

# A Public Health Model for Correctional Health Care

*A guide for correctional facilities to put public health services into practice*



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# **A Public Health Manual for Correctional Health Care**

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*"We need to ensure compassionate and quality health care to those incarcerated in our jails and prisons, based upon the fundamental public health principles of healthy communities, universal access, and human rights. Documents such as this go a long way towards helping us reach this goal."*

Mohammad N. Akhter, MD, MPH  
Executive Director,  
American Public Health Association



*"My case manager has helped me in the way I see myself and feel about myself. I am more confident about my future and the things I need to do to continue living healthy...Having the same provider [in the community and in jail] has given me a sense of control over my situation and my life...For the first time in my life I feel important and cared for."*

Richard  
Former inmate at Hampden County Correctional Center

*"Hampden County's model shows the value of integrating public health techniques into correctional health care practices. It realizes that better patient outcomes can be achieved when various agencies coordinate total patient care."*

Edward A. Harrison, CCHP  
President, National Commission on Correctional Health Care

*"The Hampden County Public Health Model for Corrections truly demonstrates that correctional settings do not exist in isolation. The model has shown that incarcerated populations are part of the community and the health and well being of corrections directly impacts the health of the larger community as inmates return home."*

John R. Miles, MPA  
Former CDC Special Assistant for Corrections and Substance Abuse

*“The medical care I receive at the jail reduces a lot of the stress...my case manager here in jail has been a great help with legal issues, health issues, and family issues.”*

Miriam (Not real name)  
Inmate at Hampden County Correctional Center

*“The Hampden County Correctional Center has demonstrated that high quality, cost-effective health care can be delivered in the correctional setting by linking with community-based health care providers and public health departments. This linkage improves community well-being and public safety, has an impact on the health of both the inmate and the community, and fosters a rehabilitative approach to health care that extends beyond the prison walls. In creating the manual for the Public Health Model of Correctional Care, the Massachusetts Public Health Association and the Hampden County Correctional Center provide a practical guide to other correctional systems and communities. I encourage other correctional systems and health care providers to apply the lessons in this manual and reach out to the communities from which their inmates come and establish the valuable public health connection.”*

Howard K. Koh, M.D., M.P.H.  
Commissioner, Massachusetts Department of Public Health

*"This jail has cast the mold for bridging correctional and community health care. The manual describing this elegant program is an asset to the literature."*

Robert B. Greifinger, MD  
Consultant in Quality Management and Correctional Health Care

*“My health in the jail is up to date, better than ever before. The attention and education provided here in the jail will hopefully help me to stay on top of my health on the outside...The care I receive here is more consistent than the care I was receiving on the outside, due to having constant access to a medical provider, nurse and case manager. It is good to know that the medical provider you have an established relationship with continues to see you while in jail or out in the community.”*

Carlos (Not real name)  
Inmate at Hampden County Correctional Center

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*Finally, to Innovations in American Government who provided the award and support that made this manual possible.*



## **INNOVATIONS IN AMERICAN GOVERNMENT AWARD**

The Innovations in American Government program is funded by the Ford Foundation and administered by the John F. Kennedy School of Government at Harvard University in partnership with the Council for Excellence in Government. The Ford Foundation has made award grants totaling \$15.9 million since the Innovations Program began in 1986. In 2000, the Hampden County, Massachusetts Sheriff's Department Health Services program was one of 10 nationwide winners of the award.

The Innovations in American Government Awards are intended to draw attention to exemplary achievements in government problem solving and to amplify the voices of public innovators in communicating their practices. Replication of recognized innovations is a major goal. More than 85% of the programs receiving Innovations Awards have been adapted by other jurisdictions.

### ***About the Innovations Partners***

*Harvard University's John F. Kennedy School of Government* is a graduate school of public policy dedicated to preparing leaders for service in government and contributing to the solution of important public problems.

*The Ford Foundation*, established in 1936, is a private, nonprofit institution that serves as a resource for innovative people and institutions worldwide. Its goals are to strengthen democratic values, reduce poverty and injustice, promote international cooperation and advance human achievement. A national and international philanthropy with assets over \$13 billion, the Foundation has granted more than \$10 billion in grants and loans worldwide. The Foundation maintains headquarters in New York City and has offices in Africa, the Middle East, Asia, Latin America and Russia.

*The Council for Excellence in Government* is a national, nonprofit and nonpartisan organization whose 750 members have served as public-sector officials. The Council's mission is to improve the performance of government by strengthening results-oriented management and creative leadership in the public sector and to build understanding in government by focusing public discussion on its roles and responsibilities.

## **ABOUT THE RESOURCE MANUAL PARTNERS**



### *Hampden County Massachusetts Sheriff's Department and Correctional Center*

The Hampden County Correctional Center (HCCC) is a medium-security facility located in Ludlow, Massachusetts. The roles of the facility are: 1) to incarcerate persons sentenced by the courts, 2) to detain persons awaiting trial as prescribed by the courts, and 3) to provide, in a cost-effective manner, the highest degree of security for the citizens of Hampden County, and safety for both the inmate/pretrial detainee populations and staff.

On an average day, the Hampden County Correctional Center houses 1,800 inmates; approximately 5,000 inmates pass through the facility each year. The public health model of correctional health care has been in development at the facility since 1992. In 1998, the Hampden County Correctional Center was named Health Care Facility of the Year by the National Commission on Correctional Health Care.



### *Massachusetts Public Health Association*

Established in 1890, the Massachusetts Public Health Association (MPHA) is the oldest public health association in the country and is an affiliate of the nation-wide American Public Health Association. MPHA seeks to improve health status through education, advocacy, and coalition building. MPHA educates its members, the public health community and the general public on health-related issues and promotes action to address public health concerns. MPHA is a comprehensive leadership and membership organization that represents an important voice for public health in Massachusetts. MPHA is working with HCCC to promote its innovative public health model as part of MPHA's correctional health campaign.

## **LETTER FROM COLLABORATORS**

Dear Reader:

On behalf of the Hampden County Sheriff's Department and the Massachusetts Public Health Association (MPHA), we are pleased to present this manual as a resource for practicing professionals in the fields of medicine, public health, nursing, corrections and public policy.

The partnership represented by this collaboration grew out of our mutual commitment to the health and well being of communities. Correctional institutions house inmates with disproportionate rates of infectious and chronic illness and psychosocial disorders. The vast majority of these inmates return to their home communities. If disease transmission is to be interrupted and the health of the general public optimized, effective health care and education must be provided *within* the correctional system.

Given the close association between correctional facilities and their host communities, there are tremendous public health opportunities that can benefit the individual inmate and entire community in terms of disease reduction, financial savings and improved public safety.

In response to this opportunity, the Hampden County Sheriff's Department in Ludlow, Massachusetts has developed a unique model of correctional health care. This public health model of care responds to the health needs of the inmate and the entire community, including the correctional system. This resource manual was developed in order to more widely disseminate practical information about the operations of the model.

This manual is designed to provide information about the benefits of a public health model of care and concrete suggestions for implementing it within correctional systems. We hope it will serve as a guide for the expansion of quality correctional health care services and as a tool for advocates of comprehensive health care for inmates.

In 2000, the Hampden County Sheriff's Department Health Services program was awarded an *Innovations in American Government Award* from the Ford Foundation. This award, one of the most prestigious and competitive national public service awards, brings public attention to the quality and responsiveness of American government at all levels and helps to foster the replication of innovative approaches.

This manual, along with a companion website [www.mphaweb.org/hccc](http://www.mphaweb.org/hccc), were supported by the Ford Foundation award. These materials were developed by the Massachusetts Public Health Association and the Hampden County Sheriff's Department and Correctional Center to assist with the innovation, replication, and dissemination process.



We hope that this project will serve as a model of collaborative bridge-building between the worlds of medicine, public health, nursing and corrections. Jails and prisons present unique opportunities for public health partnerships. Collaboration between public health providers, federal, state and local agencies, correctional health care providers, inmate organizations and community advocacy groups can lead to significantly improved health for communities. We encourage such beneficial partnerships in your community.

**Michael J. Ashe, Jr.**  
Sheriff  
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President  
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Director of Education and Advocacy  
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## **EXECUTIVE SUMMARY**

The United States has the highest incarceration rate in the world, with 1 in 32 of U.S. adults under some form of correctional supervision. Incarcerated individuals experience disproportionately higher rates of infectious and chronic diseases, substance abuse, mental illness and trauma than the general population. Inmates are also overwhelmingly poorer, less educated and more likely to be persons of color than the general population. Since the majority of inmates are eventually released back to their communities, interventions to address their health and mental health problems present opportunities to improve both the public's health and safety.

The *Public Health Manual for Correctional Health Care* is a practical guide to the components, operations, and benefits of implementing a comprehensive public health model of care in correctional facilities. It offers a framework for providing a spectrum of health and mental health services to inmates, linking them to the community from which they came and to which they return. This successful and innovative system builds collaborations between correctional health and public health, with reduced costs realized by contracting with non-profit providers in the community. The following five elements form the basis for all services and programs in the Health Services Department at HCCC:

- Early assessment and detection
- Prompt and effective treatment at a community standard of care
- Comprehensive health education
- Prevention measures
- Continuity of care in the community upon release

While there are many challenges to changing a health care delivery system that has used the same practices and providers for many years, we believe that - with sufficient support - the public health model of correctional health care can be replicated in a variety of settings. Some facilities may choose to replicate the model as a whole, while others will adopt it incrementally or select only specific components. Additionally, the model may need to be modified to address the specific needs of a population or correctional system.

Key elements for successful implementation of the model include:

- Support of the model from high-level correctional administrators, including a dedication to improving inmate and community health;
- Commitment to collaborate openly with state agencies and local non-profit providers;
- Willingness to substantially change the existing correctional health care system and culture;
- Commitment to aggressively seek new sources of funding and support to implement and sustain the model.

The benefits of adopting a public model of correctional health care are many, including:

- Improved inmate & community health
- Improved public safety
- Improved correctional staff safety
- Improved use of the health care system
- Cost savings for communities
- High quality health care at a cost no greater than the national average

We hope that this document will encourage new partnerships between corrections administrators their state health departments and the non-profit providers in their surrounding communities. Further collaborations aimed at addressing the many needs of the incarcerated population will help to build healthier and safer communities across the nation.

## **PURPOSE OF MANUAL**

**The goals of the manual are:**

1. To disseminate information about the public health model of correctional health care nationally
2. To outline the theoretical rationale and implementation methods of the public health model in corrections
3. To serve as a technical assistance resource for public health, health care and correctional professionals
4. To provide advocates and public policy-makers with information concerning the public health burden and health needs of the incarcerated population
5. To serve as a source of “how-to” information for correctional health care practitioners and health services administrators
6. To contribute to the knowledge base in the field of correctional health care
7. To stimulate additional research about the health care needs of inmates and innovative programs to meet those needs
8. To facilitate the development of new public policies and interventions that support health promotion, disease prevention and access to quality health care for inmates and the communities to which they return

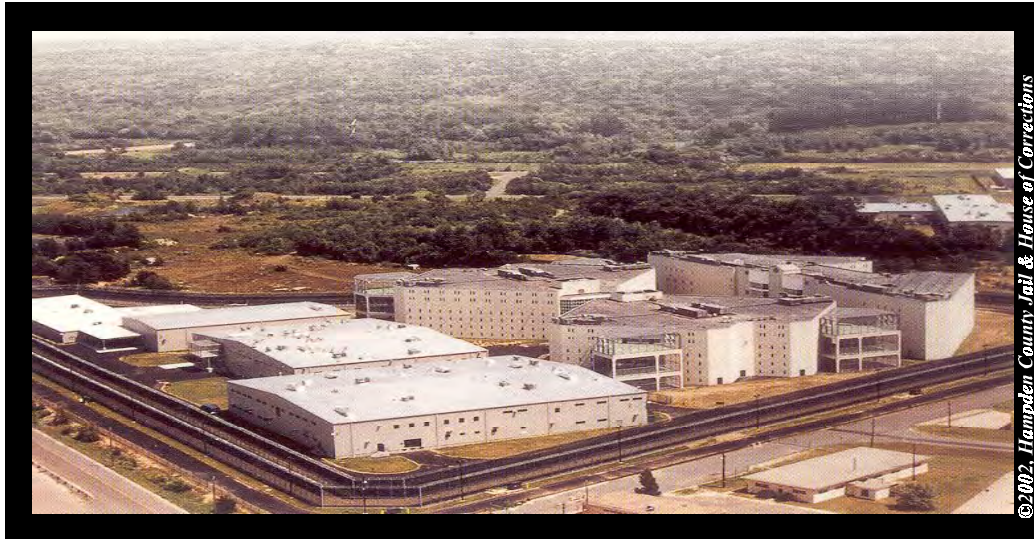
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## **I. INTRODUCTION TO A PUBLIC HEALTH MODEL FOR CORRECTIONAL HEALTH CARE**



*“Prisoners are the community. They come from the community, and they return to it. Protection of prisoners is protection of our communities.”*

Joint United Nations Program on HIV/AIDS, 1996

*“Is a jail a fortress in the woods where inmates are warehoused or is it part of the community? Our inmates come from the cities and towns of Hampden County and they’re going back from whence they come. “*

Hampden County Sheriff Michael J. Ashe, Jr., 2000

### **The Need for a Public Health Model for Correctional Health Care**

Correctional institutions have long been reservoirs of physical and mental illness and of psychosocial problems, all of which flow back into the community as inmates are released. Only recently have medical and correctional institutions begun to recognize the full extent to which serious public health problems can and must be addressed through the correctional system.

Given the close association between correctional facilities and the community, it has become apparent that a tremendous public health opportunity exists within the penal system. The opportunity to intervene with a population at high risk for many physical and mental illnesses benefits individuals, their communities, and society at large with reduced disease rates, financial savings, improved public safety and better use of the health care system.

