Issue 3 November 2008

COCHS Connection

A Message from the Editor

In September, I attended the annual meeting of the National Association of Community Health Centers (NACHC) in New Orleans. The five-day event offered several dozen break-out sessions discussing a wide range of community health issues such as staffing, management, funding, and policy. COCHS was happy to lead a discussion regarding the role of community health centers (CHCs) in public safety.

I was struck by what I learned about CHC patients: often young, poor, under-insured or uninsured, or homeless. There's a lot of overlap between CHC patients and people detained in jails. The truth is that jails and CHCs see many of the same people.

That was really the starting point for COCHS. Working together, local corrections officials and health providers in Hampden County, MA, realized that most jail inmates came from medically underserved areas served by community health centers. These same people also were at high risk for chronic illness, and, for the most part, were returning to the same communities from which they were incarcerated.

Forming a partnership to coordinate and continue care provided in the jail after release into the community simply made sense. This approach addresses the needs of inmates during and after incarceration and those of their communities.

That's why we in local corrections and community health need to work together, so that we can connect that care, leverage our resources, and improve public health.

Speaking of working together, I'm pleased to announce that COCHS has entered into an agreement with NACHC's legal counsel, Feldesman Tucker Leifer Fidell LLP, to collaborate on the development of a set of tools that will describe the legal relationships possible between health care centers and correctional facilities. We anticipate that these tools will help foster new partnerships and support innovative approaches around the provision of community-based inmate care. We're grateful to NACHC for the opportunity to team up with them on this important project.

During the NACHC meeting, I spoke with many CHC staff people and board members who understood the value and importance of connecting their CHC to their local jail. Many of them knew that some of their patients had a history with the local jail. Others couldn't understand why they didn't have a working partnership with the local jail already. Well, it takes some work, but it can be done, especially if we bear in mind that there is no one-size-fits-all approach. We have to figure out the best approach for each community.

At the conference we confirmed that the CHC community is full of bright, dedicated, and thoughtful people working hard to improve their communities. We also confirmed that COCHS is on the right track.

Paul Sheehan
Chief Operating Officer
Community Oriented Correctional Health Services

COCHS
COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

To subscribe to *COCHS Connection,* please send an email to newsletter@cochs.org and indicate if you would like to recieve the newsletter by email or in hard copy through the mail. In addition, we welcome your comments, feedback, and questions. COCHS is supported in part by the Robert Wood Johnson Foundation.

A Message from the Annie E. Casey Foundation

The Annie E. Casey Foundation fosters public policies, human service reforms, and community supports that help meet the needs of vulnerable children and families. How do inmate re-entry and inmate health care fit into this mission?

It's very simple. People who are incarcerated typically come from poor, minority communities. Many of them are also fathers and mothers. Of the 1.5 million people in prison, 800,000 are parents. Some 1.7 million children under age 17 are associated with them.

Restoring ex-offenders to society isn't just about the individual; it's also about that person's family and community. By helping inmates overcome barriers to employment, housing, and health care, we also strengthen families and support children. That's why we are engaged in this work.

To date, the Annie E. Casey Foundation has focused its re-entry efforts on inmates returning from prison, not jail. We are very interested in learning whether COCHS' experiences bringing health care to jail inmates can be adapted and applied to prison populations as well. We know that the inmate population has a high incidence of communicable diseases and that ex-offenders frequently do not get the health care services they need for their conditions. Their poor health puts the public at risk, and increases the likelihood that they will commit new crimes after release and wind up behind bars again.

COCHS' innovative approach of bringing community-based health practitioners into correctional facilities opens the door to providing a continuum of care not only to the inmate but to the inmate's family. The research is clear that maintaining connection to one's family while incarcerated and upon release leads to a reduction in criminal activity and reduced recividism. COCHS's approach provides a vehicle to maintain and strengthen those family connections.

Children who live in disadvantaged neighborhoods are already at high risk. Having a parent who's incarcerated increases their risk. If we want to give these children a better chance, we need to help their parents, or nothing will change. That's where re-entry comes in.

We look forward to hearing more about the impact of the COCHS approach.

