the NATIONAL REENTRY RESOURCE CENTER

A project of the CSG Justice Center

Essential Elements of Reentry:

Primary Care and the Transitions Clinic Approach

October 25, 2010

Brought to you by the National Reentry Resource Center and the Bureau of Justice Assistance, U.S. Department of Justice

© 2010 Council of State Governments Justice Center

Speakers

- Clemens Hong, MD, MPH
  Co-Founder, Transitions Clinic
  Instructor, Harvard Medical School
- Ronald Sanders
  Senior Community Health Worker, Transitions Clinic
- Shira Shavit, MD
  Executive Director, Transitions Clinic Network
  Assistant Clinical Professor, University of California, SF
- Emily Wang, MD, MAS
  Co-Founder and Director, Transitions Clinic, New Haven
  Assistant Professor, Yale University School of Medicine

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Outline: Primary Care and Transitions

- Background
- Transitions Clinic: Creating the Model
- Role of the Community Health Worker
- Evaluating the Transitions Clinic Model
- Future Directions
- Conclusion

Background: Inmates Return to the Community

- 700,000 federal and state prisoners are released to the community in the United States each year[1]

- Many states have initiated programs for the early release of individuals with chronic medical conditions

1. Sabol W, Minton, TD, and Harrison PM. Prison and Jail Inmates at Midyear 2006. Bureau of Justice Statistics; US Department of Justice 2007.

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Prevalence of Disease

- 37% with chronic disease[1]
- Increased prevalence of communicable diseases
- 65-80% of prisoners with substance use and abuse history[2]
- 13% with severe mental illness[3]
- Many are diagnosed with chronic conditions while incarcerated

Image Courtesy of Ray Chavez and CA Prison Health Care Receivership

1. Review of 1,088 prisoners at San Quentin Reception Center, 2006
2. Bureau of Justice Statistics, "Prisoners in 2006
3. Bureau of Justice Statistics, "Mental Health Problems of Prison and Jail Inmates"

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Transitioning Health Care

- No discharge planning from prison
- Given a limited supply of medication
- Little or no follow-up available in the community

1. Sabol W, Minton, TD, and Harrison PM. Prison and Jail Inmates at Midyear 2006. Bureau of Justice Statistics; US Department of Justice 2007.
2. California Prisoners and Parolees 2007. Summary Statistics on Adult Felon Prisoners and Parolees, Civil Narcotic Addicts and Outpatients and Other Populations, www.cdcr.ca.gov.

Reintegration Difficulties

- **Employment:** Unable to apply for certain jobs including all forms of public employment
- **Public Assistance:** Prohibited from collecting food stamps, WIC, Pell grants, federal student aid
- **Housing:** Prohibited from public housing
- **Medical Assistance:** Lapse in Medicaid

Health Care Access Upon Release

- 85% uninsured or no financial resources for health care

- Recently released inmates are more likely to use the emergency department for health care

Lincoln T, Kennedy S, Facilitators and barriers to continuing healthcare after jail: a community integrated program. J Ambul Care Manage 2006
Flanagan NA. Transitional health care for offenders being released from United States prisons. Can J Nurs Res 2004;

The NEW ENGLAND JOURNAL of MEDICINE

Release from Prison—A High Risk of Death for Former Prisoners

- 12 times increased risk of death in first 2 weeks after release
- The leading causes of death:
  1. Drug overdose
  2. Cardiovascular disease
  3. Homicide
  4. Suicide
  5. Cancer

I. Binswanger, et al NEJM 2007; 356:157-65

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Transitions Clinic: Creating The Model

Chronicle / Michael Macor

Defining Parolee Specific Care

Tailored care for newly released prisoners with chronic medical conditions immediately upon release (within 2 weeks)

- Culturally-competent community health worker (CHW) to assist with patient navigation and basic case management
- Primary care providers with experience caring for patients with a history of incarceration
- Partnerships with existing community organizations that serve formerly incarcerated individuals

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Core Values: Patient Centered

- Patient-centered model
- Cultural competence/humility
- Community-based medical home
- Harm reduction approach
- Multidisciplinary team/centrality of the CHW
- Broad view of health and wellness

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Photo courtesy of Kenny Goldberg, KPBS