A comprehensive public health program of early detection/assessment, health education, prevention, treatment and continuity of care is instrumental in reducing the incidence and



prevalence of disease in correctional facilities and communities. The public health model of correctional health care values wellness, treatment of disease, prevention of illness and access to care during and after incarceration. The model takes a comprehensive approach to the physical and mental health care needs of inmates and their communities. The public health model of correctional care delivers high-quality health care based on community standards and establishes close linkages with providers in the communities to which inmates return. These linkages ensure continuity of care and ongoing management of medical and mental health problems. Providers are dually based at the correctional facility and in the community. This integration allows for substantial collaboration and communication between corrections and health care professionals.

The public health model also benefits inmates, whose health problems have often gone unaddressed in the community. For many, it is the first time they have received adequate health care from a caring group of providers. The commitment to continue their care is evident in the high rates of inmates who keep their medical appointments after release.

Taking advantage of the period of incarceration is consistent with established public health mandates to control communicable diseases and promote effective prevention measures. The program model not only treats acute health needs, but also evaluates the long-term care needs of the inmate population. A correctional jurisdiction that adopts the major components of the public health model can reap the benefits of improved inmate, staff, and community health and safety.

## **How Did We Get Here?**

### ***A History of the Public Health Model of Care at the Hampden County Correctional Center***

The process by which Hampden County Correctional Center (HCCC) pursued and developed its collaborations with local community health centers has its history in the HIV/AIDS epidemic. In the early 1990s, Brightwood Health Center, a large community health center located in Springfield, Massachusetts that served a diverse, urban population within a predominately Latino neighborhood, employed a physician and nurse to provide weekly care to HIV+ inmates at the jail. It quickly became evident that the practice of bringing community providers on-site had many advantages, including practicing a community standard of care, as well as linking inmates with opportunities for follow-up care after release.

In 1992, the original jail facility in Springfield, built more than 100 hundred years ago, was replaced with a modern facility at the current Ludlow location. At that time, the Sheriff charged the medical department with developing a community-based system of health care that was in accordance with the overall jail philosophy that correctional facilities are an integral and important part of the extended community.

Each of the city of Springfield's community health centers estimated that 3-5% of their patient population was incarcerated on any given day. The average time spent at HCCC for pre-trial inmates was 12-14 weeks, so these patients returned quickly to the community. On average, HCCC admits and releases more than 5,000 inmates per year. Although generally in jail for only a few months, the period of incarceration often turned out to be beneficial for inmates.

While incarcerated, inmates received comprehensive health care treatment and learned to cooperate in the treatment. Gradually, inmates saw the value of ongoing health care delivered by providers interested in their welfare. This set of events helped inmates to become more active partners in their own health care. Patient compliance and adherence to treatment were enhanced.

At the same time, the Brightwood Health Center staff realized that the model of care they were delivering for persons with HIV would be equally beneficial for all inmates, especially those with chronic diseases. The concept of health care teams based on residential geography and community service areas was thus born in collaborative discussions between HCCC and the health centers. After much discussion and negotiation, it was agreed that the existing HIV model (in which health center staff work both in the jail and the community) should be expanded. At that point, three health centers agreed to collaborate. Later, a fourth health center came on board.

The comprehensive spectrum of health care and social support programs available from the health centers ensures that inmates receive high quality care while reducing barriers to good health (i.e. homelessness, substance abuse relapse and lack of health insurance). Health care providers and social service professionals work together as part of a team from each health center; a case manager's expertise in the social service needs of inmates strongly complements the health care delivered by physicians and nursing staff.

This model of collaborative health care and support services available both "behind the walls" and in the community contributed to the pursuit of additional services such as optometry, dental care and educational services. HCCC is constantly looking for ways to improve and secure collaborative relationships while maintaining close cooperation with the local health centers.

### ***Development of linkages with the Community Health Centers***

With growing rates of HIV/AIDS in Western Massachusetts, many community health centers, like Brightwood Health Center in the North End of Springfield, became major treatment providers for residents with HIV. Staff at the health center became increasingly aware of the impact of incarceration, as their HIV patients were absent from the neighborhood for long periods of time and going untreated while in jail.

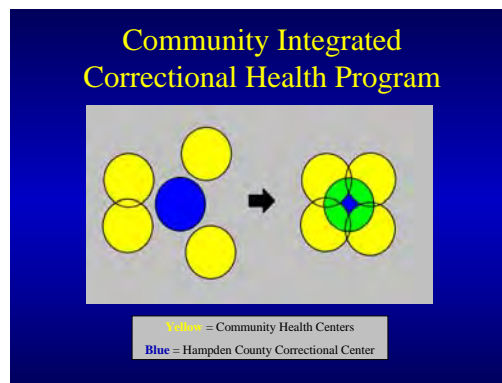
Health center providers approached HCCC with a request to provide confidential HIV care to inmates at the jail. Brightwood Health Center staff began to provide treatment on-site to maintain contact with their HIV patients and monitor their progress. Because state funding for HIV medications did not cover inmates while they were incarcerated, the staff at Brightwood Health Center sought ways to collaborate with the jail to ensure continuity of care for HIV+ inmates. Later, changes were made that allowed county jails to get reimbursed by the state for all HIV/AIDS-related medications, including pegylated interferon and ribavirin for AIDS patients with hepatitis C. This was a crucial decision supporting the public health model and allowed for the proper management of all HIV/AIDS patients within the jail.

Discussion soon moved beyond the needs of HIV patients and focused on delivering care to inmates with chronic conditions using the same community model. The demographic profile of

HCCC inmates underlined the need for such expansion: More than 80% of the residential zip codes of inmates came from neighborhoods serviced by a community health center. The match was obvious and the expansion of the model -- by assigning inmates to health center providers based on zip codes -- was underway.

Engaging the other three health centers in the model involved numerous meetings, discussions and planning decisions. One of the centers was in the formative stages of its development and needed time to incorporate the jail work into its overall operations. Eventually, it took three years to incorporate all four centers into a plan to provide care at the jail and for inmates upon their release.

As the model was refined, the issue of continuity of care became critical. The need for a “bridge” between the jail and the community resulted in the creation and development of dually-based Case Manager positions for inmates with chronic diseases, allowing the jail and health centers to more fully monitor ongoing treatment plans and inmates’ progress, and support inmates upon their release. The case management component of the model demonstrates its value in increased rates of treatment adherence, improved show rates for post-incarceration clinic appointments, and reduced use of local emergency rooms for primary health care.



### ***Development of linkages with the Massachusetts Departments of Public Health and Mental Health***

The state Department of Public Health (DPH) played a key role in providing financial support for development of the public health model of care. The DPH AIDS Bureau funded HIV services for inmates throughout the state at both county and state correctional facilities, including dedicated staff positions to conduct HIV testing, counseling and prevention services in correctional sites.

As HCCC and Brightwood Health Center further defined the collaborative public health model, they engaged the DPH in discussions about HIV care and potential expansion of its role in the model. The DPH looked favorably upon the public health model and explored replication to other correctional facilities. With the success of linkages in HIV care, HCCC and MDPH identified additional areas in which to collaborate.

Given the prevalence of sexually transmitted infections among inmates, DPH established HCCC as a site for pilot testing of urine chlamydia screening and a partner notification process. When DPH established a statewide hepatitis C screening, education and case management program, HCCC was awarded the first contract in western Massachusetts under the new initiative. DPH's Bureau of Substance Abuse Services and the state Department of Mental Health (DMH) in part supported the Substance Abuse Treatment Unit and mental health services at HCCC.

The linkage with state agencies proved to be critical in the initial development and expansion of the model as well as ongoing service delivery. Relationships with state agencies provide for innovative programs, targeted services to high-risk populations and cost-effective delivery of health care to inmates. State funding augments the resources of the Health Services department and contributes to improved public health in the region.

### ***What We Learned about Community Linkages***

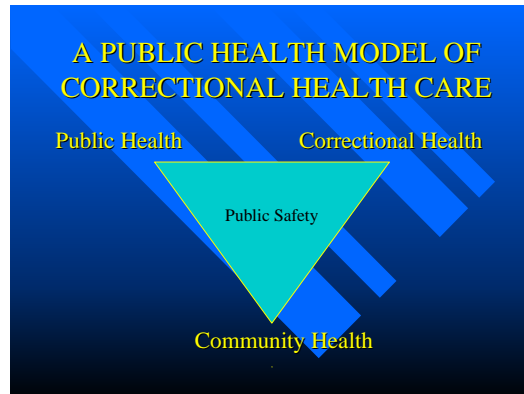
HCCC has found that the following are critical to establish and maintain community linkages:

- Support for linkages from the highest levels of leadership at the jail and local/state agencies
- Analysis of the demographics at work in the neighborhoods from which inmates come, thereby identifying mutual goals and overlapping public health needs of the service population
- Prioritizing public health benefits in decision-making; planning is not driven solely by economics
- Willingness to learn more about each other's facilities, operations and missions
- Clarification of roles and responsibilities via written contractual agreements
- Providing adequate monetary support to community partners; HCCC pays community health center staff based on time spent at the jail, not fee-for-service
- Regular, at least quarterly, meetings with HCCC staff and contractual partners to assess progress and address any issues
- Joint placement of health care and case management staff at the jail and at the local health centers for continuity of care
- Cross-agency training opportunities for staff
- Institutionalization of partnerships via renewable contracts reviewed annually
- Incorporation of the partnership into each agency's ongoing mission
- Joint grant writing and funding opportunities to support partnerships
- Education of the community, public health, and local leaders about the model, stimulating their engagement and support for sustained services
- Advocacy and education by community partners about the operations and philosophy of the public health model helps to allay community suspicion and advocates' concern about what happens "behind the walls"

## Benefits of the Public Health Model

*“Sending incarcerated persons back into the community with their serious health needs untreated ultimately costs more to the individual, the community and the taxpayer.”*

Thomas Lincoln, MD Medical Director  
Hampden County Correctional Center (HCCC) and  
Baystate Medical Center, Springfield, MA



The following benefits of implementing a public health model of correctional health care have been experienced at HCCC. The data presented below, some of which is unpublished, is derived from studies conducted at HCCC.

### ***Improved Inmate Health***

- The individual inmate’s serious and often unmet health care needs are addressed and ongoing treatment is maintained via discharge planning and continuity of care in the community
- Providers working at community health centers are often from the local community served and represent the culture of the neighborhood; when staff demonstrate cultural and linguistic competence, communication, trust, and the relationship between inmates and their caregivers are all enhanced.
- Research shows that more than 88% of HIV+ inmates referred for ongoing care after release from HCCC keep their initial medical appointments at their designated community health center

### ***Improved Public Health***

- Each year, the program at HCCC introduces comprehensive health care to thousands of high-risk persons who previously went untreated. Most of the inmates are uninsured, poor and undereducated about health issues.
- Public health improvement is evident by immediate

continuity of care after release; for infectious diseases, adequate treatment and education to prevent future transmission provide tangible public health benefits to the inmates' families, sexual partners and communities; early detection and treatment of infectious diseases prevents costly complications

- On any given day, there are between 80-100 cases of HIV, and approximately 20 persons being treated for latent TB at HCCC; annually, more than 1,400 cases of sexually transmitted diseases are treated. The community benefits from the provision of curative treatment for communicable disease, prevention of secondary infections and surveillance of reportable conditions. Given the number of infectious diseases detected in jails, these facilities may be the first to identify emerging trends in communicable disease patterns, such as the surge in TB in the late 1980's and early 1990's
- Jails serve a sentinel function for the community; if a jail detects a sudden increase in STD's, they are in a position to warn local public health officials that an outbreak or marked increase may be occurring in the community. Since inmates are admitted to jail directly from the community, *jail becomes a reflection of the community*. The value of the public health sentinel function cannot be overestimated.
- The educational components of the model raise awareness about the risks for communicable disease, ways to reduce risk and behaviors to improve overall health; inmates learn to manage their chronic diseases to prevent complications and improve health
- Community health center workers continue linkages via outreach and follow-up once an inmate has returned to the community to support disease management, recovery from addiction and prevent disease transmission
- Family and social ties are strengthened as inmates and their families receive care at local clinics; stronger social ties improve individual and community health
- Immunization against hepatitis A and B provided to at-risk inmates improves community immunity and interrupts disease transmission
- Prenatal care provided to inmates while in jail improves birth outcomes, prevents vertical disease transmission such as HIV and educates women about well-baby care, childhood immunizations, and nutrition
- Mental health care and substance abuse treatment begun in jail and continued in the community improves overall public health, individual employability, family and social functioning.
- The public health model lends itself to research projects. The scientific literature needs more good research efforts and outcome studies in correctional health issues. Grants to support research are becoming more prevalent in corrections. Research funds often allow program enhancements that would otherwise not occur. Employing staff with an

orientation toward research is extremely helpful in obtaining outside funding and conducting research.