Ira Barbell
Senior Associate
The Annie E. Casey Foundation

Why Medical Homes Matter

A 2006 survey by the Commonwealth Fund found that when people have health insurance coverage and a medical home – defined as a health care setting that provides patients with timely, well-organized care and enhanced access to providers – racial and ethnic disparities in access and quality are reduced or even eliminated. In addition, when people have medical homes, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.

"The results suggest that all providers should take steps to create medical homes for patients," the survey report says. "Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients."

Among the survey's findings:

- With medical homes, preventive care is more routine. Two-thirds of adults who have a medical home receive reminders to get preventative care.

- Medical homes improve chronic care management. Only 23 percent of adults with a medical home report that their health care provider did not give them a plan to manage their care at home, compared with 65 percent who have no regular source of care.

- Forty-two percent of hypertensive adults with a medical home say that they check their blood pressure and that it is well-controlled, compared with 25 percent of those without a medical home.

- People with medical homes report high levels of care coordination. Three-quarters of adults with a medical home who saw a specialist report that their regular doctor helped them decide which specialist to see and communicated with the specialist about their medical history, compared with 58 percent of adults lacking a medical home.

Source: The Commonwealth Fund, "Closing the Divide: How Medical Homes Promote Equity in Health Care." 2007. Available at www.cmwf.org.

Medical Homes: Natural Partnerships between Local Jails and Community Health Centers

By Dick Bohrer, Partner, Martin, Blanck and Associates, Inc., Member, COCHS Advisory Committee

More than 9 million people are released from our nation's 3,300 jails each year, and it's imperative to establish medical homes for them. Keep in mind that nearly all these ex-offenders return to the communities from which they were incarcerated. Their rates of chronic and communicable diseases, mental illness, and addiction are high. If we want to improve the health of communities, then this population – both high-risk and underserved – must be included in local efforts to improve access to both quality preventive and primary care services and essential health and social services.

Having a medical home means having a regular doctor or other health professional who oversees and coordinates care. According to the Commonwealth Fund, care provided through a medical home should be "accessible, continuous, comprehensive and coordinated, and delivered in the context of family and community."

Although the term "medical home" is relatively new, examples of medical homes in this country date back more than 40 years. They're called community health centers, and they function as medical homes for vulnerable populations in medically underserved communities.

Increasing recognition of the need to reform health care in the United States makes discussion of medical homes more important than ever. Most debate over health reform focuses on insurance coverage. But it's not enough to change how we pay for care; we must change how we provide care as well. The concept of the medical home, with its emphasis on the provision of continuous and coordinated care, addresses that issue. But let's be clear: Medical homes are not only for the middle-class and those who have health insurance. For medical homes to have an impact on the health of communities, they must include those special populations that need them most: the poor, the uninsured, the homeless, the mentally ill – and jail inmates.

Few jail inmates have ever had a medical home. In fact, many of them have never seen a doctor as adults until entering jail.

As short-term incarceration facilities, jails cannot create medical homes for inmates on their own. But by partnering with community health centers, they can ensure that inmates have a health practitioner in the community they can continue seeing for care after they are released.

These partnerships are not easy to establish. Jails and health centers are very different institutions, with different missions and cultures.

And yet, they do have some important things in common.

First, jails and health centers are in the community and of the community. They're both on-the-ground operations and they both are concerned with local people, most of them poor, many of them minorities.

That's the second thing: Jails and health centers serve many of the same people, only in different settings and at different points in their lives.

Third, jails are required by law to provide health care to their inmates. In fact, they must provide the community standard of care. Over time, jails have become *de facto* providers of primary care, emergency care, and treatment for mental illness and addiction to underserved populations. They are part of the local safety net, just like community health centers.

Fourth, jails and health centers have a stake in promoting inmate re-entry into the community. For jails, successful re-entry means less crime and less recidivism. In addition, re-entry fits in with health centers' social service mission to support community empowerment.

