Local Correctional Health Care Gets Big Boost From Large Foundation—

National Replication is the Goal

PAUL SHEEHAN

You've heard it over and over again and you've seen it in your own facilities: Every day, inmates with chronic or mental illness are released into the community where they spread disease and crowd emergency rooms. Oftentimes they end up right back in custody—only now they're sicker than when they left.

The Robert Wood Johnson Foundation, (RWJF) the largest philanthropic organization in the country devoted to improving health care took a long look at this issue and reached a helping hand into the world of correctional health and reentry by providing a $7.4 million grant to Community-Oriented Correctional Health Services (COCHS), a new, nonprofit organization established to assist jurisdictions that would like to connect their local correctional facilities and their community-based health services.

COCHS is focused on the *Community Health Model of Correctional Health Care*, the goal being to not only provide quality care inside the facility, but connect returning inmates to their local community health centers for continued care after release. By working through a local provider, it turns local jail health services into a satellite of the local community health center.

The model and its different forms have received a great deal of attention over the years, winning praise from several health care, justice, and other public and private

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Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons, Recommendations, p. 13

groups as a good way to reach high-risk, hard to serve populations. Building relationships with local health providers is recommended in the recently released *Confronting Confinement, a Report on Safety and Abuse in America's Prisons.* In fact, the idea for connecting community health and correctional health care has been around for a long time and has proven to be a good thing for a community. There are currently several outstanding 'health-care reentry' programs operating around the country.

In early 2005, RWJF staff visited the Hampden County Sheriff's Dept. and Correctional Center in Ludlow, Massachusetts where for over ten years Sheriff Michael Ashe has contracted with nonprofit neighborhood health centers to provide physicians and case managers inside his pretrial and short-term, sentenced facility. In their model, health center physicians and case managers are dually based, and treat inmates that hail from and return to the same neighborhood where the community health center is located. This continuity of care has encouraged inmates to maintain post-release care with the local health centers and stay away from emergency rooms for treatment, while still controlling costs and maintaining quality.

After seeing Hampden and later researching the issue around the country, the question for RWJF was: *If there is so much illness in corrections and if community health centers are a logical part of the solution, why aren't more jurisdictions doing it this way?*

The answer: It doesn't happen because it's a lot of work. Connecting two very large, complex systems is a project that not every jurisdiction has the necessary time and finances to invest.

The foundation felt that if technical assistance and support was made available to jurisdictions, more communities would do it. In early 2006, the RWJF established COCHS to act as the technical support bridge between the health center system and the correctional system.

The Mission of COCHS is to work on behalf of the entire community, not just the jail or health system, but to help all parties through the complex planning process so that when completed, no one gets overwhelmed or surprised.

Right out of the gate, COCHS was contacted by the Washington D.C. Mayor's Office. For several months, COCHS worked in DC and helped to facilitate a system allowing Unity Health Care, the largest community health provider in the District, to become the health service provider inside the walls of the DC Department of Corrections.

Connecting the systems wasn't easy. It was a tremendous change for the leadership and staff of corrections, Unity and COCHS. But the commitment from the partners and support of the local community and elected officials was solid.

During initial meetings of DOC and Unity, groups toured the correctional facility. During those tours, many of the inmates said hello to various Unity staff, pointing out the need for a Community Health Model of Care. On October 1, 2006, Unity Health Care began providing the care inside the jail and so far things have gone well.

Dr. Steven F. Scheibel, Medical Director for COCHS, admitted that a project this size and this complex would not have been COCHS choice as their first project. "The foundation felt that because DC is such a high profile community and they were the first to call us—we should get right to it." Now that Unity and the change has been in place for a few months, the partners in Washington, DC agree that the move to a community health model has been positive.

Bringing it to a Community

As in Washington, DC and other communities that develop their own version of the model, it's important that corrections and the health centers see themselves as partners in this process. Trust and mutual respect are vital. Both need to know that the other has an important job to do and that by being partners, they can make a big difference for the whole community. Figuring this out is a complex process. COCHS recommends several months of planning and it's easy to see why.

Depending on the community, the partnership would likely formally begin with the health centers being contracted to provide care in the facility. Obviously, many hours of discussion are needed beforehand, and the health center may need to go through a bid process or a sole source contracting process may be appropriate.

Then, to meet the contract requirements, health centers would have to increase their medical staff as if they were opening another community-based center, because in some sense, they are.

"Ideally, the contracted physician(s) would be working at both locations," says Scheibel, "a few hours per week at the center and a few at the jail so the inmate can see the same person inside and then again post-release." Scheibel, who was the Regional Medical Director for Prison Health Services before joining COCHS in 2006, goes on to say that "Health Centers were designed and built with the

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Mission of treating patients from certain communities. Inmates are still part of the community so contracts with the local jail can help them meet that Mission."

To effectively share medical information, the two systems should be linked by an electronic data system. That way, when an inmate with a health history in the community comes to the correctional facility, that history can frequently be accessed, making for a clear assessment of the inmates' health and housing needs

For example: A female in the community tests positive for gonorrhea. A short time later she is taken into custody. During intake, she may not be quick to disclose her health issues, but the center may already have that history.

Again, developing a contracting process, ramping up staffing levels, training, building computer linkages, etc., are not easy. These tasks may be challenging enough to intimidate a community away from adopting this model, but this is where COCHS comes in. COCHS can use their philanthropic support to do some of this work on behalf of a community.

Other Benefits

Many of the benefits of the model are easy to see, such as keeping health care dollars in the community, potential reductions in emergency room visits by former inmates and potential reductions in disease in the community, but other benefits are hidden and unique. Federal Qualified Community Health Centers (FQHC) have access to the 340(B) Prescription Drug Program, which reduces the costs of medication. That savings can be passed on to the jail. Also, if the jail contracts with a local health center for physicians, some of the liability may shift to the health center, changing the dynamics of potential litigation.

Not all communities can implement all aspects of the model, but the concepts of bringing community providers into corrections can provide long term benefits for a community.

Endnotes

Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons, Recommendations, p. 13. www.prisoncommission.org/report.asp, page 42.

Robert Wood Johnson Foundation: Vulnerable Populations Category, http://www.rwjf.org/porolios resources/grant.jsp?id=55964&iaid=1.

Paul Sheehan is the Chief Operating Officer, Community Oriented Correctional Health Services. Prior to joining COCHS, Mr. Sheehan was employed by the Hampden County Sheriff's Department and Correctional Center in Massachusetts where he was responsible for the development and management of several facility and community-based programs. A primary focus was the refinement and expansion of the Public Health Model of Corrections. He researched, wrote and managed most of the grants and grant-funded programs for the Department and he was responsible for the development of various intelligence-sharing and information-exchange efforts with local police departments and other law enforcement agencies, with a primary focus on the reentry needs of high risk offenders.

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