### ***Cost Savings***

- Significant downstream savings in community health care costs from the early and effective detection and treatment of disease
- In fiscal year 1998, the cost of health care at HCCC was \$7.23 per day per inmate, less than the average of \$7.89 per day per inmate in a 2001 study of the 30 largest US jails
- Grants and state contracts provide substantial funds to deliver services such as HIV/AIDS education, STD and TB screening and treatment, a pilot study of urine chlamydia screening and reimbursement for HIV medications
- Substantial savings are realized by using community-based, non-profit providers for health care, pharmacy, dental care, optometry, health education and mental health services; these services are provided at lower cost than if HCCC used its own staff under state payroll or negotiated salary requirements
- Community cost-savings are seen by enrolling eligible inmates into Medicaid which helps to ensure that patients, upon release, will use community health care services instead of more costly emergency rooms for primary care treatment
- An in-depth and ongoing study of the cost-effectiveness of treating inmates with HIV/AIDS concluded that the HIV/AIDS programs likely pay for themselves when all costs to society are considered; potential indirect savings could be as high as \$270,000 per participant depending on adherence and assumptions about transmission rates and treatment in the absence of the HCCC program<sup>33</sup>
- Using an economic analysis model based on costs, demographics at HCCC and effectiveness data from the scientific literature, providing HIV counseling and testing was found to be cost-saving to the community
- The community health centers derive financial benefit from their collaboration with HCCC; contractual agreements pay the centers on a fee-for-service basis for costs of staff based at the jail *and* health centers; the annual contracts are evaluated, modified and renewed to adequately cover expenses and provide a predictable source of income for health centers; after release, inmate health care costs are covered under third party reimbursements such as Medicaid

### ***Improved Public Safety***

- Health care enhances public safety; when a person is healthy and receiving proper and adequate care, they are more likely to exhibit appropriate behaviors, thereby reducing crime in the community

- Providing mental health and substance abuse treatment to inmates during incarceration increases the likelihood of recovery from drug addiction
- Continued support for recovery from drug addiction can reduce future criminal activity as part of acquiring illegal drugs

### ***Protection of Correctional Staff Safety and Health***

- The facility itself benefits; with good health care, inmates are more content and cooperative within the correctional system; mental health problems which can adversely affect inmate behavior and facility operations are properly diagnosed and treated
- Identification and treatment of infectious diseases among inmates protects the health of facility staff by reducing communicable disease transmission

### ***Better Use of the Health Care System***

- With almost half of the male inmates and nearly two-thirds of the female inmates at HCCC reporting use of local emergency rooms for their health needs in the previous year, the financial and public health drain on resources is significant; inmates also report frequently waiting for symptoms to become severe before seeking care. This leads to more costly treatment. A major benefit of the public health model is the dramatic decrease in the use of the emergency room as the primary care provider. *Once inmates are released back to their community, they utilize the community health center to which they were assigned based on their zip code of residence.*
- By establishing a relationship with a primary care provider while incarcerated, the inmate develops a greater understanding of the role of primary care, preventive care measures and how the health care system functions in the community.
- Inmates who are more involved in their own health care acquire knowledge and skills to avoid health risks, learn about positive health behaviors and can be active partners with their providers.
- It is cost-efficient for released inmates to use community health centers for consistent, high-quality, primary care delivered in their neighborhood; HCCC data shows that more than 88% of inmates referred for ongoing care after release keep their initial medical appointment at their designated community health center.

### ***Recidivism***

- Researchers at HCCC have documented recidivism rates that are lower than national averages; in a 3-year study of inmates released from HCCC in 1998, 36.5% were reincarcerated in a Massachusetts correctional facility between 1998 and 2001. A national study involving prisons in 15 different states and examining a similar three year-period, showed a reincarceration rate of 51.8%. Although many factors affect recidivism rates, researchers believe the lower rate at HCCC reflects favorably upon the intensive model



of comprehensive health care, education, pre-release support and ongoing follow-up after release provided at Hampden County.

## **Obtaining Support for the Public Health Model**

The public health model of correctional care requires support from a variety of external and internal constituencies. Because the general public and policy makers are frequently reluctant to support extensive funding for inmate services, creative informational techniques are useful. The most effective messages for public consumption focus on the positive community outcomes of using a comprehensive approach to inmate health care. Persuasive data on cost-savings, improved community health, and improved public safety may more readily resonate with the general public. HCCC has found that the message must be brought to the community regularly in order to build public opinion in support of such programs.

### ***External Support***

In addition to the community health care providers who work within the program and are often its strongest advocates, HCCC successfully uses all of the following as methods to obtain and sustain external support for the model:

- Regular communication with local and regional print and electronic media to inform the general public about the benefits of the model, with particular emphasis on the improved health and safety outcomes; HCCC's Communications Department regularly coordinates press releases and informational updates to the local media
- Publicizing the receipt of national awards, accreditations and other recognitions bestowed upon the public health model
- Delivering presentations at national health care, public health, and corrections conferences to highlight research findings and the operations of the model to corrections and public health professionals
- Actively participating in local, regional and national organizations on correctional health care and inmate health advocacy; bringing the message about inmate health care needs to community health planning councils and consortia
- Encouraging articles in publications reaching health care community members such as medical school alumnae newsletters, correctional health care and medical journals
- Conducting Sheriff's Department sponsored community events and open houses to demystify the correctional environment and break down barriers with the local community. For example, the Hampden County Sheriff's Department is involved with numerous local social and recreational activities. An open house to showcase the new facility in 1992 drew more than 25,000 local residents. The Sheriff's Department uses the proceeds from an annually-sponsored road race to support local Boys and Girls Clubs and maintains Springfield's premier Little League baseball park through inmate labor. The

Restitution Program inmates perform grooming and upkeep of the grounds of the Basketball Hall of Fame and Riverfront Park area, two major tourist attractions in the region.

- Education and advocacy with public policy makers to inform them of the benefits of the model; in fall 2001, HCCC served as the site for a statewide legislative committee hearing on the health care needs of inmates

### ***Internal support***

HCCC builds internal support for the public health model of care through extensive communication between on-site departments and jail functions. The following outlines some of the strategies used to sustain internal support for the program:

- Health Services Director reports on program progress and new initiatives at high-level jail administrative meetings
- Nursing staff go directly to inmates' living quarters to deliver health care for minor illnesses; nurses develop relationships with security staff and inmates
- Health Services staff are available for consultation on health issues to all HCCC departments
- New Correctional Officer (CO) employees receive orientation and training on health services procedures, operations and specific health topics
- Security staff support of the program is gained through improved inmate behaviors and compliance with facility policies and procedures; as CO's experience the benefits of the health care program, they become crucial allies with health care staff
- Health services department works closely with vocational, educational and other rehabilitative support services at HCCC
- In-house communication vehicles such as newsletters and employee information handbooks highlight the importance of good health for inmates and staff

### **How Replicable is the Model?**

There are many challenges to changing a health care delivery system that has used the same practices and providers for many years. However, with sufficient support, we believe that the public health model of correctional health care can be replicated in a variety of settings. Some facilities may choose to replicate the model as a whole, while others will adopt it incrementally or select only specific components. Additionally, the model may need to be modified to address the specific needs of a population or correctional system.

Key elements for successful implementation of the model are:

- (1) Support of the model from high-level correctional administrators, including a dedication to improving inmate and community health;
- (2) Commitment to collaborate with state agencies and local non-profit providers;
- (3) Willingness to substantially change the existing correctional health care system and culture;
- (4) Commitment to aggressively seek new sources of funding and support to implement and sustain the model.

### ***Community Resources in Metropolitan areas***

United States Census data from 1999 found that 217 out of 263 US metropolitan areas have between 100,000 and 1 million residents and therefore are of a size to emulate the model with similar-sized teams. Where community health centers are less prevalent, physician practices, HMO's, and outpatient clinics could serve as partners. In addition, homeless shelters, substance abuse treatment centers, mental health care providers, HIV/AIDS organizations, and urban faith-based programs are serving similar populations and may welcome collaboration.

### ***Application to Types of Correctional Facilities***

The public health model and its components may be most easily replicated in a facility where inmates are drawn primarily from nearby communities. Although the model was developed in a county jail, it can serve prison populations either when the prison is near a population center or, as happens at HCCC, when prison inmates are transferred to a local jail facility within six months of discharge. Under this model, inmates' health care needs are addressed in preparation for discharge into the community.

Additionally, specific components of the model can be applied to any correctional setting including prisons and juvenile facilities. The model's administrative structures and linkages with non-profit community providers must be matched to the individual needs and resources of a facility. For any institution examining the model, it makes sense to analyze program elements which best fit with a facility. The model is not designed to be "one size fits all", but rather an overall approach to correctional health care that can be tailored to a setting and its specific needs. If a correctional facility offers the five essential elements of the model to their inmate population, it can adopt the public health model of care regardless of how the services are specifically provided.

### ***Adopting the Model in Stages over Time***

In some cases, it may not be possible to fully develop all five of the model's components simultaneously. A process by which all or most of the elements are developed over time and gradually implemented within a facility may be more feasible. If only a limited number of the elements can be realized initially, the missing elements can be added as the program adjusts to new procedures and operations. It may also take time for a facility to develop the supportive collaborations needed to implement the model. Planning, identifying allies and securing sources of financial support may take considerable time.

State and local public health departments are natural allies in adopting the model. Financial support can be sought to bring services to the correctional facility and to continue intervention

after release. The public health community is often attempting to reach the same populations and collaboration reduces duplication while enhancing efforts to identify and curb epidemics.

Replicating the program and relaying the message about the public health model of correctional care is an ongoing process requiring time, effort and resources. It can be challenging to persuade the general public, policy makers and institutional staff that the model makes sense and justifies the efforts. Inmates are a marginalized population that taxpayers are often unwilling to support. For any facility planning to adopt all or part of the model, securing and maintaining community and in-house support must be given high priority.

## **II. THE PUBLIC HEALTH BURDEN IN CORRECTIONAL FACILITIES**

*“We have to improve access to public health for this population. This is a population that is most affected by all the social ills of our country, including mental illness, substance abuse, poverty, lack of education, disintegrating communities and broken families.”*

John Miles, MPA  
Former Special Assistant for Corrections and Substance Abuse,  
Centers for Disease Control and Prevention (CDC);  
Editor, Journal of Correctional Health Care

### **Demographics of Criminal Justice Populations**

Within the overall correctional system, there are numerous types of facilities and institutions. *In Massachusetts*, the correctional system includes:

**Jails** - county facilities that house individuals awaiting trial

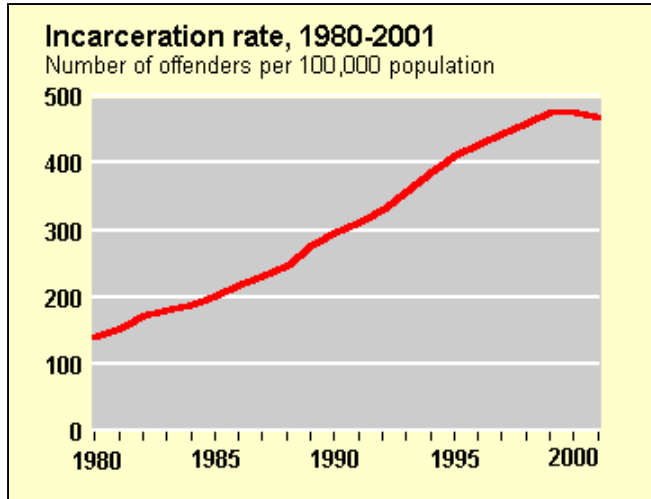
**Houses of Corrections** – county facilities that primarily house inmates with sentences less than 2 ½ years; jails and Houses of Corrections are overseen by elected Sheriffs in Massachusetts

**Prisons** – state facilities that primarily house inmates with sentences over 2 ½ years, under the Massachusetts Department of Corrections (DOC).

At the facility in Hampden County, the jail and the House of Correction are physically combined in the same facility on the same grounds. This is true of most county facilities in Massachusetts.

Around the nation, sentencing guidelines, correctional institutions’ functions and types of facilities vary from state to state.

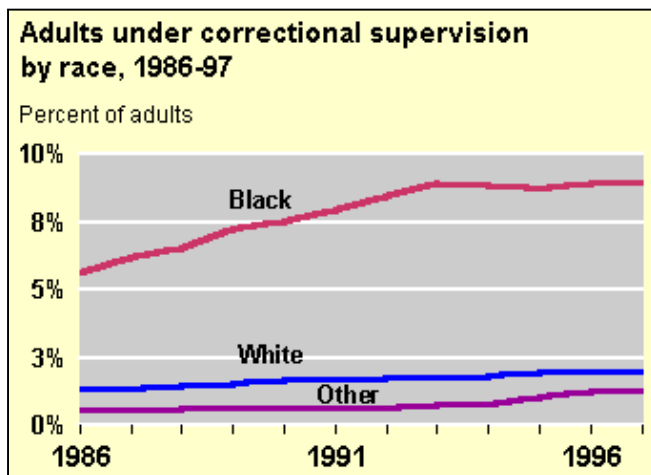
## Correctional Populations in the United States



Source: U.S. Dept. of Justice. Bureau of Justice Statistics. **Correctional Populations in the United States, 1997** and Prisoners in 2001.

The United States has the highest incarceration rate in the world<sup>1</sup>. In 2001, nearly 6.6 million adults in the United States were under some type of correctional supervision, with one in every 32 adults behind bars, on probation, or on parole<sup>2</sup>. Since 1980, the number of U.S. inmates in prisons and jails has more than tripled; the state prison population increased by 299%, the federal prison population increased by 417% and the number of local jail inmates increased by 225%. Approximately 2 million persons are behind bars in the United States on any given day. Nearly 12 million people are released annually from all U.S. correctional facilities<sup>3</sup>.

## Gender and Racial Disparities



Source: Dept. of Justice; Bureau of Justice Statistics Correctional Surveys (The National Probation Data Survey, National Prisoner Statistics, Survey of Jails, and The National Parole Data Survey) as presented in **Correctional Populations in the United States, 1997**.

Men constitute the largest proportion of the incarcerated population, but the rate for women has been increasing dramatically and more quickly than for men. Since 1980, the number of women in prison has increased at nearly double the rate for men.<sup>4</sup> In 1998, about 1 in every 109 American women was under the care, custody or control of correctional agencies.<sup>5</sup>

Young adults comprise the largest proportion of persons in the correctional system but the numbers of adolescents and those over the age of 50 are increasing rapidly.<sup>6</sup>

People of color are disproportionately represented in incarcerated populations. If current levels of incarceration continue, a black man will have a 1 in 4 chance of going to prison in his lifetime; a Latino man will have a 1 in 6 chance and a white man will have a 1 in 23 chance of serving time. In 1996, people of color constituted 63% of all US jail inmates, almost three times their proportion in the population as a whole. In 1997, 9% of blacks in the U.S. were under some type of correctional supervision, compared to 2% of whites<sup>7</sup>.