Health Centers: Past, Present, and Future

The first community health centers opened in the mid-1960s at the height of the War on Poverty and the civil rights movement. Their mission was to provide health and so-

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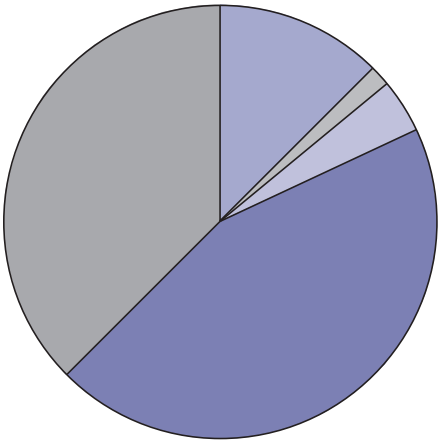
About Community Health Centers

Community health centers form an essential part of the nation's health care safety net. More than 1,150 community health centers with 7,000-plus service sites provide health care and other services to millions of people in vulnerable and underserved communities every year, regardless of whether or how much they can pay. Directed by boards with majority consumer membership, community health centers focus on meeting the basic health care needs of their communities. Their services include physical, mental, and dental care. According to the National Association of Community Health Centers (NACHC), they save the health care system $9.9 billion to $17.6 billion a year by helping patients avoid emergency rooms and by making better use of preventive services.

National Association of Community Health Centers
2008 Community Health Institute Health Center Program Overview
Calendar Year 2007

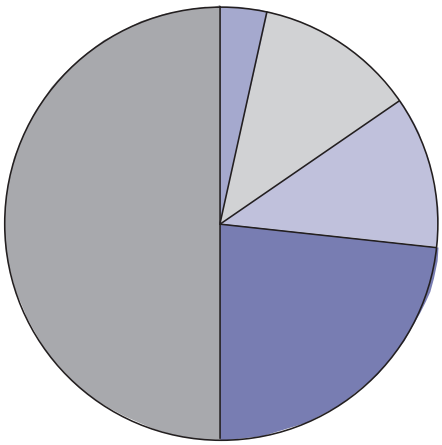
Patients by Insurance 2007

- Private Insurance 16%
- Other Public 3%
- Medicare 8%
- Medicaid 35%
- Uninsured 39%



Patients by Age 2007

- 65 and up 7%
- Under 5 12%
- 5 to 12 13%
- 13 to 24 19%
- 25 to 64 49%



16.1 Million Patients (1 in 20)

- 91% Below 200% Poverty (1 in 7)
- 39% Uninsured (1 in 8)
- 930,589 Homeless Individuals
- 826,977 Migrant/Seasonal Farmworkers
- 133,518 Residents of Public Housing

63 Million Patient Visits

- 1,074 Grantees (53% Rural)

7,000+ Service Sites

- Over 100,000 Staff
- 8,000 Physicians
- 4,700 NPs, PAs, CNMs

Source: Uniform Data System, 2007 Preliminary Data

Quick Facts about Community Health Centers

Patients

- 16.1 million patients
- 91 percent of patients are below 200 percent of poverty level (1 in 7)
- 39 percent are uninsured (1 in 8)
- 930,589 are homeless people
- 826,977 are migrant/seasonal farm workers
- 133,518 are residents of public housing

Community Health Centers

- More than 7,000 service sites
- 63 million patient visits
- 100,000-plus staff
- 8,000 physicians
- 4,700 nurse practitioners, physician assistants, and certified nurse midwives

About NACHC

Organized in 1971, the National Association of Community Health Centers (NACHC) works with a network of state health center and primary care organizations to serve health centers in a number of ways:

- Provide research-based advocacy for health centers and their clients.
- Educate the public about the mission and value of health centers.
- Train and provide technical assistance to health center staff and boards.
- Develop alliances with private partners and key stakeholders to foster delivery of primary health care services to communities in need.

For more information, visit www.nachc.com, or call 301. 347.0400.

Interview

Research Expert Jeff Mellow on the Elements of Inmate Re-entry

Jeff Mellow, PhD, is an associate professor in the Department of Law, Police Science and Criminal Justice Administration, at the John Jay College of Criminal Justice. He is also a senior research associate at the Criminal Justice Research and Evaluation Center at John Jay, an advisory board member of the National Institute of Corrections' Transition from Jail to the Community Project, and principal investigator for the evaluation of the COCHS program in the District of Columbia jail system. His research interests focus on inmate re-entry. Here, Mellow discusses the factors needed to make re-entry succeed and the role of health care in inmate re-entry.

