison and in the community when they are released. Breaking Free Online uses interactive modules that ask users to identify their own behavior and patterns. The literature suggests that Breaking Free Online is effective for allowing peer mentors and clients to work together to take ownership of the recovery process. A product like Breaking Free could be useful for individuals in jail for several reasons. First, idle time in the jail could be turned into an opportunity to engage in a behavioral health program that does not rely on the availability of trained staff. Further, a product like Breaking Free could begin inside the jail and be continued on probation or community supervision. Software

like Breaking Free Online, and many of the applications previously mentioned, can be powerful tools for client engagement. Each of these provides clients with reminders that they matter and someone is engaged in their wellbeing and recovery.

But use of technology and telepsychiatry are just the beginning of the changes we can expect to see. Telepsychiatry and e-ROSC operate in a linear model: one specialist; one patient. There are models that are focused on multiplying the force of a doctor. Instead of one specialist, one patient, there are ways technology can move from one specialist to hundreds of patients. The most prominent example of this is coming out of Albuquerque, New Mexico, through Project ECHO. Project ECHO began with a problem that we will all relate to: people with complex needs are often the hardest people to reach. In Albuquerque, Dr. Sanjeev Arora realized that in order to meet the needs of his patients with chronic hepatitis C, he had to change the way that he practiced medicine. Even though the drugs to treat hepatitis C existed, fewer than 5 percent of the individuals in New Mexico were receiving the treatment that would cure them. Many of these folks were behind bars or living out in rural New Mexico. His knowledge, as a liver specialist, was locked away in Albuquerque. In his words, he needed to demonopolize his knowledge so that primary care specialists could manage these illnesses in their local settings. He travelled around rural New Mexico and began to train both community and correctional providers to manage the complicated needs of individual with hepatitis C. The result of his efforts: a 2011 New England Journal of Medicine study showed that the primary care clinicians trained by Dr. Arora achieved slightly better cure rates than their patients and had fewer serious adverse effects than those who saw hepatitis C specialists. By paying

attention to the needs of the community, Dr. Arora was able to use technology to improve health for individuals who would have never had the opportunity to access care.

Innovations like Project ECHO will be essential to empower doctors, nurses, case managers, and community health workers to prevent hospitalizations among patients with multiple chronic diseases— one of the essential goals of projects like DSRIP.

Part of the power of Project ECHO comes from its ability to ensure that culturally competent individuals can provide care. By allowing the knowledge from a specialist hundreds of miles away to reach a primary care physician, embedded in his community, we can witness new ways to reach those who have been unreachable because of cultural divides. Combining the demonopolization of knowledge with the software interfaces of programs like Breaking Free Online and the help of peer support will fundamentally change who (or what) is considered capable of addressing an individual's needs.

I hope that what I have described has given you a better sense of where we are going in world of correctional health. The entire health system is changing, and our correctional facilities will not be immune. This, however, is a good thing. Now that more people have access to health insurance than ever before, we will begin to understand better what the needs of this community are, and to see the ways that untreated behavioral health conditions have impacted both public health and public safety. To see this future come to pass, we will be looking at technological innovations, finding peer-support solutions, and creating proper incentive structures to further integrate correctional and behavioral health; individual and community health; and assure that those 400 individuals and other

individuals like them have uninterrupted access to the care they need in the community and not behind bars.