While states through the U.S. reflect a variety of different racial incarceration rates, significant disparities between rates for inmates of color and white inmates are common and widespread. For example, in the year 2000<sup>8</sup>:

- In 12 states, black men were incarcerated at 12-16 times the rate of white men.
- In 15 states, black women were incarcerated at 10-35 times the rate of white women.
- In six states, black youths were incarcerated *in adult facilities* at 12-25 times the rate of white youth.
- In 10 states, Latino men were incarcerated at 5-9 times the rate of white men.
- In eight states, Latina women were incarcerated at 4-7 times the rate of white women.
- In six states, Latino youths were incarcerated *in adult facilities* at 7-17 times the rate of white youth.

## **Health Status of the Incarcerated**

The incarcerated population is mostly poor, urban, undereducated and suffers a high prevalence of health problems. Most inmates have been medically disenfranchised prior to incarceration. At HCCC, 80% of the chronically ill inmates have not received regular medical care prior to incarceration and many have been using the local hospital emergency room as their primary care provider. Incarcerated populations have higher rates of substance abuse and risk behaviors such as intravenous drug use and violence than the general population.<sup>9</sup>

These behaviors and high-risk lifestyles increase the prevalence of infectious diseases such as HIV/AIDS, tuberculosis, sexually transmitted diseases and hepatitis. In addition to infectious disease, drug addiction, lack of access to health care, poverty, substandard nutrition, poor housing conditions and homelessness can contribute to increased risk for chronic conditions such as hypertension, cardiovascular disease, skin conditions, gastrointestinal disease, diabetes and asthma.

## Use of the Health Care System

A study in Massachusetts found that 82% of inmates throughout the state reported no history of a regular medical provider and 93% had no form of health insurance.<sup>10</sup> At HCCC, one-third of the incoming inmates had not visited a medical provider when they needed to in the past 12 months because of cost. However, nearly half of the men and two-thirds of the women had used the local emergency room for health care in the same time period.

## Disparities in Health Status

As a group, inmates report more disabling conditions, poorer perceptions of health status and less frequent use of primary health care services than the general population. The following outlines some of the major disparities in health status.

### *Infectious Disease*

- Based on several national surveys, compared to the general population, the rate of HIV/AIDS is five times higher among incarcerated individuals, rates of hepatitis C are 9 to 10 times higher and rates of tuberculosis are 4 to 17 times higher<sup>11</sup>
- Epidemiological data suggest that 30-40% of the inmate population is infected with Hepatitis C, primarily through drug use<sup>12</sup>

A 1994 survey of 31 state prison systems showed a tuberculosis infection rate of 14% among inmates; jails and prisons may be significant amplification points in local and regional TB epidemics<sup>13</sup>

**Percent of Total Burden of Infectious Disease Found Among People Passing Through Correctional Facilities, 1996**

Condition	Estimated # of releases w/ Cond'n	Total # in US Pop'n w/ Cond'n	Releases as % of Pop'n w/ Cond'n
AIDS	39,000	229,000	17%
HIV+	98,000-145,000	750,000	13-19%
HepBsAg+	155,000	1-1.25 million	12-16%
Hep C+	1.3-1.4 million	4.5 million	29-32%
TB disease	12,000	34,000	35%

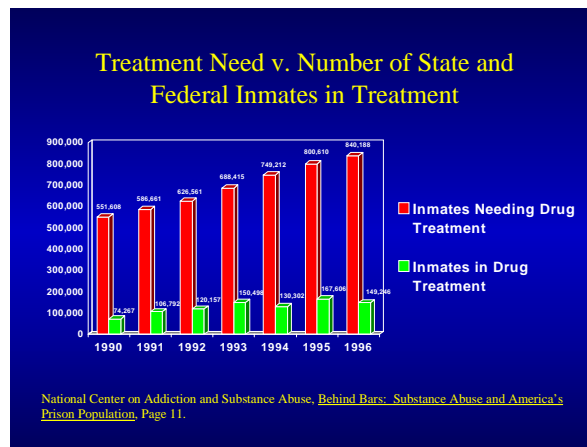
Source: Hammet T, Abt Associates, Nat'l HIV Prevention Conf. Aug 1999



### Chronic Illness

- Rates of chronic diseases are higher than the general population and are likely to increase as the incarcerated population ages<sup>14</sup>
- Federal Bureau of Prisons data shows that almost 5% of inmates have asthma, 3.6% have diabetes, 7.8% have high blood pressure, and 2.6% have heart problems<sup>15</sup>
- At HCCC, 16.9% of males and 29.3% of females reported having asthma; 10.6% of males and 14.7% of females report high blood pressure; 29.3% of males and 41.4% of females report bone/joint problems

### Substance Use



- The correctional system houses more serious drug users than any other social institution
- 70% of federal inmates and 80% of state and local jail inmates report a history of drug use, abuse or dealing; Half of all prisoners were under the influence of drugs or alcohol at the time of their offense<sup>16</sup>
- Female inmates generally report higher rates of drug use than male inmates; women in state prisons were more likely to have committed their offense while under the influence of drugs<sup>17</sup>
- 20% of state prison inmates and 17% of jail inmates report using intravenous drugs at some time in their lives<sup>18</sup>

A recent survey of inmates at HCCC found that:

- 66% of men and 60% of women reported alcohol use in the 3 months prior to incarceration
  - 33% of the drinkers reported daily drinking while 75% reported binge drinking
  - 11.4% of males and 23.5% of females had ever shared needles
- More than 70% were regular cigarette smokers

### ***Mental Health***

- Approximately 670,000 mentally ill people are admitted to US jails each year, nearly 8 times the number admitted to state mental hospitals; jails in major cities such as Los Angeles and Chicago are now some of the largest mental health facilities in the nation<sup>19</sup>
- The Bureau of Justice estimates that 16% of the incarcerated population currently has or were known to have had a major mental illness requiring an overnight stay in a hospital<sup>20</sup>; this contrasts with only 6% of the general population experiencing major mental illness
- One-third of mentally ill inmates are also alcohol dependent<sup>21</sup>
- Suicide is the leading cause of death in jails and prisons; inmates have a suicide rate 11 to 14 times higher than the general population<sup>22</sup>

### ***Violence and Trauma***

- Studies show that inmates experience violence victimization rates much higher than the general population; between one-third and one-half of incarcerated women have experienced childhood abuse, sexual abuse or involvement in abusive relationships<sup>23</sup>
- Male inmates report higher rates of prior abuse than non-incarcerated men; of male state prison inmates, 12% reported physical or sexual abuse prior to incarceration<sup>24</sup>
- More than a quarter of state and federal inmates report being injured since admission to prison; the likelihood of injury increases with time served in prison<sup>25</sup>

### ***Oral Health***

- At HCCC, 34.5% of males and 38.8% of females reported problems with their teeth and gums; only 23.1% of males and 39.7% of females had visited a dentist or dental clinic in the 12 months before incarceration.
- A statewide study in Maryland showed that inmates had more missing teeth at every age and a greater percent of unmet dental health needs than the general population<sup>26</sup>



### ***Women's Health***

The “typical” female offender is<sup>27</sup>:

- A woman of color
- Age 25-29
- Unmarried
- Has 1 to 3 children
- A likely victim of sexual abuse as a child

- A victim of physical abuse
- Has current alcohol or drug addiction problems
- Has had multiple arrests

Female inmates have higher rates of all of the following compared to male inmates<sup>28</sup>

- Asthma
- Seizure disorders
- Hypertension
- Diabetes
- Mental health disorders
- Hepatitis
- Heart Disease
- Gastrointestinal problems
- Genitourinary disorders
- STD's
- HIV and AIDS

### **Women and Substance Abuse**

Female inmates are more likely than male inmates to:

- Use drugs regularly
- Use drugs in the month prior to incarceration
- Be under the influence of drugs at time of crime
- Use illicit and legal drugs to self-medicate and feel better emotionally



### **Women and Mental Health**

- Female inmates have twice the rate of major mental illness as male inmates
- More than half have a family member who is or has been incarcerated.
- Almost three-quarters of female inmates have attempted suicide at some point in their lives and most began their substance abuse and chemical dependency histories as young adolescents.<sup>29</sup>

### **Reproductive Health**

- In 1997, 6% of US women admitted to jails and 5% of women admitted to prisons were pregnant at the time of admission; slightly more than half received pre-natal care while incarcerated.<sup>30</sup>
- Most jails and prisons require women to be separated from their infants after delivering in a local hospital
- A national survey found that while 90% of women admitted to US prisons received a gynecological exam upon admission, only 22% of women admitted to jails did.<sup>31</sup>
- In some jurisdictions, access to abortion is hindered by restrictive public policies.

At the Hampden County Correctional Center, 200 women are incarcerated on any given day, about 12% of the overall jail population. The following statistics highlight some of the special health issues and circumstances faced by incarcerated women at HCCC<sup>32</sup>:

- Average age was 32, slightly older than male inmates

- 85% are mothers with an average of 3 children under the age of 12
- 90% are addicted to substances
- 80% of their crimes are related to their addictions
- One-third have no stable home to return to upon release
- Two-thirds have not worked for more than three years in their lives
- 60% demonstrate moderate but serious mental health issues such as post-traumatic stress disorder (PTSD), mood disorders, depression, anxiety, moderate bi-polar traits, eating disorders, and obsessive disorders
- Rates of HIV infection were higher among female than male inmates at HCCC
- 61% were sexually abused as children
- 78% had experienced sexual and physical violence
- 37% had made one or more efforts to commit suicide

## **Health Disparities and Racial/Ethnic Diversity**

In the general, non-incarcerated population, African-Americans, Latinos, Asian/Pacific Islanders and Native Americans continue to bear a disproportionate burden of morbidity and mortality. Given the disproportionate over-representation of these populations in correctional facilities, jail and prison inmates reflect these broader cultural disparities in health status.

For example:

- African-Americans continue to experience death rates that exceed the death rates of white, non-Latinos for all of the following:
  1. Heart disease
  2. Stroke
  3. Lung cancer
  4. Breast cancer
  5. Motor vehicle crashes
  6. Homicide
- African Americans, Latinos, Asian/Pacific Islanders and Native Americans all have tuberculosis case rates that exceed that of whites; these rates range from almost 6 times the white rate for Latinos to more than 17 times the white rate for Asian/Pacific Islanders<sup>33</sup>
- African-Americans and Latinos have the highest case rates for primary and secondary syphilis<sup>34</sup>
- African-Americans and Latinos represent approximately 12% and 14% of the US population respectively but 47% and 19% of new AIDS cases<sup>35</sup>
- African-American and Latino women lack access to pre-natal care at twice the rate of white women<sup>36</sup>

These disparities in health indicators pose tremendous challenges and opportunities for correctional health care services. The public health model of correctional care presents an outstanding opportunity to ameliorate a significant portion of racial health disparities on a national level.

### **III. THE PUBLIC HEALTH MODEL IN CORRECTIONAL FACILITIES: AN OVERVIEW**



*“We now have persuasive evidence that medical intervention, inmate education and continuity of care after an inmate’s release can decrease morbidity, mortality and the incidence, prevalence and transmission of communicable diseases throughout the community.”*

Thomas Conklin, MD  
Director of Health Services  
Hampden County Correctional Center

#### **Principles of the Public Health Model**

The objective of the public health model of correctional care is to provide a comprehensive spectrum of health care services beginning within the first days of incarceration and continuing into the community upon release. The model emphasizes wellness, health education and prevention; it uses a proactive versus reactive approach to quality health care; it serves a public health sentinel function in the community and is fully integrated with local and regional social services.

The public health model features five major elements:

1. Early detection and assessment
2. Prompt and effective treatment at a community standard of care
3. Prevention measures
4. Comprehensive health education
5. Continuity of care in the community via collaboration with local health care providers

These five elements form the basis for intake, on-site service delivery and special programs within the Health Services department at HCCC. This successful and innovative system links inmates to the community from which they came and to which they return. This thread of continuity maintains a high standard of inmate health care and provides for improved individual and public health.

#### Unique Features of the Model at HCCC

Many of the elements of the public health model of correctional care already exist in jail and prison facilities around the nation. Correctional institutions may use some, but not all, of the elements and do so in varied ways based on local resources. The model as implemented at HCCC includes these unique features:

- A daily triage system where nurses and mental health clinicians go directly to inmates' living quarters to assess health status, deliver care and respond to non-emergency complaints
- Financial contracts with local community health centers, mental health care, dental health care and optometry provider vendors to deliver services on site and in the community
- Health care teams dually working in the jail and the community comprised of physicians, nurses, nurse practitioners and case managers; an inmate's assigned team is based on his/her residential zip code
- Comprehensive inmate health education, especially for infectious disease prevention, substance abuse and for chronic disease patients
- Extensive discharge planning and follow-up using the dually-based health care providers to deliver continuity of care after inmates are released from jail
- Outcome-based research studies integrated into ongoing health care through collaborations with local schools of public health, nursing and social work

## **Overview of the Five Elements of the Public Health Model**

*Note: For more detailed descriptions of the operations of each element, see section IV.B.*

### ***1. Early Detection and Assessment***

Thorough assessment of each inmate is the first step in the public health model. Given the complex and significant public health needs exhibited by inmates, this process is conducted to determine the extent of the acute, chronic, physical, mental and dental health needs of each inmate and to prioritize treatment, prevention and educational interventions. Evaluation of incoming inmates also determines the need for case management, social services, family outreach workers, vocational support, specialized counseling and overall health and educational needs of each individual. The assessment process can prevent inmates who pose a health risk to themselves or others from being housed in the general inmate population.