Q. What is needed to support successful re-entry of inmates into society?

A. You need to have both interagency connectivity and client connectivity. We know that jails can't do re-entry alone. The issue is way too complex and they only have the population for a short time. With that said, buy-in from all the partners and stakeholders in the community is a must. Does everybody want it to work? And are they willing to work hard to make it work? That starts with dynamic leadership – people who are engaged and excited about working with the jail population pre- and post-release. It's a holistic approach, which has not been traditionally used when transitioning inmates back to the community. But the evidence-based research indicates that it has to be done. It's the only way to produce the successful outcomes we all want.

Q. Who are the partners needed to make re-entry succeed?

A. All of the public, private, and community-based agencies that touch the majority of the jail population. We sometimes forget that people in jail have multiple problems and needs, regardless of their offense. The criminal justice system is not the only government agency they come into contact with. There's also the public health system, the mental health system, homeless shelters, and agencies that provide substance abuse services, family counseling and public assistance. People in jail tend to be frequent users of government services. The partners and stakeholders have to be leaders from all of those organizations.

Q. What is the difference between re-entry for jail inmates versus prison inmates?

A. Jails are part of the community. They're locally run and independently operated. There are more than 3,000 jails in the United States, compared to only 50 state departments of corrections. In addition, jails and prisons house very different populations. At the jail level, the majority of the population is pretrial detainees, about 60 percent, with the rest serving sentences typically of a year or less. They're only in jail a short time: Over 80 percent are released within a month, and the average length of stay is about 20 days. There are limited programming and treatment opportunities in jail, unlike in prison where staff has more than a year to work with them. So it becomes even more important to link with outside agencies, because inmates are leaving so quickly from jail before all their needs are met.

In a way, you could say that brief incarceration is a barrier to successful re-entry for people released from jail. But jails have advantages, too. They're generally located smack in the middle of the city or county, so the jail staff should have more contact with outside community service providers. Because of the location of the jail, outside agencies can do more in-reach in a jail than in a prison, which typically is located far away. Instead of saying that jails were never designed to do re-entry and they don't have the capacity, we should view the jail as a perfect place to do outreach to this client population. Outside agencies are going to start seeing these people eventually anyway, so why not start interacting with them while they're incarcerated?

Finally, it's important to remember that jail inmates are already in the community. They're home. They've just been incarcerated for a short period of time.

Q. What is the role of health in supporting re-entry for jail inmates?

A. I believe it is integral. All too often, we view public safety and public health as mutually exclusive issues. But they have to be addressed together. When we think about the most pressing needs that inmates have following release, we tend to think about housing and employment, but we should also think about substance abuse, mental health, chronic illness. It's hard for people to maintain employment and housing if their physical and mental health needs are not met. Serious health issues can completely destabilize a person's life. A substance abuser will have a difficult time gaining and maintaining employment. The mentally ill who are discharged without medication and a transition plan increase their chance of engaging in behavior which got them arrested in the first place.

All too often, we view public safety and public health as mutually exclusive issues. But they have to be addressed together. When we think about the most pressing needs that inmates have following release, we tend to think about housing and unemployment, but we should also think about substance abuse, mental health, and chronic illness.

Q. What are your thoughts on the COCHS approach to community-based inmate health care?

A. In essence, the focus of COCHS is on this whole issue of connectivity – on developing a bridge at the systems level between the jail and the health care community. When we look at how health care is budgeted for jails, it comes out of the county's correctional budget and not in part from other county , state, or federal programs. COCHS says it's time to bring back partnerships, starting with the recognition that health care should be dually based, both inside and outside the jail, and then developing these

important linkages. We know the difficulty of getting people to use health care services. Long-term service use for this high-risk, high-need population can be very low, especially for primary care. The belief, which I think is extremely valid, is that if you develop a relationship with the inmates and you have comprehensive discharge planning, you will ultimately see an increase in health care use. And that helps society, by reducing the spread of infectious disease and increasing the use of preventive care services.