Ron Sanders and Juanita Alvarado, CHWs at Transitions Clinic

Transitions Clinic

- Community-based intervention that provides transitional care and a primary care medical home for parolees with chronic medical conditions and their families

- Established in 2006 via focus groups with community partners and individuals with history of incarceration

Transitions Clinic

- In collaboration with San Francisco Department of Public Health
- Located at Southeast Health Center, Bayview Hunter's Point
- Community Advisory Board made up of majority of members with a history of incarceration

Community Advisory Board Members

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Transitions Clinic

- **Transitional care** (refills, paperwork, referral to primary care)
- Ongoing **primary care** for our patients and their families
- **Onsite services:**
  - Dental (basic)
  - Optometry
  - Social work
  - Health education classes (smoking cessation, diabetes education)
  - Podiatry
  - Nutrition
  - Mental health
  - Substance abuse treatment (Suboxone)

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Transitions Clinic

Linkage to community resources via community health workers:

- Medicaid reinstatement
- Substance abuse treatment programs
- Vocational rehabilitation
- Mental health services
- Housing referrals
- Tattoo removal
- Legal aid
- Community advocacy

the NATIONAL REENTRY RESOURCE CENTER

Transitions Clinic

Unduplicated patient visits: > 500

Clinic sessions: 3-4½ days,
10-12 patients/session

Patient appointments:
30% open access/intake
70% follow up

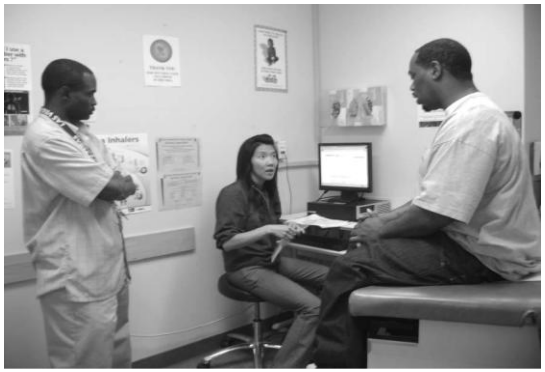
Staff: Physician 0.3 FTE
NP 0.1 FTE
CHWs 1.8 FTE

Case Management:
30-40 active patients

Coverage:
Healthy San Francisco
(county program)

Initial Visit

45 minute visit



- Medical needs assessment
- Medication refills
- Mental health screening
- Counseling and testing infectious diseases
- Substance use assessment and referrals
- Social service needs assessment and referrals
- Specialty healthcare referrals
- Medical record review/request
- Incarceration history and literacy evaluation
- Primary care follow up

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Transitional Care: Continuity of Care

San Quentin State Prison

Outreach begins in prison:

- Ensures access to medical records
- Enhances continuity
- Avoids inappropriate healthcare utilization
- Reduces risk

Community Rounds:

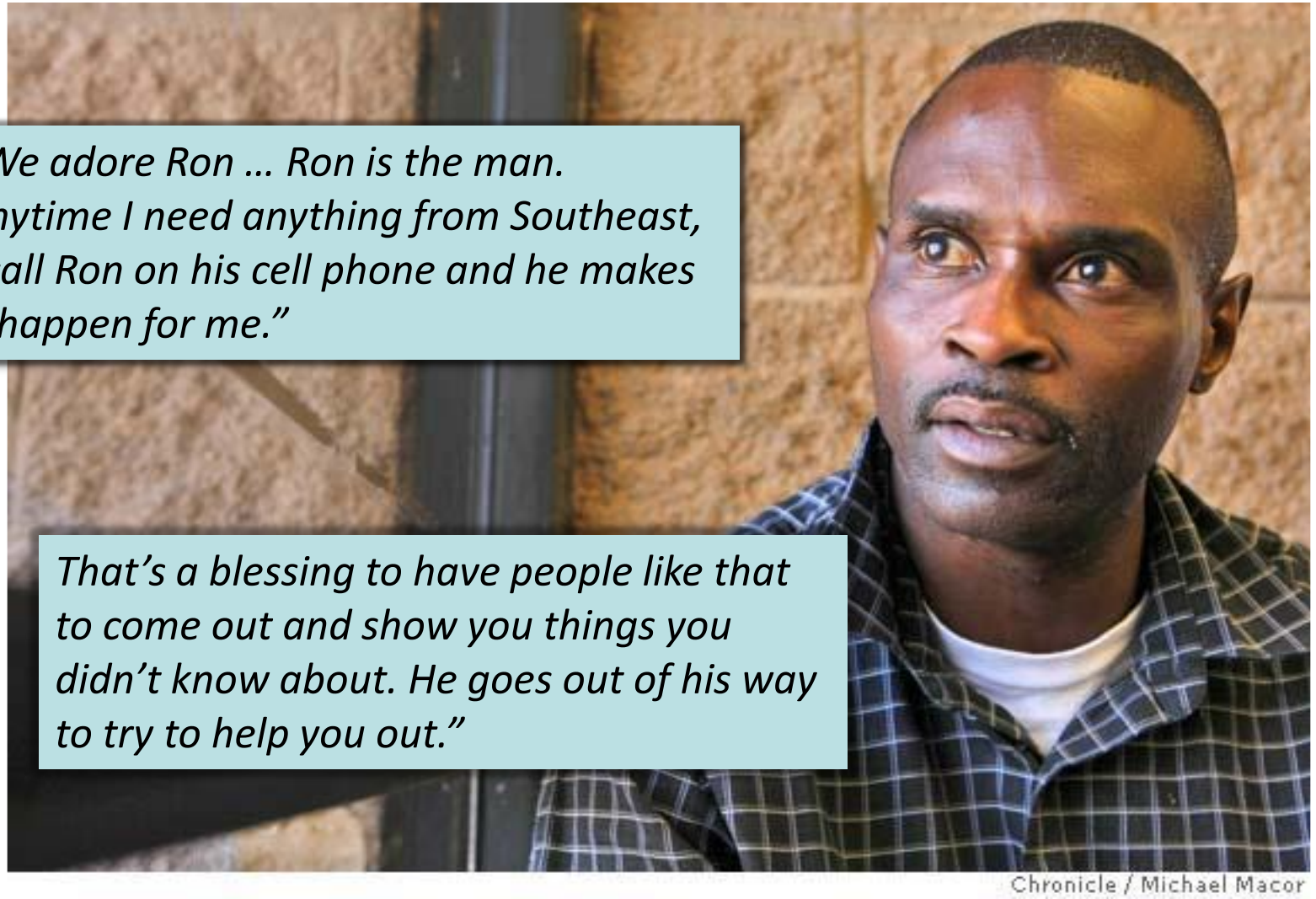
Communication with providers and patients during incarceration

Transitions Medical Home

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

ROLE OF THE COMMUNITY HEALTH WORKER



Ronald Sanders, Transitions CHW

Role of the Community Health Worker

- Patient-centered and culturally appropriate care
- Outreach
- Patient Navigator
- Referrals
- Support
- Substance use counseling
- Health education
- Chronic disease self-management

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Patient-Centered and Culturally Competent Care

They [Transitions clinic staff] don't judge you – they treat you like a human being, like you're still a person. That's something that prison takes away from you, and when you get out, society takes that away from you… I think that's what makes Transitions clinic so successful."

"The first time I went in there [Transitions] it was like I was coming home."

"Even though we are ex-cons and have been in prison we are still human beings … the people at Transitions treat us like human beings."

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Role of the Community Health Worker

Outreach

Meeting our patients where they are at (literally)

- Mandatory parole meeting
- Home
- Jail/prison
- Hospital
- Treatment facilities
- The streets

Patient Navigator

Guide for the complex medical system, medication assistance, health insurance and attending appointments

Home visit with Transitions Patient

TRANSITIONS CLINIC

Role of the Community Health Worker

Referrals:

- Housing ,employment, job training , education and other social services.

Health Education:

- Educating patients about their chronic diseases especially new diagnoses.

Support:

- Available by cell phone day and night.
- Emotional support and advice related to medical issues and reintegration challenges.

