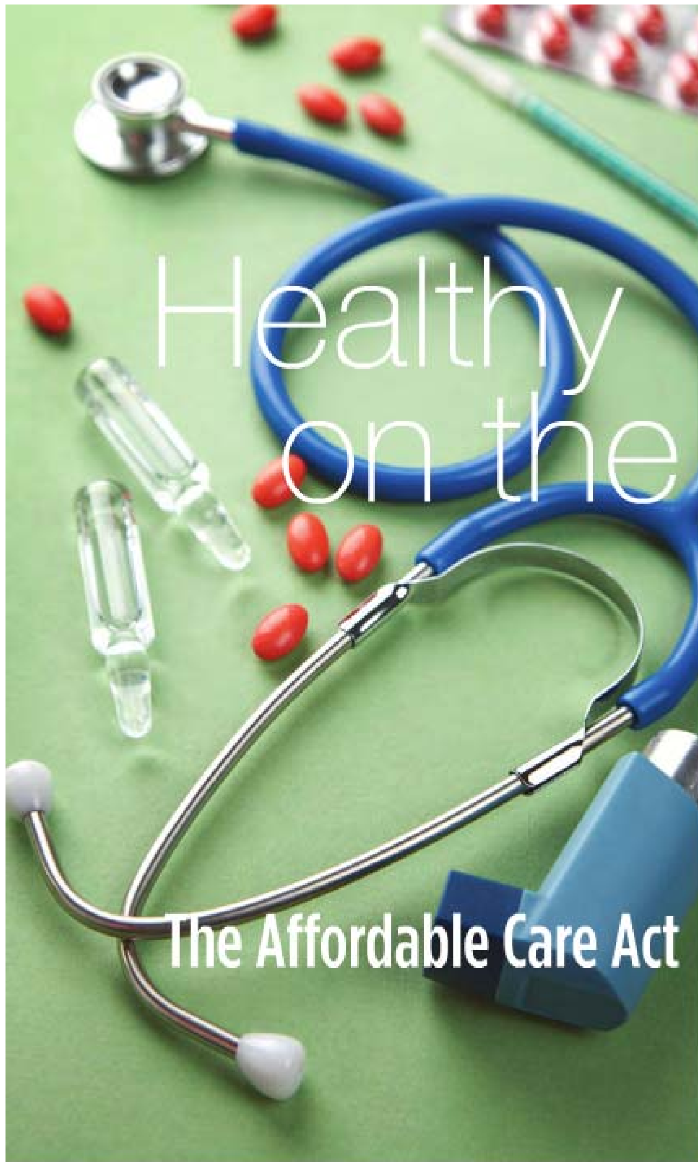

Healthy on the Outside

The Affordable Care Act provides medical coverage to many parolees.

BY MICHAEL GROHS, CONTRIBUTING EDITOR

PRISONS are no health spas. According to the Alliance of Mental Illness, more than half of all inmates have a mental health problem. A report by the Treatment Advocacy Center also found the recidivism rate for people with mental health issues is higher than that of other inmates. Ninety percent of inmates in Los Angeles County with mental health problems were repeat offenders, and nearly a third of those had been incarcerated more than 10 times. And that's just the mental health problems. As a whole, inmates tend to be a less physically healthy group than the rest of the population. Infectious disease, addiction, diabetes, coronary disease, and other chronic maladies are prevalent in many. For decades, many inmates entered the institution with such conditions, and then upon release lost access to treatment, which affected their health as well as the risk of recidivism.

According to the Urban Institute, nearly all returning prisoners have some type of chronic health condition that requires treatment or management (substance abuse, hepatitis, depression, HIV, diabetes, asthma), and many have more than one. Most have no insurance upon release. Before the ACA, Medicaid only covered five groups of people: pregnant

“Under the Affordable Care Act…. we’ve helped enroll 85% of eligible parolees before their release.”