At HCCC, the assessment and screening of inmates begins during the initial receiving and booking procedure. The booking staff and health services staff work cooperatively to assess the mental and physical status of each inmate so that clinical decisions about immediate needs and serious health problems can be made.

In addition to the physical assessment, all inmates undergo a dental health assessment and mental health evaluation performed by a nurse within 14 days of admission. Based on the results of the overall comprehensive screening, a treatment plan for each inmate with chronic or severe illness is developed.

Inmates are provided with an informational handbook in English and Spanish describing how to access health services while in jail. The procedures for accessing health care are also verbally explained to each inmate during the course of the initial assessment and subsequent visits.

## **2. Treatment**

Based on the initial evaluation, inmates with chronic or serious illness are provided appropriate treatment in accordance with an individualized treatment plan. The jail uses the following resources to meet the multi-faceted treatment needs of inmates:

- An on-site pharmacy for dispensing medications
- A daily “sick call” triage system in the inmate housing units (“living pod”) for acute but time-limited, low to moderately severe health care needs that can usually be treated with over-the-counter medications in the living pod; 56 nursing protocols have been developed for use during “sick call”
- A nursing clinic 5 days per week held in the health services department; inmates are divided by residential zip code and assigned a treatment team that represents their neighborhood catchment area
- Individual and small group disease-specific educational sessions for improved management of chronic conditions i.e., diabetes, hypertension, asthma
- On-site substance abuse and mental health treatment services
- Emergency services available by contract with local hospitals for medical, dental and mental health emergencies
- Surgical services at local hospitals as needed

## **3. Prevention**

Within the public health model, prevention services are generally comprised of:

- Education about infectious disease to prevent future transmission
- Screening to detect chronic, treatable conditions
- Instruction in managing chronic conditions to avoid serious complications
- Immunizations against communicable disease for at-risk inmates
- Facility-wide environmental policies and procedures that support disease prevention
- Cessation counseling and relapse prevention for chemical dependence such as tobacco and alcohol/drug use

At HCCC, prevention measures are integrated into the intake, assessment, education and discharge planning procedures. Numerous prevention services are delivered by nursing staff, physicians, counselors, and peers. Some of the key prevention services offered include:

- HIV counseling and testing, with emphasis on disease transmission prevention
- Hepatitis A and B vaccines for at-risk inmates
- Hepatitis C counseling and testing
- Influenza and pneumonia vaccines; and other vaccines as required, i.e., measles, chicken pox, etc.
- Screening exams for infectious and chronic diseases upon intake
- Dental health education and instruction in dental hygiene
- Pre-natal care for pregnant inmates
- Occupational health and safety measures for inmates working in facilities such as kitchen, laundry, housekeeping, etc.



- Facility-wide health promotion policies, such as a complete ban on tobacco use
- Smoking cessation counseling
- Prescribed exercise classes for diabetic inmates
- Extensive suicide prevention training and procedures to ensure inmate safety
- Regular wellness activities such as exercise and nutrition education for inmates; ongoing wellness and fitness programs for staff

#### ***4. Health Education***

Health education and promotion are key elements of the public health model at HCCC. A significant goal is for inmates to return to their communities better educated about disease prevention and management. For inmates with chronic conditions, disease-specific sessions enhance knowledge, support ongoing management of their illness and increase compliance with prescribed treatment regimens.



Health education begins during the inmate orientation period and is delivered through a variety of methods including one-on-one education, group education, and educational resource materials. The inmate library contains health education materials such as videos, books and pamphlets in English and Spanish.

Patient education groups for chronic disease management are facilitated by a Nurse Educator and are provided for diabetic, asthmatic and HIV-positive inmates. On-site support groups for alcohol/drug recovery and coping with HIV infection are also available to inmates. Family members are encouraged to meet with the Nurse Educator to learn more about chronic disease management.

HIV/AIDS and STD education are offered as part of counseling sessions with staff members, group education, regular staff training for correctional officers and an inmate peer education team trained by the HIV Coordinator.

Inmate wellness programs are offered periodically. Subjects covered include tobacco use, exercise, nutrition, stress management, disease prevention and how to access the health care system.

## ***5. Discharge Planning, Case Management and Continuity of Care***

The discharge planning element of the public health model is critical to the success of the program and is the feature which can pose the greatest challenges to a correctional facility looking to adopt the model.

*Discharge planning begins when an inmate is admitted.* The intake and assessment process provides key information to be applied in planning for release and, as part of the health care team to which an inmate is assigned upon admission, a case manager is involved with inmate care and service planning from the start. The case manager provides information, referral and help in coordinating continued care for an inmate after release.

Discharge planners and case managers have information on a wide range of medical, social service, substance abuse treatment and psychiatric services available in the community. Non-medical discharge needs are also addressed, including transitional housing, vocational training or placement, family reintegration and financial assistance including Social Security and Medicaid enrollment. Chronically ill inmates receive extensive discharge planning.

The physician who treats the inmate in jail will usually be the inmate's physician following discharge. Continuity of care also allows inmates diagnosed in jail to have their prescription medications and treatment regimens continued in the community. All of this reduces interruptions in treatment that can adversely affect the course of diabetes, HIV, hypertension, hepatitis and other chronic conditions.

## **Research, Program Enhancement, and Assessment Studies**

The public health model at HCCC includes a significant commitment to conducting outcome research and program enhancement studies on health issues relevant to the inmate population. Research studies provide support for the public health model of correctional health care, inform service delivery, expand knowledge in the field and stimulate further examination of prominent inmate health issues.

### ***Protection of Inmate Rights in Research***

Prisoners are a specially protected group in human subject research due to the coercive environment of corrections.

At HCCC, research has been “non-experimental” in that there are no true control groups, and no randomized study designs. The research has primarily been based on information collected as part of routine medical care or enhanced medical care as part of demonstration projects. Those studies that involve extra interviewing, such as questionnaires or focus groups, require written informed consent.

All research projects require approval and review by the HCCC Research Director and the Institutional Review Board (IRB). The Institutional Review Board at Baystate Medical Center agreed to be the IRB for the jail for health services and is charged with assuring that: the research is appropriate to inmates; benefits from the study are not coercive; risks are comparable to those

that would be accepted by a free person; selection of subjects is fair and immune to bias by jail authorities; the language is understandable to the study population; inmate participation will not influence the parole process; and adequate provisions for evaluations following participation in the study are in place.

Projects conducted in collaboration with other institutions also require IRB review at those institutions and all Institutional Review Boards must have an inmate representative. Given the nature of the corrections environment, research studies that are simply gathering information from anonymous routine care records are also reviewed. In addition, key HCCC staff has completed training in human research subject protections. Baystate Medical Center Research department sponsors specific training sessions.

Depending on the study design, additional protection of subjects may be implemented. For example, a study of chronic conditions followed the federal code of regulations for privacy certification. This process was created to prevent information gathered in research studies from being subpoenaed without the individual's consent.

### ***Research Funding and Resources***

Funding for major research activities has been obtained from outside sources such as the Centers for Disease Control and Prevention, the Massachusetts Department of Public Health, and private foundations. Collaborations with local schools of public health and medical facilities provide additional resources. Staffing levels augmented by research funding allows for smooth integration of research activities with inmate health care.

The following briefly highlights the scope, topics and sources of funding support for program enhancement research conducted at HCCC:

1. Study of Incoming Inmates' Health Problems, Health Facility Use, and Health-related Behaviors (University of Massachusetts School of Public Health and CDC)
2. Public Health Model Demonstration and Evaluation Study (Soros Foundation, National Institute of Justice, and the Centers for Disease Control and Prevention)
3. Sexually-Transmitted Disease Research
  - STD Surveillance Project (CDC and MA Department of Public Health)
  - Chlamydia Screening (MA Department of Public Health)
4. Study of Tuberculosis Treatment in Jail (MA Department of Public Health)
5. HIV/AIDS Research and Program Enhancements
  - Economic Evaluation of the HIV Counseling and Testing Program (CDC Cooperative Project)
  - Economic Analysis of HIV Treatment (Abt Associates)
6. Hepatitis Studies

- Hepatitis Seroprevalence Study (Baystate Medical Center, Integrated Care Group, Pharmaceutical Strategies, Inc., University of Massachusetts School of Public Health)
  - Hepatitis C Counseling, Education and Case Management (MA Dept. of Public Health)
  - Hepatitis C Women's Group (University of Massachusetts School of Nursing)
7. Parenting Needs Assessment (Brightwood Health Center, Baystate Medical Center, American Academy of Pediatrics)
  8. The Benefits of Urine-based Chlamydia Screening and Partner Notification (MA Department of Public Health)

For more detailed information about the design, implementation and results of the above research studies at HCCC, contact Dr. Thomas Lincoln at Brightwood Health Center, 380 Plainfield Street, Springfield, MA 01107; phone: (413) 794-8375 and e-mail: [Thomas.Lincoln@bhs.org](mailto:Thomas.Lincoln@bhs.org)

## **IV. IMPLEMENTATION AND OPERATIONS OF THE PUBLIC HEALTH MODEL**

### **External Community Collaborations**

#### ***Community Health Centers***

HCCC contracts with three local community health centers in Hampden County that provide care and case management both on-site at the jail and after release. More than 80% of the inmates at the facility come from the geographic areas covered by these health centers. Inmates requiring clinical care are sorted by residential zip code or previous health center affiliation and are assigned to a health care team that serves that locality. The health care team is comprised of a primary nurse and a nurse practitioner based at the jail full-time and a part-time physician and a case manager who are dually based at their health center and HCCC.

The advantages of these external collaborations are numerous:

- Inmates establish a relationship with providers prior to release, increasing the likelihood of continuing care in the community.
- Interdependence between the jail and outside providers helps to break down barriers around communication, information sharing and standards of care for the most medically underserved in the community.
- Diverse services and a greater number of services are available than would be financially feasible if the jail were the sole provider.
- Health centers have responsibility for the people in their communities; inmates represent a very important group of previously uninvolved patients and the public health model allows them to reach a priority population from the communities they serve.
- By establishing a contractual relationship, the jail and health centers have predictable financial arrangements to cover the costs of delivering care

Administratively, the health centers benefit when jail staff facilitates enrollment of inmates onto public insurance such as Medicaid. Financially, the community health centers benefit significantly from working with HCCC. The contractual arrangements between the partners provide income to cover the expenses of staff time for employees working in the centers and in the jail. Inmates who are enrolled in Medicaid provide third party reimbursement to the health center when care is delivered after release from jail. With so many community health centers struggling to contain costs and deliver high quality health care, the HCCC contracts support the model of dually-based staff and reduce the use of free care after discharge.

#### ***Hospitals***

HCCC does not maintain its own inpatient infirmary. As a result of the collaborations with local community health centers, HCCC has ready access to the local hospitals affiliated with those health centers. The physicians follow their HCCC patients when hospitalization is required, further solidifying relationships and insuring continuity of care. The physicians working dually at HCCC and health centers have admitting privileges at these hospitals for all in-patient care.

Each of the three health centers has administrative and clinical links to hospitals to facilitate admissions. For two of the health centers, their affiliation with Baystate Medical Center in Springfield also provides access to a major teaching hospital affiliated with the Tufts University School of Medicine. This relationship allows for increased access to physicians in training, research opportunities and the resources of a major teaching hospital.

In addition to the three local hospitals, Lemuel Shattuck Hospital, a public health hospital in the Boston area, serves as a statewide resource for county jails and the Department of Correction. Admissions to this hospital from HCCC take place on a more infrequent basis, due to geographic distance. Health services staff works with the Special Operations Department at the jail to coordinate transportation of inmates for emergency, as well as less urgent, care at outside facilities. Inmates must sign all applicable release forms and next-of-kin family are notified of the need for hospitalization for life-threatening situations.

Upon determination by staff physicians of the need for hospitalization, arrangements are made for safe inmate transport. Health care and security staff work closely together to determine the method of transportation and security precautions. Prior to transfer to another facility, the inmate's medical records are reviewed to assess the inmate's suitability for travel.

Health services staff is in communication with the receiving hospital staff to allow for preparation time. Medical staff provides written instructions on any requirements including medication needs and administration of such medication, observation and care during travel. Medical staff also works closely with the Transporting Officer to note other needs such as behavioral management problems, necessary procedures or any other relevant information for inmate transport.

In order to maintain inmate confidentiality, all medical information is kept in sealed envelopes for review by the medical personnel involved in the inmate transfer alone. Inmates must provide verbal or written releases in order to be transferred to the hospital and inmate health needs are reviewed again upon return from the hospital. If an inmate requires new treatments or a change in housing situation due to a medical condition, health services staff are involved in implementing such. Health services staff work in conjunction with housing unit supervisors to apprise them of any needed changes in an inmate's housing situation.

While inmates are hospitalized, health services staff is in daily communication with hospital staff to update the inmate's records, assess progress and plan for hospital discharge. Discharged inmates are seen in the health services clinic immediately upon arrival from the hospital, prior to return to the housing unit.

### ***Other Community Agencies***

Community agencies are a key element in maximizing services to inmates. Community-based agencies enhance ongoing clinical care and provide an additional link to community services upon release. At HCCC, many local and regional social service agencies and faith-based programs are invited into the jail to best meet the needs of inmates.

### Health Education

Health education is frequently provided by community-based agencies such as AIDS service organizations. These services are provided by specific contractual arrangement or on a volunteer basis. Agencies seeking to reach the same at-risk populations as found in jails are appropriate partners in the delivery of care. For example, a local AIDS service provider developed a series of workshops and discussions with female inmates about HIV risk, sexually transmitted diseases and ways to improve communication with their partners to reduce risk. The workshops were designed and conducted by the local agency staff who themselves had been incarcerated and were now in recovery from drug abuse. Female inmates have the opportunity to learn more about how to become a paid peer educator upon release and use the agency drop-in center for assistance.