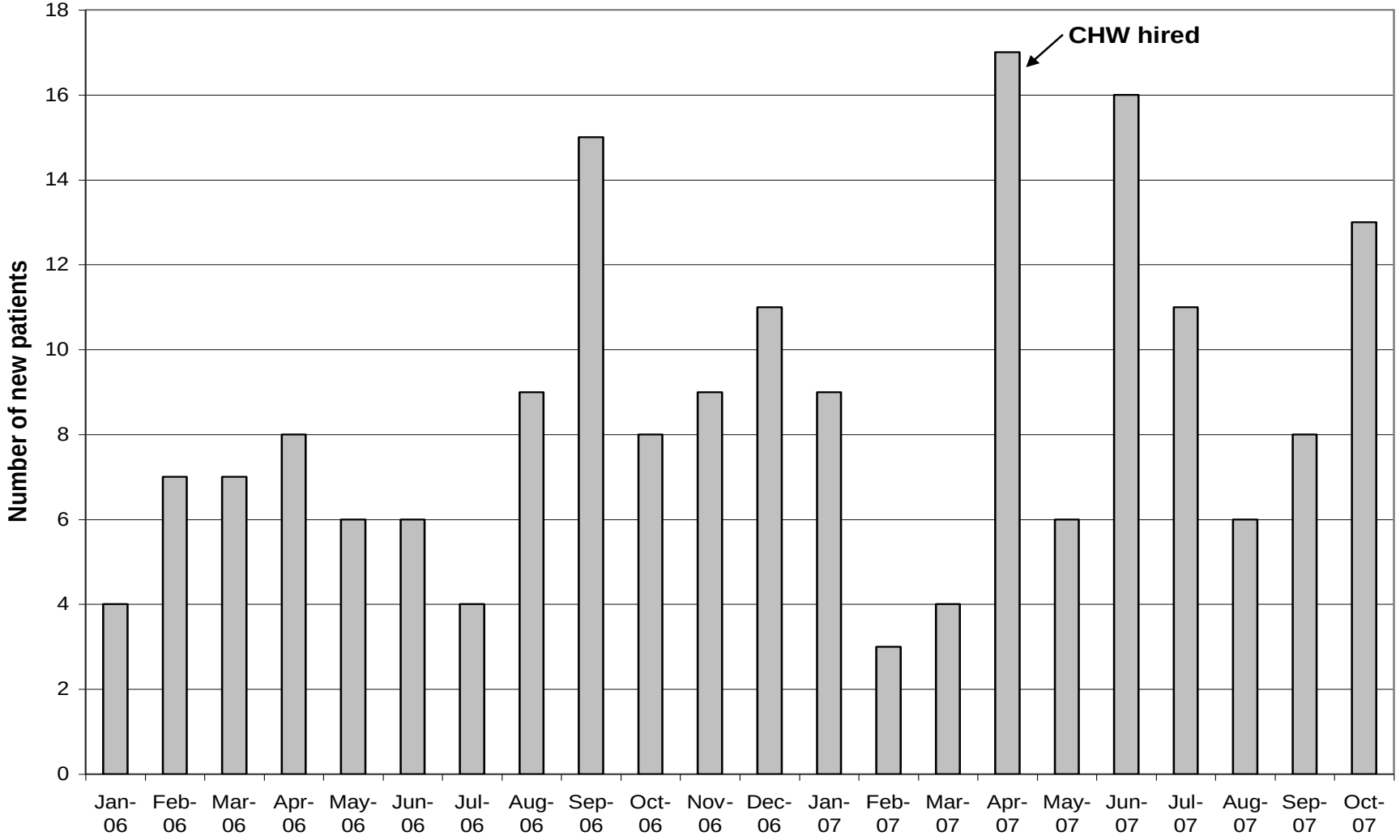
Chronic Disease Self-Management:

- Education about self-reliance and chronic disease management.

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Number of New Patients at Transitions



Evaluating the Transitions Clinic Model

- Used a Community Based Participatory Research (CBPR) Approach

- CBPR is defined as "a collaborative process that equitably involves all partners in research, both the community and researchers, and recognizes the unique strengths that each brings"[1]