—DANA SIMAS, CDCR

women, children under a certain age, parents of those children, seniors, and the disabled. Excluded were poor, childless, single males, the group of people who make up a huge percentage of the prison population. In January 2014, the categories were eliminated in states that accepted Medicaid expansion under the Affordable Care Act (ACA), and now there are those who believe the ACA could potentially have an unintended consequence: prison reform.

Corrections medical providers have taken strides to ensure that inmates who are being released are being aligned with post-incarceration medical access. Dana Simas, information officer at the California Department of Corrections and Rehabilitation says, “We have doubled our efforts to enroll inmates into Medi-Cal before their release given the new qualification criteria under the Affordable Care Act. Currently, we’ve helped enroll 85% of eligible parolees before their release.”

Organizations contracted to provide the medical functions of correctional facilities are also moving full steam ahead to ensure treatment is continued upon release, and the evidence is showing that it is lowering the rate of recidivism.

The Re-entry Process

Mike Pinkert, founder, chairman, and CEO of MHM-Centurion, points out that navigating the Medicaid system could be a bewildering process for someone who may have not had contact with the outside world for some time. Susanne Moore, executive vice president of NaphCare, adds, “Often, the inmates under our care in our client partner facilities have had little or no medical care prior to incarceration.” Generally, says Pinkert, upon discharge, inmates are usually given a 30-day supply of medications and then referred to a community mental health center, a federally qualified health center, or a private provider “where continued care is maintained and ongoing prescriptions can be provided.” He furthers that because of the ACA, there is a coming “convergence” of Medicaid and correctional healthcare that should make the transition from incarceration to release more seamless.

Ellen Rappaport, the director of re-entry at Wexford Health Sources, explains that achieving this goal was “much more challenging before the ACA.” Wexford’s re-entry process begins at intake. When their discharge planning team gets a list of names 30 to 60 days prior to release, more intensified discharge planning is initiated. They then assess the patient’s needs, schedule follow-up appointments with community agencies who are familiar with this particular population, fill out an application for Medicaid (and Medicare, as applicable), and then align the inmate with services upon release. There is also the coordination of medication, and the inmate is given a 30-day supply of meds as well as a “Continuity of Care Form” discharge document. The Nurse Discharge Planner later makes a follow up call to ensure that the patient showed up to the initial visit. Rappaport notes that partnerships and collaboration among the state, community, and Wexford continue to strengthen inmates’ transition from custody to community.

What professionals in all aspects of the industry seem to agree on is that success depends on planning for release from the beginning and forming partnerships. Moore states, “NaphCare’s goal is that the inmate/detainee/offender patient re-enters the free world with four things in hand: a Medicaid or insurance card, a first appointment, a supply of their prescription medication, and their medical records.” Those relationships are developed during the period of incarceration. “Over time, the relationship between NaphCare providers and the outside specialists naturally develops into a collaborative arrangement, with the common goal of improving the inmate’s health.”

Developing partnerships plays a crucial role in the re-entry process. As Nick Little, Wexford Health vice president of Quality, Compliance, and Business Affairs says, “As many entities as possible.”

The Conditions of Concern

Generally, the conditions that are of primary concern for the discharge planner, says Rappaport, are “complex medical conditions” such as cancer, uncontrolled diabetes, cardiac and respiratory conditions, seriously mentally ill patients, HIV, and hepatitis. There is, though, she explains, an automatic release process through the onsite medical teams for those inmates enrolled in chronic care clinics

whose conditions are under control. These inmates get a 30-day supply of medication along with the Continuity of Care form.

Most providers state that the range of services is quite broad. Says Curry Butler, statewide coordinator of Case Management for MHM-Centurion's Tennessee Department of Corrections, even if an inmate inquires about minor medical treatments such as getting a physical or a dental appointment, the case manager will assist the inmate to obtain the appointment. Dr. Jane Haddad, PsyD, vice president of Clinical Operations at MHM-Centurion says, "Release planning is offered to all inmates when released from incarceration if they are receiving ongoing treatment/medication."

What Works?