### Oral Health Services

Tufts University School of Dentistry provides all dental and oral surgery services at HCCC. This contractual arrangement provides the opportunity for dental professionals in training to rotate through the facility. A similar model is used for medical residents working in the four community health centers.

### Mental Health Services

Behavioral Health Network, a major non-profit mental health care provider in the region, is contracted to deliver mental health care to inmates at HCCC. The Network's linkages to services in the community enhance continuity of care. The community health centers provide additional links to mental health care through their provider networks and hospital affiliations.

### Vision Care and Optometry Services

Two local optometrists under contract with HCCC provide optometry and eye care services. The contract provides for weekly, on-site vision and eye health care for inmates.

### ***Benefits of Collaborations with Community Agencies***

By contracting with community-based providers, HCCC is able to increase services, keep costs down and enhance the relationship between the jail and the neighboring community. Public health and social service providers reach the population most in need and can continue that relationship after an inmate's release. These collaborative partnerships support high standards of care and do much to diminish the separation and segregation that often exists between correctional facilities and the broader health care system.

### ***Practical Considerations for Collaborations***

Based on the experience at HCCC, the following are some of the program principles and operations found to enhance external collaborations:

- Contractual arrangements must be fully integrated into ongoing operations of all partners and not dependent solely upon the support of particular staff or leadership of an agency at a given time
- Community health centers and HCCC have made long-term commitments to serving the health care needs of inmates during incarceration and after release
- Contractual relationships with local health centers are reviewed annually and updated as

needed; contracts have become an institutionalized aspect of health care delivery for the health centers and HCCC

- Provider teams including physicians, nurse practitioners, nurses and case managers work closely together to provide coordinated care
- Providers spend dedicated time in the jail; each physician spends, on average, 4-12 hours per week at the jail
- Inmates are assigned to health care teams based on residential zip code and health center service areas to support re-integration back into their families, social networks and sources of support
- Health care providers are well-versed in the health issues of chronically disenfranchised, medically underserved populations
- Health care and social service providers are well-trained and non-judgmental around issues of substance abuse and relapse
- Providers are linguistically and culturally competent to treat an ethnically diverse population; staff at health centers is often reflective of the neighborhood and its culture
- Case managers are knowledgeable about a wide array of services available in the community including housing, employment, educational opportunities, food support, alcohol and drug recovery programs and faith-based services to facilitate links with community after inmate release
- Community agencies are willing to work on-site at the jail in order to reach an underserved audience and to sustain involvement with clients after release; community agencies are invited to come to the jail as visitors to see inmates and advise them of services available in the community post-discharge. Agency visitors go through the security clearance procedures similar to all visitors including signing in, metal detection tests, etc. Making a connection to the agency staff or volunteers prior to discharge strongly promotes active follow-through to seek services once inmates return to the community. Agencies that come to the jail must be well-established, reputable providers recognized as proficient in their field.

## **Internal Collaborations**

In order for the public health model of care to function well, collaborations are essential both within the facility and in conjunction with the outside environment. Within the facility, the provision of health care demands close cooperation and communication between health service providers, security staff, and jail administrators. Leadership and support for the model must be evident from the highest degree of administrative authority and oversight.

### ***Administrative Links***

At HCCC, the public health model demonstrates significant collaboration with internal departments and staff. Administratively, the Health Services Director reports directly to the Superintendent, insuring high-level support and oversight. The joint efforts of the medical and security staffs are enhanced through ongoing meetings to discuss the relationship between health needs and security issues. Cooperation is evident in the initial intake and booking procedures for newly arriving inmates. Both security and health services staff play major roles in evaluating the



health status of inmates. These joint efforts require ongoing cooperation and communication at both the administrative and frontline staff levels. All new staff must be oriented and trained in these procedures to ensure continuity and compliance with established policy.

Administrative meetings are held monthly between the Sheriff and departmental managers and documented via minutes. Health services staff meet monthly to review procedures and collaborations with other departments.

### ***Staff Training***

A key area of internal collaboration is that of staff training and education. All correctional officers undergo intensive six-week training and all must receive Cardiopulmonary Resuscitation (CPR), Automatic Electronic Heart Defibrillator (AED) and First Aid. Correctional Officers are required to obtain an additional 40 hours of training during the year. Health Services staff conducts a significant number of available in-house training courses.

The curriculum for correctional officers includes health-related topics such as sex offenses and offenders, women's issues, HIV/AIDS, and infectious and chronic disease. The health educator from the medical staff routinely instructs correctional officers during these sessions and special training in mental health issues, inmate health needs, stress management, and illness prevention are also a regular part of interdepartmental collaboration.

At the same time, health services staff must be trained and oriented to the special issues of working in a correctional facility. As part of all health services staff orientations, new employees spend several days working with security staff to learn more about procedures for inmate transport, sick call, emergencies and the role of security staff in general. The sick call triage system greatly facilitates extensive interaction between health services staff and correctional officer staff.

Continuing education and training for all staff is strongly encouraged at HCCC. Health services staff is required to obtain continuing education credits to maintain clinical licensure and HCCC staff is actively involved in local, state and national professional organizations dedicated to correctional health issues. Proponents of the public health model from HCCC regularly conduct presentations at national conferences and workshops.

## **Operations of the Public Health Model**

### ***Element One: Early Detection***

#### **Policies and Procedures**

##### ***Health Assessment***

At HCCC, approximately one-third of the inmates stay for three days or less, one-third stay for four to 90 days and one-third stay for 91 days to two years.

Upon entering the correctional facility, inmates undergo several levels of initial assessment and evaluation from the preliminary screening conducted at booking to a more detailed health assessment conducted by nursing and mental health staff.

*Initial Booking/Receiving Assessment*

At the time of booking, a trained correctional officer conducts a preliminary health screening. This screening consists of inquiry into:

- Current illness and health problems including sexually transmitted diseases and other infectious diseases
- Dental problems
- Mental health problems, i.e., seizures, psychiatric disorders, etc.
- Use of alcohol and other drugs including type of drugs used, mode of use, amounts used, frequency, date or time of last use, history of any problems after ceasing use
- Past and present treatment and hospitalization for mental disturbance or suicide
- Possibility of pregnancy
- Suicide prevention screening
- Other health problems

Intake and booking staff receive special training before conducting initial screenings. Their observations focus on the behavior, state of consciousness, mental state, appearance, sweating, tremor, body deformities, ease of movement and the condition of skin including bruises, needle marks, infestations, jaundice, etc. Booking staff notifies the health services staff immediately about any inmate with an obvious illness, injury or who is demonstrating suicidal, violent or unusual behavior. Once the booking staff completes their initial screening, the inmate is sent to health services for more detailed evaluation.

If the Correctional Officer working in admissions judges the patient to be severely injured or ill, he may refuse admission to the jail. Instead the officer will direct the accompanying arresting officer to transport the patient immediately to the nearest emergency room to better meet the needs of the patient. Arrestees with acute injury or illness are not accepted into the jail until they are medically cleared at the local hospital and appropriate medical information is returned to the jail.

*Medical Intake Evaluation*

All inmates undergo a thorough health assessment conducted by a Registered Nurse and a physical examination conducted by a Nurse Practitioner. This assessment, generally conducted on the third day of admission, covers all areas of health needs including acute and chronic diseases, health history, major systems review, vital signs, and a physical exam. All inmates are screened for syphilis, tuberculosis, and diabetes. A complete blood count, urinalysis and STD testing are performed and x-rays are done as needed. All female inmates are tested for pregnancy and they receive a pelvic exam with Pap smears and cultures. Voluntary testing for HIV is offered to all inmates; HIV counseling and testing is provided by a staff member at designated times in the health services unit.

For inmates in the orientation unit, health services staff prioritizes their further evaluation, conducting the assessment prior to a housing placement. For any inmates who have previously been in the facility, medical records and charts are obtained.

For the nurse conducting the intake evaluation, the following information is entered into the computerized data systems:

- Review of earlier receiving screening
- Medical history (allergies, medications, immunizations)
- Mental health history
- Dental history
- Family medical history
- Evaluation of mental status
- Physical signs
  - Weight
  - Height
  - Blood pressure
  - Respiration
  - Pulse
  - Temperature
- Substance use history
- Review of suicide prevention screening
- Mental health evaluation
- Disability determination

Nursing staff also serve as key providers of information about accessing care, how to use sick call, medication distribution procedures, medical emergencies and the availability of health education services. Inmates are reminded to read their Inmate Handbook and receive additional literature about health issues. Inmates sign forms documenting their receipt of information and provide consent and permission for further health care delivery.

#### *Full Health Assessment*

A full health assessment is conducted by a nurse practitioner within 14 days of admission to the facility. This assessment includes:

- Review of all previous information obtained via preliminary screening
- Completion of physical examination with comments about mental health, dental status, identification of problem areas, initiation of tests and treatment as necessary. Results of the physical exam and the establishment of a Master Problem List are entered into the medical record.
- Recommendation concerning housing, job assignment and/or program participation as appropriate.

A follow-up physical exam schedule is created based on the following guidelines:

- 1) Inmates less than 40 years of age will receive a repeat physical exam every 5 years unless more frequent exams are needed.

- 2) Inmates over the age of 40 will have a physical exam every two years unless medically indicated more frequently
- 3) Inmates over the age of 50 will have a physical exam every year

#### *Dental Health Assessment*

Oral health screening is a vital part of the inmate health assessment process and is conducted at several levels. Initial oral health screening is done as part of the intake; it is repeated during the physical exam by the physician or nurse practitioner who has been properly trained and designated by the dentist. The screening includes visual observation of the teeth and gums, noting any obvious or gross abnormalities requiring immediate referral to the dentist.

Oral hygiene instruction and dental health education are provided to each inmate during the initial intake. Educational measures address proper oral hygiene including brushing, flossing, use of fluoride, etc.

Based on the preliminary screening, a comprehensive oral health examination is conducted for inmates with dental health problems. The exam includes:

- Review of dental history
- Dental education as needed
- X-rays for diagnosis as needed
- Exam of hard and soft tissues by means of illumination light, mouth mirror, explorer and charting of teeth

Follow-up treatment and appointments are scheduled as needed.

#### *Mental Health Assessment*

The mental and psychological status of the inmate is also assessed by nursing staff during the intake procedure. At booking, the receiving staff notifies the health services department of anyone who is suicidal, violent or who demonstrates unusual or bizarre behavior. If there are no acute medical needs, the inmate is referred to the mental health services staff for further evaluation. . A key issue is to determine whether an inmate needs to be placed on continued or frequent observation. If so, the inmate is admitted to the inpatient Forensic Unit on the grounds of the facility<sup>\*</sup>; if not, the inmate proceeds to the orientation unit. The availability of counseling and mental health services are outlined in the orientation unit as well as the HCCC Inmate Handbook given to all inmates. Based on the results of the mental health assessment, treatment recommendations are made and initiated.

#### *Suicide Risk Assessment*

At HCCC, staff adheres to a strict policy of suicide prevention. All inmates are evaluated for suicide risk including a review of any prior history of suicide attempt(s). Special precautions are used with patients who are seriously depressed or withdrawing from drugs or alcohol. An

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<sup>\*</sup> Note: In 2002, the ESU closed due to state funding cuts. The services described here depict operations before its closure. Efforts are currently underway to advocate for restored funding and reopen the ESU.

inmate's previous experience with mental health and substance abuse treatment are also scrutinized.

### **Documentation**

At each level of assessment and evaluation, staff completes documentation including intake forms (which are computerized), health histories, consent forms and all necessary paperwork. Inmates must sign forms authorizing the release of health information and specific release consent for HIV test results.

### **Resources Needed**

The public health model utilizes a comprehensive system of evaluation and assessment in order to establish baseline health indicators for individuals and the inmate population as a whole. The system relies upon close collaboration between initial booking staff and health services staff for immediate identification of serious medical need. Training of booking staff is essential to provide for adequate assessment and initial screening skills. This element of the system also firmly establishes the jail's philosophy that inmate health issues are a primary concern.

Health issues are addressed in the orientation unit where newly arrived inmates learn about all of the services, programs and opportunities available to them. At this juncture, inmates are reminded that their health needs are paramount and that staff is available to provide health care, support and assistance. For many inmates, this may be their first experience with a system that cares about their health needs and is willing to address them in a compassionate manner.

Intensive health assessment sets the stage for the remaining elements of the public health model. Acute and ongoing treatment decisions naturally flow from adequate assessment and screening. Screening also provides groundwork for education and prevention as staff identifies what inmates need to know more about regarding disease prevention.

For the model to function effectively, dedicated resources are needed in the following areas: staff time, training, space to conduct health assessments, and an array of health services including dental health care, mental health care and substance abuse treatment. The assessment process requires that various departments in the jail communicate frequently, coordinate efforts, assess severity of illness, plan for further evaluation and deliver services in a timely fashion.

This collaboration involves the staff and management of the security team, orientation unit, health care services and mental health care, dental health care, and correctional officers. Assessment and evaluation are an ongoing, daily function for all of the staff. The public health model provides for a collaborative effort where inmate health care is a significant function of the facility.

## ***Element Two: Treatment***

### **Triage System**

#### *Daily Sick Call*

HCCC uses a triage system for treating mild-to-moderate, non-emergency health complaints and requests for care. Triage and treatment of minor illnesses are provided by nurses directly in the inmates' housing units. This triage system, known as "sick call" to the security staff and inmates, provides treatment for minor illnesses and allows nurses to evaluate which inmate(s), if any, need to be seen in the clinic.

Nurses conduct triage equipped with a portable cart containing all necessary supplies and equipment. Carts are kept locked when not in use and a list of supplies are maintained as part of the central supply. To maintain confidentiality, all "living pods" are equipped with a private room for use by the nurse during triage.



This feature of bringing care directly into the inmates living quarters is a unique component of the public health model. Inmates provide their name, number and request for "sick call" to the correctional officer who documents it on the log. The correctional officer may also make the initial request for health care triage on the inmate's behalf.