Q. Are certain types of communities more amenable to this approach than others?

A. I think the COCHS model is fluid enough to work in any community, whether it's in a rural, suburban, or urban area. I don't think it has anything to do with the size or location of the community. It has everything to do with the leaders in the community, and if they are really engaged and committed. It has to include the whole health care community, because the goal here is not only to have excellent health care inside the jail but to continue that care into the community. The whole health care community has to come together to serve the jail population and develop data management tools to follow that population post-release and determine the effectiveness of the COCHS model.

Q. What is needed to implement a community-based approach to health care?

A. You need to have the right organizational culture, with engaged and committed leaders. You also have to formalize the relationship between the jail and the health care communities. It can't just be done on a handshake. When people come together, they have to draft a memorandum of understanding, and possibly a contract and subcontracts. They have to share data. If it's not formalized, the likelihood for success is low. Open and constant communication is key. If it's one-sided, and one agency is being forced upon another, it's unlikely to succeed. People have to trust each other.

Funding is important as well. Typically, staff either will be increasing their workload or they will be redesigning their work. Discharge planning and follow-up into the community become important. It's very much like a medical home model, with the primary care physician acting at times as a case manager. Resources are needed to train people and hire new staff. And you need to incentivize the process as well. For example, performance-based contracts with health clinics and programs that are able to keep inmates engaged in health services post-release. The more interaction with the client, the better the outcomes should be.

People released from jail live in our communities. They work in our communities. We interact with them on a daily basis, and they are often members of our families. It's just common sense to reduce the potential for the spread of infectious disease in the community, whether it's TB, HIV, hepatitis, or STDs.

Q. What is the benefit of community-based inmate care to society at large?

A. The benefits are to public health, public safety, and better use of public moneys. If someone comes out of jail with a substance problem, you really cannot work with them on their other issues until you deal with their substance problem. The same can be said for inmates with mental health problems and other chronic diseases. People released from jail live in our communities. They work in our communities. We interact with them on a daily basis, and they are often members of our families. It's just common sense to reduce the potential for the spread of infectious disease in the community, whether it's TB, HIV, hepatitis, or STDs. Then there are chronic disease conditions, like hypertension and diabetes, where we can save taxpayers a great deal of money in the long term through preventive care, compared to leaving these diseases untreated until the person has to be hospitalized. We're getting better at taking care of people's health needs and stabilizing them while they're in jail, but the health care gains tend to dissipate after release without a transitional health care plan.

TJC Selects First Two Pilot Sites

In September, the Transition from Jail to Community (TJC) Initiative selected Denver, Colorado, and Douglas County, Kansas, as its first two pilot sites.

TJC represents a partnership launched in 2007 between the National Institute of Corrections (NIC) and the Urban Institute (UI) to help jurisdictions across the country respond to the unique challenges and opportunities around transition from local jails back to the community.

TJC involves the development, implementation, and evaluation of a model for jail to community transition that entails both systems change and collaborative relationships between jail and community partners.

Hampden County (MA) Sheriff Michael Ashe is a member of TJC's Advisory Group.

Denver and Douglas County are the first of six sites that will be selected to participate in the initiative. They will serve as learning sites for the TJC model to allow more evaluation and refinements before the next four sites are selected through an open request for proposals (RFP) in 2009.

Participating jurisdictions will get technical assistance and training over two years from the Initiative that will focus on generating outcomes such as: improved health; reductions in reoffending, substance abuse, and homelessness; and, increased employment and family connectedness.

In Denver, leadership for the initiative comes out of the Crime Prevention and Control Commission – established by Mayor John Hickenlooper in 2005 to examine the city's criminal justice system – which had previously launched a jail-to-community re-entry program.

The Douglas County site will also build on a re-entry initiative currently underway. TJC support will help all the key partners – jail staff, policymakers, and community stakeholders – work together to move the effort forward.

More information on the TJC Initiative is available at: http://www.urban.org/projects/tjc, or by emailing tjc@urban.org . More information on the RFP for the four additional sites will be posted on the website in early 2009.

Letter to *New York Times:* Support Re-entry

The Second Chance Act, signed into law last spring, focuses on promoting successful re-entry for the increasing number of people who return to their communities from jail or prison. The following letter to the editor, written by COCHS Medical Director Keith Barton, MD, appeared in the May 27, 2008, issue of *The New York Times* in response to a news report on the Second Chance Act.