1. W.K. Kellogg Foundation

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

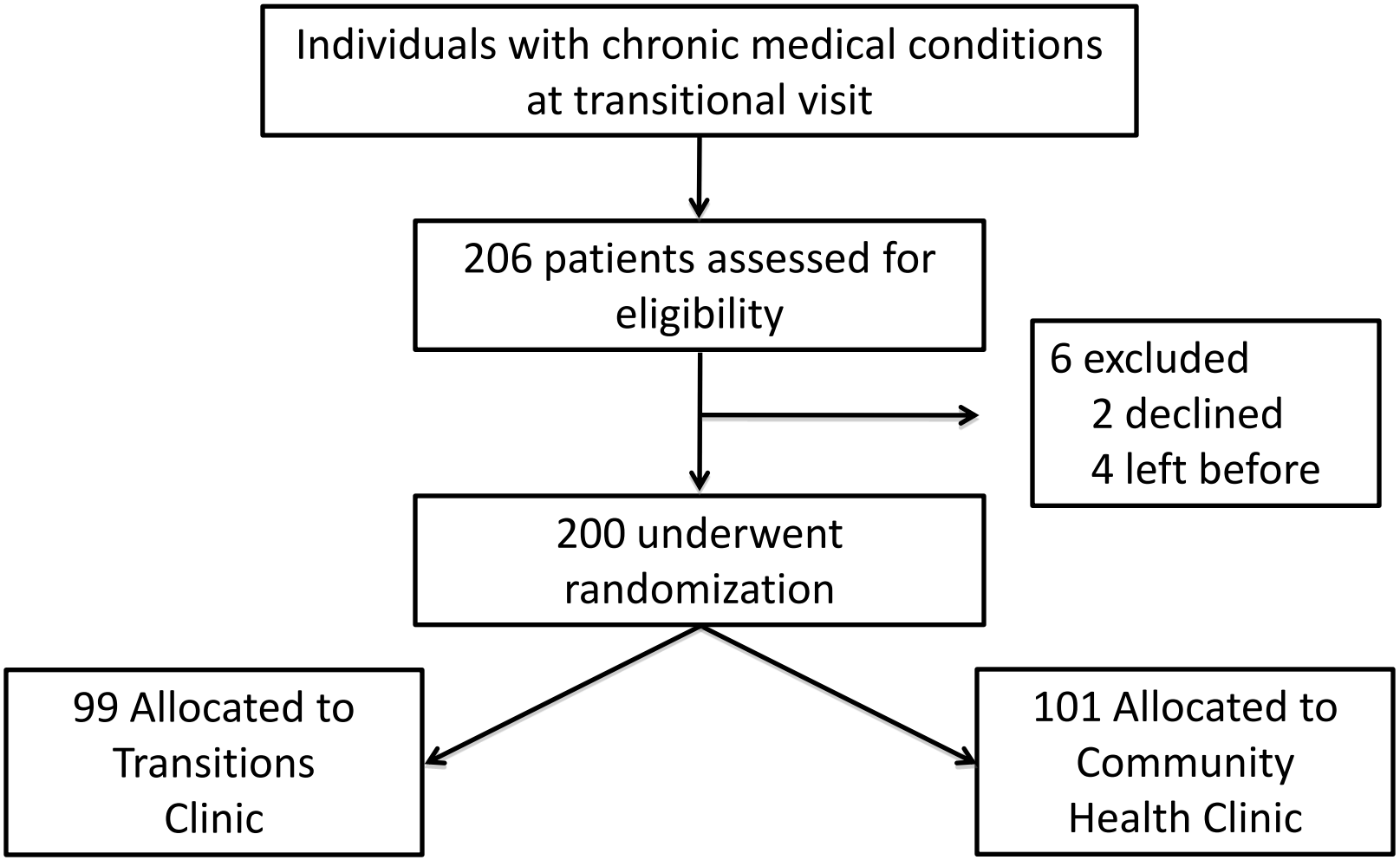
CBPR: Defining Our Community

- Our patients
- Community organizations (All of Us or None, Legal Services for Prisoners with Children, Critical Resistance)
- Southeast Health Center/San Francisco Department of Public Health
- Public Defenders Office, Mayor's Office
- Safe Communities Reentry Council
- California state legislators

CBPR: Defining our outcomes

Does parolee-specific care at Transitions Clinic improve primary care utilization, acute care utilization, and return to jail?