Following the evaluation, the nurse determines whether the problem is:

- A minor illness, which can be treated in the pod utilizing standard protocols
- More serious, requiring further assessment in the health clinic
- Urgent, requiring immediate attention in the health clinic

The triage system is available 7 days per week, 24 hours per day. Full-time nurse practitioners, registered nurses and part-time physicians are on site throughout the week for sick call. Inmates needing additional care are generally seen within the same day or 24-hours of the request. Telephone triage is available for correctional officers to discuss an inmate's health situation with a nurse at any time.

#### *Mental Health Care Triage*

Mental health care staff also provides daily sick call. Five Master's degree level clinicians spend their day in assigned living pods. They spend time with correctional officers and will see any patient who requests their services. Officers can also request that a clinician see any inmate about

whom they have concerns. This system -- having a registered nurse and mental health clinician on the pods and interacting with officers -- has many benefits.

#### *Advantages of Triage System*

Inmate illnesses and mental health problems are detected early and treated promptly, resulting in prevention of more severe problems. On-site triage adds greatly to a quiet and calm correctional environment where inmates feel that their physical and mental health care needs are met. Safety for inmates and staff is enhanced. Triage allows for inmates to be seen in the environment in which they live. The system helps to break down barriers between nursing staff, inmates and correctional officers.

Another advantage is the support and interaction between the clinical and correctional personnel. Officers are often uncertain about whether an inmate's health complaints are "real" and of a serious nature. Knowing that the nurse or mental health clinician will be making daily rounds is a source of staff support and cooperation.

If any inmate's classification status precludes receiving care in the pod, arrangements are made to provide services in the place of the inmate's detention. For inmates in the segregation unit, a registered nurse makes wellness rounds at least three times per week, interviewing all inmates to determine their health status. Inmates can be placed on the medical triage list by the correctional officer to be seen five days per week while in segregation.

#### **Treatment Protocols**

The Health Services Department maintains a comprehensive set of treatment protocols for the nursing and physician staff to follow in clinical care decision-making. These protocols are reviewed and updated at least annually; more frequently as advances in treatment are developed. Newly hired staff and medical residents rotating through the department are trained in these protocols as part of their orientation.

#### **Off-site Treatment Services: Hospital and Emergency Needs**

Through the health centers, HCCC has access to local hospitals and multiple outpatient providers as needed. Special medical programs including chronic care, convalescent care and multidisciplinary care not available on-site are also obtained through agreement with local providers.

As a result, the physician familiar with an inmate's medical needs oversees their hospitalization and progress. In fiscal year 2000, HCCC had 105 hospital admissions, 596 hospitalization days and 291 emergency room visits.

For inmates requiring longer-term chronic or convalescent care, an individualized treatment plan is developed in accordance with inmate needs. Some of the conditions that may lead patients to require this type of care include:

- Chronically ill
- Physically disabled
- Frail elderly

- Terminally ill
- Inmates with special mental health needs
- Developmentally disabled

For each of these patients, the treatment plan is designed to accommodate their special medical needs, address health issues and determine the setting most appropriate for care. Special needs can often be met at HCCC itself, but contracts with local providers expand the options for a broader range of care facilities.

### ***Element Three: Prevention***

HCCC provides a range of prevention-focused activities and programs for inmates and staff. The prevention focus is linked to obtaining and maintaining better health for those inmates without major medical conditions and achieving a high level of chronic disease management and quality of life for those inmates with identified illnesses. HCCC also recognizes the importance of wellness and health education programs for staff throughout the facility. Recreational and exercise programs are available for staff as well as ongoing health promotion and disease prevention-focused services for inmates.

Prevention, education and health promotion are integrated into the clinical services at all levels. Inmates are introduced to the array of prevention and education programs available in orientation and during the medical intake process. Inmates are encouraged to attend programs specific to their personal risk factors as identified through assessment. Referral to in-house services is provided during the establishment of an individualized treatment plan for inmates.

For many inmates, the period of incarceration is an opportune time to examine their health histories, risk behaviors and the consequences of those risks. It is often a “teachable moment” where inmates’ readiness to learn more and begin the change process is high. Most inmates can significantly benefit from health information and education, given their usually limited prior experience with the health care system. Although many inmates have engaged in risk behaviors such as drug use and sexual risk-taking, their understanding and knowledge of disease transmission risk and risk reduction are often minimal. Health services and other jail staff support inmates’ efforts to achieve behavioral change and take advantage of available prevention services.

A prevention-focused educational plan is developed whenever an inmate is diagnosed with an infectious or chronic disease. Inmates with chronic diseases are provided information and training concerning management of their illness in individual sessions and the health educator nurse is assigned to their case. Disease-specific group health education sessions are held weekly for patients with diabetes, asthma, and hypertension. This intensive health education provides inmates with information, as well as group support in maintaining compliance with treatment regimens and lifestyle changes such as diet, exercise and cessation of tobacco use. Educational resources including brochures, fact sheets, videos and handouts are made available in numerous languages to best meet the needs of the inmates. Health education staff develops materials at appropriate literacy levels for inmates to enhance comprehension and relevance.



### **Prevention-Related Services**

The scope of prevention-related activities offered at HCCC runs the gamut of health issues and the health educator develops programs to address new needs as they arise. These services address needs while the inmate is incarcerated *and* after release. For example, through a grant with a local pharmaceutical company, all Type I diabetic patients leaving HCCC are given a glucometer, while inmates with HIV are connected to ongoing support services and counseling to prevent future HIV transmission after release.

The following are some of the prevention services offered at the jail:

- HIV counseling and testing
- Comprehensive STD education, screening, evaluation and diagnosis
- Hepatitis A and B vaccines
- Hepatitis C infection counseling and testing
- Influenza vaccines for staff and inmates
- Pre-natal care for pregnant inmates
- Intensive substance abuse treatment and relapse prevention
- Pap smears, routine pelvic exams and mammography

### **Health Promotion and Wellness**

Health promotion activities are linked to the prevention of chronic disease, improved mental outlook, stress management and improved inmate behavior. Consistent with the overall philosophy at HCCC, health promotion and wellness activities are provided for inmates and staff. For example, the facility-wide policy banning tobacco use by anyone on the grounds supports persons who have stopped using tobacco, encourages inmates and staff to quit, prevents health problems for non-smokers and sends a message that tobacco use is a major health concern.

#### *Inmate Health Promotion*

Inmates have access to numerous outlets for health promotion and wellness including daily physical fitness activities, athletic competitions, health classes, and stress management workshops. Inmates have access to the gymnasium for supervised activities at least three times per week. Weekly and monthly schedules are developed by the fitness staff for intramural athletic activities such as basketball, volleyball, aerobic conditioning, etc. Fitness staff is available to provide supervision, training and access to equipment. Inmates also have access to leisure time activities such as board games, ping-pong, cards, and other activities during designated leisure times.

In addition to physical exercise and recreational activities, health promotion services include smoking cessation counseling, medically necessary special diets, and access to the library containing health promotion information and materials (e.g. videos and brochures). To address the spiritual health needs of inmates, religious activities are an ongoing part of the jail. A chapel and Muslim prayer room are available, as well as regular religious services in the Catholic, Protestant and Muslim faiths, where both Spanish and English services are available. Religious counseling is also made available to inmates as an option for guidance and support. In addition to the structured in-house services, several local faith-based volunteer groups regularly visit the jail for specific religious studies.

### *Staff Health Promotion*

The Sheriff's Department has made a strong commitment to the health and well-being of staff members as an extension of its philosophy. Wellness and fitness programs for staff are designed to promote health, enhance work morale and support self-esteem. Because of the substantial physical and emotional demands of working in correctional environments, staff can personally benefit from ongoing programs. The institution benefits in reduced staff turnover, personnel "burnout" and overall employee health care costs.

As part of overall training and orientation, employees attend a wellness seminar each year. The Fitness Department is responsible for coordinating and conducting the session where topics covered can include stress management, nutrition, weight control, and exercise demonstrations. Sessions are developed to be interactive and multi-media.

Physical fitness programs are also available to staff and schedules are posted throughout the institution. Activities include: aerobics, walking club, running club, weight training, self-defense, softball, basketball, volleyball, and golf. The fitness staff is available to provide consultation to staff members on nutrition, body composition testing, fitness testing and recommendations for exercise routines.

For some designated staff at the facility, annual physical fitness testing is an employment requirement. Staff is notified of testing standard criteria.

### **Resources Needed**

In order to integrate health promotion and prevention activities into the ongoing health care of inmates, a degree of responsibility for such is incorporated into most job descriptions. The clinical care staff is consistently addressing health education and prevention needs during encounters with inmates. The full-time Nurse Educator and full-time HIV Educator dedicate significant resources to patient education and prevention, and serve as a resource for other staff. Resources are also dedicated to developing and acquiring health education materials. The development of jail-wide policies that support and maintain health promotion and prevention for both inmates and staff require an allocation of training resources and commitment from the highest levels of administration.

HCCC has a rich and substantial relationship with the state public health department, whose resources support HIV education, hepatitis C screening and case management, and innovative STD screening. In addition, linkages with local pharmaceutical representatives have augmented resources for patient teaching, including diabetes, asthma, and HIV education.

### ***Element Four: Health Education***

For many correctional facilities in the United States, a comprehensive program of health education has not been implemented. The ongoing contact with a very high-risk population provides many opportunities for health education programs to deliver accurate information, develop self-help and self-care skills, support readiness to reduce health risks, and improve inmate confidence in health care providers. Effective health education enhances inmate self-

efficacy, feelings of control over one's health decisions, and can improve the psychological well-being of inmates. Supporting fellow inmates' health through peer education contributes to social connections that benefit the individual and the community.

At HCCC, several features of the health education components of the model are noteworthy. Full-time staff is dedicated to planning and delivering health education to inmates. Educational programs for groups and one-to-one education are delivered in the inmates living quarters and in the clinic. Topics for health education are often suggested by the inmates themselves and health educators develop programs to address these concerns. Disease-specific and more general wellness topics are addressed via group classes, promotional materials distributed in the clinic and "pods", bulletin boards with changing information throughout the facility, inmate handbooks and orientation for new admissions, health information on videos, and consultation sessions with health educators.



### **Patient Education**

Health education is an integral part of ongoing patient care with multiple levels of programs developed at the jail to reach inmates. Education about communicable diseases and risk factors for HIV, hepatitis C, STD's and TB are incorporated into the initial contact with the jail. During the 72-hour orientation period where new inmates are informed of all facility rules, policies and operations, the health education component of health services is highlighted. During orientation, inmates are also educated about how to use the health services while in the jail. Given the diversity of the inmate population, the health educators design and develop programs and materials that will be culturally and linguistically appropriate. Special attention is paid to developing health education tools that do not require advanced literacy skills for comprehension.

Educational materials such as videos, brochures, posters and pamphlets are available in English and Spanish. The Health Services staff melds educational information into all clinical encounters and refers inmates to particular groups and more intensive one-on-one education based on specific needs and health issues. A peer education program for increasing HIV/AIDS awareness is overseen by the AIDS Coordinator. Health education is also fully integrated into the Substance Abuse Unit, the Women's Unit and vocational training. Inmates have myriad opportunities to receive health education tailored to their needs and learning styles at HCCC.

*Without the help, assistance and support of the correctional officers, most of the following educational programs would not be possible.* In many cases, it is the correctional officer who escorts and delivers the inmate to an educational program. HCCC is fortunate in that the security staff is supportive of educational efforts and set a healthy tone for the inmates, reinforcing the importance of health education and inspiring inmates to maintain their commitment to health.

### **Disease-Specific Patient Education**

The availability of disease-specific education for inmates is an important asset of the public health model. For inmates with chronic and manageable diseases, intensive education and skill-building in methods to prevent complications, maintain health and reduce the risks of longer-term damage to bodily systems can have tremendous benefits. HCCC dedicates significant resources to individual and group education activities for inmates with diabetes, asthma, hypertension, HIV/AIDS, and other chronic diseases.

Targeted, disease-specific health education is a high priority for this population that experiences so many chronic conditions. The full-time Nurse Educator meets with inmates one-on-one to provide detailed instruction in disease causes, risks for complications, ongoing management, medication schedules and behavioral changes to achieve adherence to treatment regimens. Group education is delivered on a weekly basis, sessions are generally 1 ½ hours in length, and provide additional self-care education, time for follow-up questions, group discussion and peer support for ongoing disease management.

The Nurse Educator is available for consultation after an inmate has been released as part of follow-up care. The Nurse-Educator may also meet with the inmate's family members to discuss the illness. (Both of these functions have been particularly helpful for diabetic patients).

The Nurse Educator serves as a resource to health services staff and others for the design and development of health education programs that meet a range of staff and inmate needs.

Educational programs have also been expanded with the addition of funding from the state public health department and private foundation sources. In 1999, the jail received a grant to expand case management services and education on hepatitis C, further stimulating collaboration with the HIV/AIDS staff to address issues of co-infection. Research funding has allowed for improved data collection and documentation of the prevention and education activities that take place in the jail and after release.

### **Peer Education**

There are multiple opportunities at HCCC for peer education. The HIV/AIDS Coordinator has developed and manages a group peer education and outreach team comprised of inmates trained in HIV transmission, risk reduction, partner communication skills, and community resources. Support groups and weekly meetings for inmates in recovery from alcohol and drug abuse are provided at the jail. Inmates with chronic diseases meet weekly with the Nurse Educator to learn more about managing their condition and gain social support from peers. A weekly support group for HIV positive inmates is also provided.