To the Editor:
Re "A Second Chance"
(editorial, May 20):

Most re-entry efforts focus on prison inmates, yet about nine million people cycle annually through our country's jails. This is roughly 10 times the number who leave prisons.

Jail inmates generally return to their communities after short incarcerations, bringing with them a higher incidence of communicable diseases and mental health conditions than exists in the general population.

Left untreated, these problems add to society's health burden, emergency room costs and municipal budgets. They also increase the likelihood that inmates will commit new offenses and return to jail again, at public expense.

Jails are required to provide health care to inmates. This mandate creates an opportunity to support re-entry efforts. By linking inmates with community-based doctors, whom they can continue seeing after release, jails can stabilize inmates' health and help improve the health and safety of the community.

The Second Chance Act is a welcome step. We can do more to support jail inmates by remembering that they are part of our communities and by providing them with community-based health care during incarceration.

Keith Barton
The writer, a physician, is medical director of Community Oriented Correctional Health Services in Oakland, California.

Medical Homes
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cial services in poor and medically underserved communities.

Forty-plus years later, more than 1,150 community health centers across all 50 states and US territories provide comprehensive care to almost 18 million Americans. In the last five years alone, health centers have opened or expanded in 1,200 communities, as a result of the President's Health Center Initiative, which has nearly doubled the federal investment in health centers to almost $2 billion a year.

Health centers maintain an open-door policy, providing treatment regardless of a person's income or insurance status. They serve the homeless, public housing residents, migrant farm workers, and others with limited resources to pay for their health care needs. Seventy percent of health center patients live in poverty, and almost 90 percent have incomes below 200 percent of the poverty level.

Looking ahead, health centers have set a goal of serving a total of 30 million patients by the year 2015, thus reducing the ranks of America's disenfranchised. Former jail inmates and their families could - and should - be among those millions of new patients.

Looking ahead, health centers – under the auspices of the National Association of Community Health Centers (NACHC) – have set a goal of serving a total of 30 million patients by the year 2015, thus reducing the ranks of America's medically disenfranchised. Former jail inmates and their families could – and should – be among those millions of new patients.

Even though establishing a partnership between a health center and a jail is a major undertaking, it can be done, and it is the right thing to do.

The story of Hampden County, MA, illustrates how this can work.

In the early 1990s, physicians from the Brightwood Neighborhood Health Clinic in Springfield, MA, noticed that some chronically ill patients were not making their appointments. Upon further review, the health center staff determined that some of the missed appointments were because a patient had been incarcerated in the Hampden County Jail and House of Corrections.

The Sheriff's Department decided to allow the health center's medical staff into the facility to provide treatment for a chronically ill patient. Upon release, an appointment was made for the inmate to continue treatment at the health center.

The connection formed for this chronically ill inmate revealed a unique public health opportunity within the Hampden County Jail.

The Sheriff's Department realized that most jail inmates came from neighborhoods that had a community health center. In 1996, the Sheriff's Department contracted for medical services with four nonprofit health centers in greater Springfield. Over time, the jail became the entry point into the health care system.

A 2004 evaluation of the Hampden County program sponsored by the National Institute of Justice found that many inmates who had medical or mental health conditions continued to see the health care providers they met in jail *after* they were released. Going to jail had enabled them to enter the health care system and to find a way to stay connected to that health care system once they returned to their community. In essence, they had a medical home.

The Hampden County program became the model for COCHS – Community Oriented Correctional Health Services – which works to foster partnerships between local jails and community health providers. Jurisdictions around the country see in COCHS an opportunity to leverage their health care dollars for the good of their communities while supporting inmate re-entry into those same communities.

At best, re-entry is tough. Having a medical home – a trusted, reliable source of continuing health care – can ease the process for people leaving jail so that they're less likely to return. Working together, jails and health centers can help break the cycle of recidivism by providing much-needed care to former inmates and their families.