CBPR: Choosing a study design



Results: Baseline

- Majority were black, male, poor
- 90% with 2^{+} chronic medical conditions
- 40% of patients were first diagnosed with chronic condition while in prison
- 67% used the ED as a regular source of care prior to incarceration

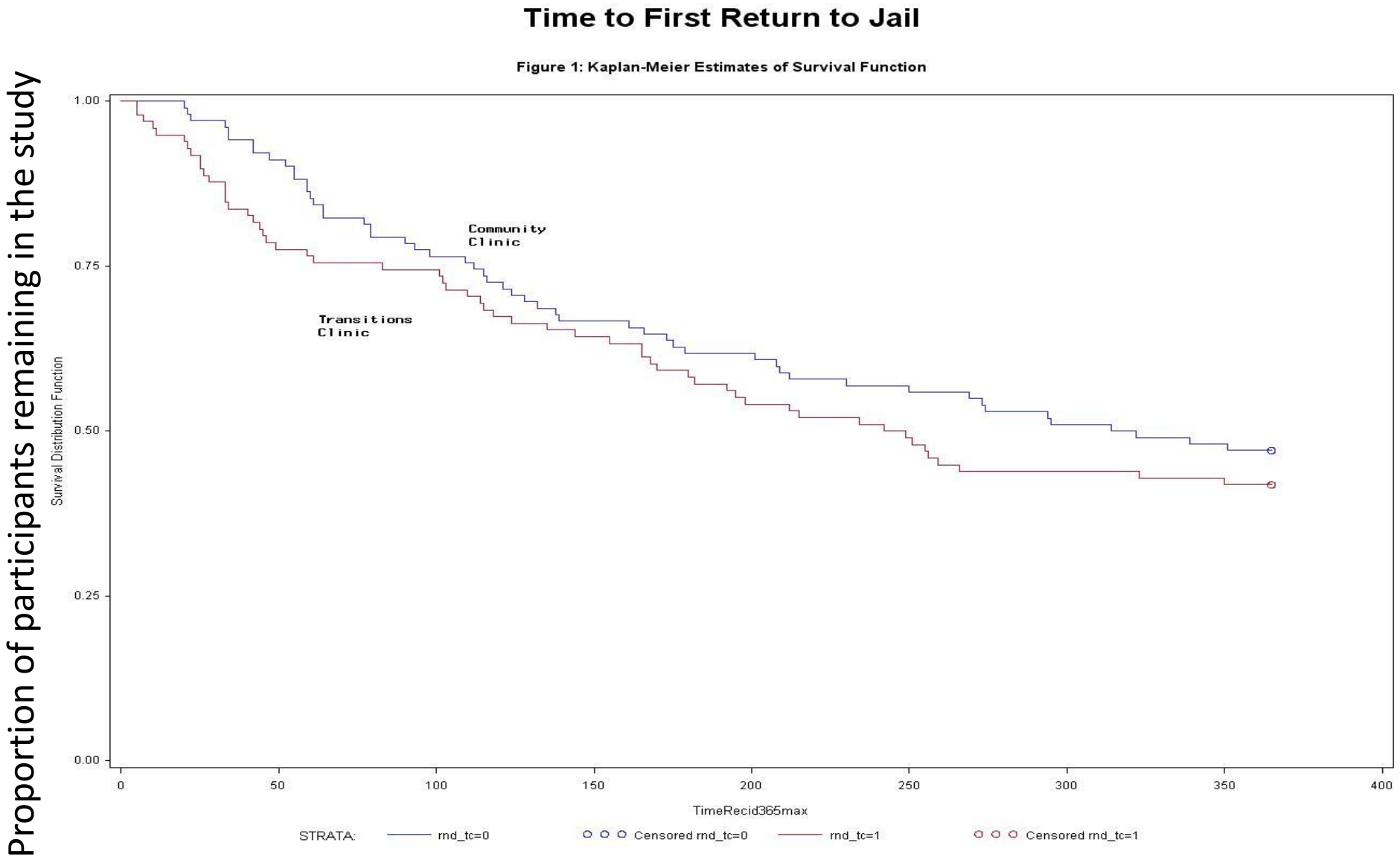
Results: Baseline

- 32% did not have medication upon release
- 20% had scheduled follow up upon release
- 14% had already visited ED before 2 week visit

Results: Healthcare Utilization

Outcomes	Transitions Clinic (N=99)	Community Health Clinic (N=101)	P value
Primary care utilization	59 (60)	67 (67)	0.32
Emergency utilization	25 (25)	40 (40)	0.03
Hospitalization	10 (10)	15 (15)	0.31

Results: Time to Arrest



Proportion of participants remaining in the study

--- randomized to Transitions Clinic --- randomized to community clinic

Study: Conclusions

- Recently released individuals engage in primary care if given early access to care
- Parolee specific care reduces emergency department visits
- Parolee specific care does not reduce arrest rates