Professionals in the field seem to agree on several factors to find success in aligning inmates with community services upon release. A few that most agree on is the aforementioned development of relationships between correctional health providers and outside services, educating the inmate on the importance of taking charge of his or her health maintenance, and taking into consideration the reentry program upon intake. NaphCare, says Moore, takes "a collaborative and interdisciplinary approach to discharge planning that begins from the time the inmate enters the facility." Most providers agree. Dr. Mark Fleming, director of Operations, Behavioral Health at Corizon says, "We typically work collaboratively with our client to help address the reentry needs of our inmates utilizing a multidisciplinary treatment plan approach that begins on Day One of incarceration and

A Corizon nurse counsels an inmate preparing for the reentry process by reviewing its reentry website.

Photo courtesy of corizon health

does not end until the person is walking out the door."

Dr. John Wilson, PhD, CCHP-MH, senior clinical operations specialist at MHM-Centurion, also explains that tele-health and tele-mental health has served an important function in the matter. Not only does it better the chance that an inmate will continue recommended treatment, it has often helped MHM-Centurion access the community services in the first place. "For some community health clinics and mental health centers, the rate of no-shows for recently released inmates has been so high that these clinics will not make future appointments for these individuals while they are still incarcerated. These clinics have waiting lists and/or limited appointment slots available, which are prioritized for their existing community-based service recipients. We have found that, once contact is made between the inmate and the future community provider through a tele-health encounter, both parties form a commitment to work with each other."

Dr. Haddad also with MHM-Centurion has realized similar success. "We have found that coordinating a meeting between community agencies/providers and an inmate either face-to-face or through tele-health significantly increases the potential of the inmate continuing medically recommended community follow-up. Bob May, senior vice president, Marketing and Development, MHM Services, Inc., furthers, "It's not too farfetched to think that soon ex-inmates will remain in contact with their in-prison health care team via handheld devices given to them upon release."

There is another aspect of the ACA that makes the transition easier, says Moore. "Another critical piece for continuity of care is their medical records, which NaphCare has the capability to send to their new provider instantaneously using secure encrypted electronic mail."

Challenges Going Forward

Naturally, there are numerous challenges to consider. Among them, the professionals seem to universally agree, is the risk of an inmate not following up on medical visits. As Little of Wexford points out, once an inmate is released from custody, the community becomes the inmate's primary care provider.

The best hope for resolution to this, says Rappaport, is to develop a system when inside to teach the inmate about their condition and to inspire him or her to take control of their own health. "Do everything you can to motivate their healthcare." Wexford also offers brochures and pamphlets for inmates to take with them to educate their family members.

Dr. Haddad agrees. "Many inmates do not prioritize continued health care follow-up upon release given their immediate concerns for housing and survival as well their limited insight into the importance of health care follow-up," a concern that again may result in community providers being reluctant to schedule appointments for inmates upon release. May furthers. "The temptation on inmates to return to their pre-prison unhealthy behaviors and lifestyles often results in non-compliance with re-entry plans."

There is also the matter of the system itself. As Little points out, community resources are already taxed, and just because the providers inside have the links to community resources does not mean the resources can absorb a large number of released ex-offender patients. On that note, Moore furthers that finding a payor source itself can also be a problem, particularly in states that have not expanded Medicaid, and few providers will schedule an appointment without one. Dr. Wilson also points out that there is a national shortage of psychiatric providers. While incarcerated, an inmate with a serious mental illness may see a provider fairly often, but once released, it could take three months to be seen by a provider, and if the supply of medications the inmate is given runs out before then, there will be a gap in coverage.

There are also numerous other issues that arise such as the unpredictable nature of incarceration. It is often uncertain exactly when an inmate will be released, a situation that is compounded in jails since an inmate may be there for two hours or a year, and providers may only have a few days' notice. Dr. Fleming also points out other issues such as a lack of experienced providers familiar with reentry in prisons and jails, insufficient funding resources, fear and prejudice of potential providers and sociopolitical realities regarding resources and support to this population. As Little says, "It's an evolving process." He adds, "The more you put into it, the less recidivism." ✪