In Brief

Second Chance Act Becomes Law

The Second Chance Act (H.R. 1593) was signed into law by President Bush in April 2008. The act – sponsored in the House by Danny Davis (IL) and in the Senate by Joe Biden (DE) – focuses on promoting the successful reintegration of the increasing number of people who return to their communities from jail or prison. The measure authorizes grants to states, local governments and nonprofits to address re-entry issues such as mentoring, job training, housing, substance abuse treatment, and other transitional programs. It also establishes a national resource center to collect data and support re-entry programs. More information is available at: www.thomas.gov .

Federal Funding for Health Centers Reauthorized

President Bush has signed legislation (H.R. 1343) to reauthorize federal funding for community health centers, which provide primary care services to the low-income and uninsured. The measure authorizes over $13 billion in funding for the Community Health Centers Program over the next five years. Annually, community health centers serve over 17 million patients in 7,000 sites across the country. The bill also reauthorizes the National Health Service Corps and the Rural Health Care Programs. More information on the measure is available on the Web site of the National Association of Community Health Centers (NACHC) at: http://www.nachc.org/pressreleasedetail.cfm?PressReleaseID=333 .

DC Wins National Program of the Year Award

The National Commission on Correctional Health Care (NCCHC) recently awarded the District of Columbia Department of Corrections (DOC) its annual *Program of the Year Award* for DOC's discharge planning program. NCCHC also praised DOC partner Unity Health Care for the DOC's support of the District's efforts. The NCCHC award is presented annually to a single program selected from the 5,000 prisons, jails, and juvenile detentions facilities that participate in NCCHC's accreditation program. COCHS provided intensive technical assistance and consulting services to the DOC and Unity in the months leading up to the official launch of the new health care model for inmates in District jail facilities in 2006. More information on the award is available at: http://www.cochs.org/files/NatlRecognitionUnityHealthCare.pdf.

Journalist Focuses on Inmate Care for Kaiser Fellowship Project

Naseem Miller, a health reporter for *The Ocala Star-Banner* in Florida, has been selected as a 2008 Kaiser Media Fellow to pursue an in-depth research project on the quality of medical care in jails and prisons and the broader impact of inmate care on public health and health care. Miller is one of nine journalists named by the Kaiser Family Foundation to participate in this year's Kaiser Media Fellowships in Health program. She has reported on Ocala Community Care, the community-based health care program for jail inmates in Marion County, FL.

RWJF Publishes Brief on Community-Based Inmate Care

"Jails and Community-Based Health Care," a new issue brief on the role of jails as providers of community health, is now available from the Robert Wood Johnson Foundation. Jails are important to the health of communities, especially to minority and low-income populations. The four-page issue brief describes how jails are part of the public health care system and why a community-based approach to care for jail inmates makes sense. To download the document, go to: http://www.rwjf.org/pr/product.jsp?id=34689.

Mentally Ill Offender Treatment Reauthorization Is Finalized

President Bush has signed into law the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act, S. 2304. S. 2304 reauthorizes the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) for an additional five years at $50 million per year. The bill also expands training for law enforcement to identify and respond appropriately to individuals with mental illnesses and supports the development of law enforcement receiving centers to assess people in custody for mental health and substance abuse problems. MIOTCRA, PL 108-414, created the Justice and Mental Health Collaboration Program in 2004 to help states and counties design and implement collaborative efforts between criminal justice and mental health systems.

NIC Posts FY 2009 Technical Assistance and Training Service Plan

The National Institute of Corrections (NIC) has posted is fiscal 2009 service plan, "Technical Assistance Information, and Training for Adult Corrections: All Corrections Disciplines, Jails, Prisons, and Community Corrections." The document describes numerous opportunities for federal, state, and local agencies and practitioners. It's available at http://nicic.org/Downloads/PDF/Library//023063.pdf. Updates to the training programs, satellite/Internet broadcasts, and technical assistance services will be announced at www.nicic.gov.

NIC is an agency within the US Department of Justice, Federal Bureau of Prisons, that provides training, technical assistance, information services, and policy and program development assistance to federal, state, and local corrections agencies. Through cooperative agreements, NIC awards funds to support its program initiatives.

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COMMUNITY
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HEALTH
SERVICES

COCHS

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Community Oriented Correctional Health Services (COCHS) is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community. Ultimately, COCHS hopes to help local communities around the country reduce the incidence of chronic disease and the cost of of health care.

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