Why our model works

- Patient-centered and culturally-appropriate
- Community-driven
- Evidence-based
- Integrated into the safety net healthcare system and replicable in other safety-net settings

Future Directions – National Impetus for Replication

- **Increasing Need/High Demand**
- **Better Health and Better Care** for these vulnerable patients, their families, and their communities
- **Reduced Costs** in setting of constrained budgets, rising health care costs and Medicaid expenditures

How can we support integration of the Transitions Clinic Model into all community health centers and safety-net clinics?

the NATIONAL REENTRY RESOURCE CENTER

TRANSITIONS CLINIC

Future Directions – The Opportunity

- Patient Protection and Affordable Care Act
  - Coverage Expansion – Medicaid
  - Focus on accountable care and cost containment
  - Investment in Community Health Centers and Primary Care Infrastructure
    - Patient Centered Medical Home
  - CDC grants for community health workers

Future Directions – For Transitions Clinic

- Publish and disseminate results from our evaluation
- Replicate the Transitions Clinic model and integrate it into community health delivery nationally
  - Current sites: New Haven, New York, Oakland
- Create Infrastructure to Educate and Train health care providers and community health workers nationally
- Create a national network of Transitions Clinics

the NATIONAL REENTRY RESOURCE CENTER

Transitions Clinic Network

- Aim: To support enhanced models of care for this population nationally
- Create a learning collaborative
  - Share best practices
  - Educate and train providers, administrators, and community health workers
- Coordinate funding, evaluation, and research
- Create a representative advisory board to ensure community engagement
- Funded by the Langeloth Foundation

the NATIONAL REENTRY RESOURCE CENTER

Anticipated Challenges for the Transitions Clinic Network

- Dependence on the safety-net delivery systems
  - Often with limited resources and poor infrastructure
- Reaching/engaging formerly incarcerated individuals
- Generalizing cultural competency training and maintaining focus on culturally-competent care
- Timely insurance coverage post-release
- Buy-in from community health centers
- Funding for community health workers

Policy Recommendations

- Ensure continuous health insurance coverage
  - Continue coverage in prison OR mandate seamless continuation of coverage post-release
- Create sustainable funding mechanisms for community health workers and fund training programs
- Create/fund coordinated Reentry Service Centers in all areas with high incarceration rates
  - Integrated these reentry centers with health care and social service delivery systems
  - Require community advisory boards

Conclusions

- Prison/community transitions are a high-risk period
- Primary care is an essential part of reentry
- The Transitions approach is effective and evidence-based
  - Key components of our model are:
    - Culturally-competent health care workers, including a community health worker
    - Early access to healthcare post-release – continuity of care between prison and community
- This model can be integrated nationally into safety-net delivery systems in the context of health reform
- The Transitions Clinic Network may help get us there

the NATIONAL REENTRY RESOURCE CENTER

Transitions Clinic Staff

Acknowledgements

Thank you to our funders who without their generosity and support this work would not be possible:

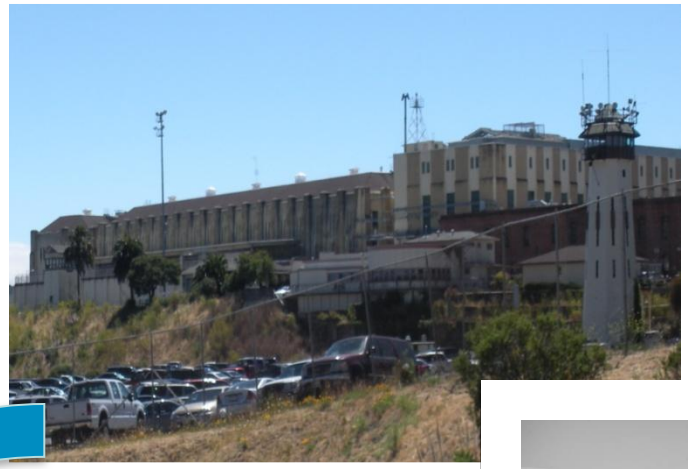
- San Francisco Foundation
- California Endowment
- Robert Wood Johnson Foundation
- California Wellness Foundation
- The Langeloth Foundation
- Newman Foundation
- University of California, San Francisco
- Department of Public Health, San Francisco
- Catholic Healthcare West
- California Policy Research Center

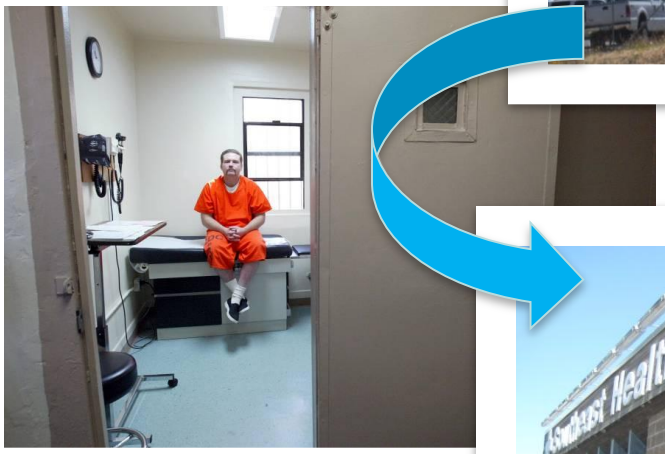
the NATIONAL REENTRY RESOURCE CENTER

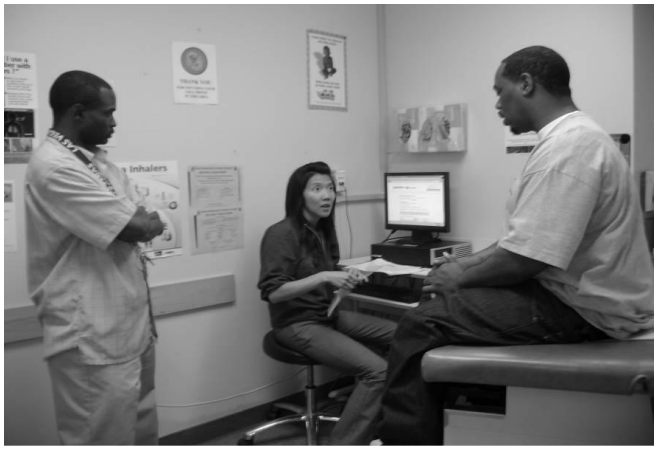
TRANSITIONS CLINIC

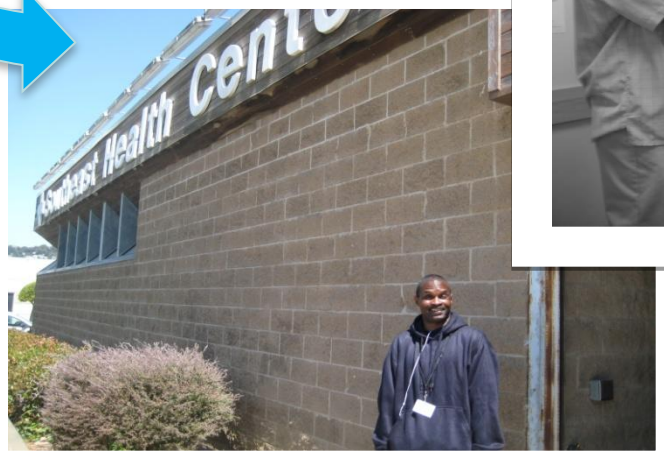
www.transitionsclinic.org

TRANSITIONS CLINIC









Comprehensive, Effective, Coordinated Care

Contact Information

Transitions Clinic

2401 Keith Street
San Francisco, CA 94134
415-476-2148

www.transitionsclinic.org

Shira Shavit, MD
sshavit@fcm.ucsf.edu

Emily Wang, MD
Emily.wang@yale.edu

Ronald Sanders, CHW
rnsnd4@aol.com

Clemens Hong, MD
cshong@partners.org

the NATIONAL REENTRY RESOURCE CENTER

(646) 383-5721
www.nationalreentryresourcecenter.org

This presentation was prepared by the National Reentry Resource Center, in partnership with Shira Shavit, Emily Wang, Ronald Sanders, and Clemens Hong. Presentations are not externally reviewed for form or content. The statements reflect the views of the authors and should not be considered the official position of the CSG Justice Center, the members of the Council of State Governments, or the U.S. Department of Justice.