#### *Peer Education: HIV/AIDS*

The peer educators, all of whom are sentenced inmates and some of whom are HIV+, are trained to provide education, outreach, support and referrals for other inmates. The peer educators design and deliver group presentations, provide informal individual education, and serve as a resource for sentenced inmates in the residential towers. Peer educators receive 2 ½ days earned "good time" benefits and a certificate of completion following their training. Inmates serving a County sentence are eligible to earn good time to be deducted from his/her sentence for each month of participation in a work, educational, vocational or treatment program at the facility. For some

peer educators, their training and participation can lead to future community service or employment opportunities upon release as a peer educator or outreach worker for local AIDS service organizations.

To become a peer educator, an inmate must:

- Be sentenced with a minimum of 9 months to serve
- Attend the peer educator training course offered by the health services department
- Be able to work well with staff, inmates and community agencies as a team and individually
- Have good communication skills; bilingual ability in English and Spanish is highly desirable, based on the demographics of the HCCC inmate population

The inmates must submit a written application to become a peer educator and obtain two professional references from jail staff. Once accepted into the program, inmates attend a series of training sessions held over several weeks; inmates receive a total of 24 training hours delivered over 10 sessions. Peer educators must attend bi-weekly staff meetings facilitated by the HIV/AIDS Coordinator and commit to providing class presentations to fellow inmates at least three times per month in order to earn good time. Peer educators also sign a contract outlining their responsibilities and role in the program. The contract can be terminated if the inmate has three unexcused absences in an 8-week period.

The HIV/AIDS Coordinator is responsible for the oversight of the peer educator program and provides ongoing training, resources and updates. Peer educators receive an extensive training manual containing medical information on HIV transmission, the immune system, local community resources, sample handouts, and HIV reference materials. The Coordinator observes classroom presentations provided by the peer educators and offers feedback to further develop communication and group process skills.

Special attention is devoted to topics of concern to the inmates, including HIV transmission risks in jail and in the community, negotiating with drug-using and sexual partners, co-infection with Hepatitis C, and risk reduction through condom use, community needle exchange programs, drug abuse treatment programs and abstinence. The availability of support for HIV testing services within the jail and in the community is emphasized.

#### *Peer Education: Substance Abuse*

For inmates in recovery from substance abuse, ongoing peer support and education programs are available at the jail. Additionally, twelve-step recovery programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) sponsor frequent meetings at the jail throughout the week. Community volunteers facilitate the hour-long meetings and provide inmates with an opportunity to continue their recovery process. The meetings also serve as an important adjunct to the intensive substance abuse treatment services available in the jail. Inmates are encouraged to attend as many meetings as needed and must obtain approval from their counselor or residential pod officer; separate meetings are held for female inmates.

#### **Resources Needed**

Extensive resources are devoted to the comprehensive program of health education at HCCC. In

addition to the dedicated full-time staff positions of Nurse Educator, Health Educator, HIV Educator, and HIV/AIDS Coordinator, health education is incorporated into ongoing nursing and physician visits. This greatly expands the resources devoted to health education. Funding from the state public health department and private grants supports targeted education for identified conditions such as HIV/AIDS, hepatitis C, and diabetes. Staff and volunteers from outside community service agencies such as AIDS service organizations and a local women's health clinic provide additional personnel for health education and prevention.

### ***Element Five: Discharge Planning, Case Management, and Continuity of Care***

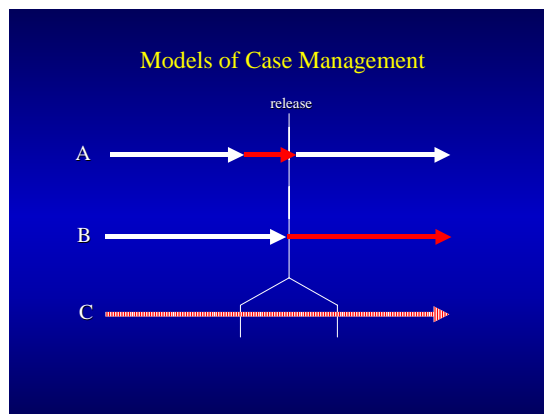
A key element of the public health model at HCCC includes intensive support for discharge planning. Discharge planning is an effective component of the overall HCCC program to provide inmates a supportive safety net, ongoing post-incarceration support and to ease the potentially difficult transition from jail to a home community. The discharge planning process involves assessment, development of a discharge plan, referral to appropriate community resources, advocacy for clients, and preparing for initial health care appointments once released. It also often involves addressing the vocational, housing and financial assistance needs inmates face such as applications for governmental support programs, i.e., Medicaid and Social Security, and with monitoring through the legal processes of parole, probation or day reporting status.

#### **Discharge Planning Model**

Within the public health model, HCCC has had experience over the years with various models of discharge planning including:

- A.) A traditional model where planning begins near discharge, with continuation of case management until release
- B.) Starting discharge planning at the time of intake and continuing until discharge
- C.) Ongoing case management beginning upon intake, continuing during incarceration and sustained in the community after release

*It is this third, more comprehensive and sustained model, that is currently in use at HCCC.*



The timeframe for implementing the discharge planning process and key staff positions needed to fulfill its function are critical pieces of effective planning and continuity of care. At HCCC, significant resources are devoted to the staffing, oversight and delivery of effective discharge

planning and follow-up services for inmates. The model of case management and discharge planning that HCCC has found to be most successful for the majority of persons with chronic conditions is the neighborhood team-based case manager working at both the jail and the health center.

### **Staff Structure**

To date, the most successful staff structure is comprised of dually-based case managers, a discharge planning nurse, and a mental health discharge planner. Each health care team has a case manager assigned to it; each team accesses the expertise of the discharge planner and mental health discharge planner as needed.

#### *Staff Position: Case Managers*

The case managers work part-time in the jail and part-time in the community at a community health center. Case managers begin work with clients when the need is identified, typically near intake and evaluation, and continue to provide case management during incarceration and in the community after discharge from HCCC. Historically, the case manager position began as an HIV case manager, but the position was expanded to include other medical conditions. The case managers are not disease-specific but rather deliver services to inmates with a variety of chronic medical conditions. This expanded model resulted in the added benefit of increased privacy of HIV status. Receiving services from a case manager was no longer exclusively seen as indicative of positive HIV status.

#### *Staff Position: Mental Health Discharge Planner*

The mental health discharge planner is jail-based and performs more traditional discharge planning functions, not yet following the client into the community. The structure of community-based, mental health services is complex and separate from medical care resources, making this specialization important. HCCC continues to explore ways to expand the model of the mental health discharge planner to create a dually-based system of therapy and case management in the jail and the community.

#### *Staff Position: Discharge Planning Nurse*

The discharge planning nurse is also jail-based but interacts with numerous community agencies and resources including the courts, placement facilities, and medical care providers. The discharge planning nurse typically manages care for inmates with complex medical needs including those requiring placement in skilled nursing facilities, rest homes, and hospitalization. The Discharge Planning Nurse also serves as the medical service liaison with the HCCC classification department. Referrals to the Discharge Planning Nurse can come from any member of the health care teams, correctional officers, counselors and from the inmates themselves.

### **Key Activities in the Discharge Planning Process**

The following are key functions and practical tasks that HCCC staff has incorporated into the discharge planning and case management operations to improve inmates' outcomes upon release and support a successful return to the community:

- 1) Track court dates of pre-trial detainees with known chronic illnesses to help facilitate their medical needs should they be released at court; work as an advocate for the client and their attorney regarding medical needs during court proceedings
- 2) Establish a plan of care with secured living arrangements to be presented to the court if it allows the inmate to be released
- 3) Accompany the inmate to a transitional, after-care or alternative sentencing program in accordance with the court's ruling if doing so ensures the client's release
- 4) Identify sentenced inmates receiving ongoing health care four to six weeks prior to their release date
- 5) Start the application process for Medicaid 30 days before release to avoid delays in securing health benefits; these benefits are needed for access to health care services once in the community, as applicants are not entitled to government funding while in a correctional facility
- 6) Assure that all inmates on medication regimens leave the facility with a five-day supply of necessary drugs and prescription refills to minimize missed doses until their first post-incarceration health care appointment

### **Discharge Planning for State Prison Inmates**

State Department of Correction (DOC) inmates from the greater Springfield area can be transferred to HCCC within six months of discharge. HCCC is the only facility in the state that has such a contract with the DOC. The discharge planning process for these inmates is overseen by staff at HCCC and enhanced by their new proximity to their home communities. Up to 300 state prison inmates come to HCCC each year to complete the final months of their sentences and comprehensive discharge planning is stressed for these inmates.

### **Post-Release Follow-up and Community Re-entry**

As part of an ongoing facility-wide program, HCCC provides After Incarceration Support Services (AISS) to former inmates. This comprehensive set of services provided to all discharged inmates, regardless of health status, provides another mechanism for follow-up and support for inmates. While the Health Services Department oversees health needs, the AISS program focuses on education, job training, employment, family support and reintegration. The discharge planning nurse and case manager are also available to assist with after-release transitional issues, particularly for complex medical needs.

Given that the medical providers at the community health centers are meshed with the community and often treat family members and neighbors, there are ample opportunities, within the boundaries of confidentiality, to inquire about health status, remind patients about follow-up appointments and to assess how former inmates are adjusting to release.



## V. SPECIFIC PROGRAM OPERATIONS

*This section of the manual provides technical details regarding specific program operations and initiatives. In-depth, step-by-step methods of service delivery and care protocols are highlighted. This section includes special emphasis on the methods used by HCCC to address specific inmate health care needs such as infectious and chronic diseases, substance abuse treatment, dental care and mental health. The operations and structures for pharmacy and laboratory services are also described. Where HCCC provides a formal curriculum of treatment, such as substance abuse, those services are described in detail. This section also highlights the in-house health services provided by outside vendors and how those services are delivered. A special section is devoted to describing the women's health services available at HCCC.*

### **Infectious Disease**

At HCCC, a comprehensive program of operations guides the response to infectious disease control. The program includes prompt detection, treatment, and education to prevent re-infection. Staff and personnel throughout the jail are regularly updated on scientific advancements in the treatment of infectious diseases. The jail also serves as a community resource for identifying emerging trends in infectious diseases and as a pilot site for new innovations. For example, the state public health department is evaluating the use of urine testing for chlamydia at HCCC. Nationally, recent outbreaks of tuberculosis and other infectious diseases within correctional facilities have been cause for concern.

At HCCC, the overall approach to managing and addressing inmate cases of infectious disease begins with the medical intake process. When an infectious disease case is identified, treatment protocols and surveillance reporting to the appropriate public health departments ensue. Common communicable diseases addressed include:

- Tuberculosis
- Scabies
- Pediculosis
- Influenza
- HIV/AIDS
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other Sexually Transmitted Diseases (STD's)
- Varicella
- Varicella Zoster

The following briefly outlines the treatment considerations and programmatic services for major infectious diseases available to inmates as part of the public health model at HCCC:

### ***Tuberculosis***

All inmates are tested for tuberculosis upon intake and those with a positive skin test receive a chest x-ray. If the chest x-ray is questionable or positive, patients are transferred to a hospital for further evaluation and treatment. Inmates with a documented positive skin test or who are diagnosed with active TB are treated according to established protocols.

## ***Influenza***

All staff and inmates are offered a flu vaccination. If an outbreak occurs, medications may be administered prophylactically.

## ***HIV/AIDS***

The HIV/AIDS services at the jail form a comprehensive system of detection, education, treatment and supportive care that addresses a range of inmate needs. HCCC has a full-time HIV/AIDS Coordinator who manages all aspects of the program. The HIV/AIDS Coordinator is part of a statewide network of jail and prison-based HIV programs supported by the public health department. This network seeks to provide a full spectrum of services to address the HIV epidemic among inmates throughout Massachusetts.

The range of services begins with HIV counseling and testing made available to all inmates upon admission and continues through discharge for inmates with HIV. HIV education and prevention are woven into a variety of educational interventions, including the initial orientation for inmates, the Inmate Handbook, medical intake processes, and annual events such as a community health fair where local agencies come to the jail to provide educational materials and information. HIV education is also fully integrated into the Substance Abuse Unit activities and staff training events for correctional officers and other jail staff. A peer-led educational program is also sustained on-site; inmates selected to participate are trained in HIV education methods and provide ongoing outreach to fellow inmates.

For HIV-infected inmates, a full range of clinical and support services are available. Full-time case managers who work both within the jail and at the community health centers develop an ongoing relationship with each client. This case management provides support, referral and linkage to community resources, and preparation for release into the community. Coupled with up-to-date medical treatment and ongoing monitoring of HIV disease progression, HIV-infected inmates receive a high level of care while incarcerated. Follow-up care is provided by the local community health center to which an inmate was assigned.

Extensive discharge planning is utilized for all HIV positive inmates. In partnership with community resources and in-house staff, the discharge planning process is designed to create a safety net of services for released inmates. Services include continued drug treatment, housing, health care, HIV support services and financial benefits available through state-funded programs at the local level, psychiatric services, food and nutrition support, and financial assistance such as Social Security and Medicaid.

HCCC has evidence that intensive discharge planning and comprehensive follow-up care for HIV positive inmates results in greater compliance with medical treatments and continued care.

This evidence is consistent with other research efforts demonstrating that HIV positive inmates can be successfully treated and supported in the community. Programs in Rhode Island and New York have shown that intensive case management and social support after release can facilitate community reintegration and reduce recidivism. The consequences of *not* providing intensive follow-up and supportive care are evident from a study in North Carolina which showed that

when inmates who had demonstrated undetectable HIV viral loads while incarcerated were released without comprehensive discharge planning and community linkage, they showed substantial rebounds in viral loads at re-arrest and re-incarceration.<sup>38</sup>

## ***Hepatitis***

As part of the public health model, hepatitis is also addressed in a comprehensive care spectrum of detection, education, prevention and treatment. Surveys have shown an overall infection rate of 21% for hepatitis C among the inmates at HCCC; among inmates in the 40-49 age range, the prevalence was 37%.

Hepatitis screening for inmates with known risk factors is recommended for several reasons: 1) to evaluate clients for chronic liver disease, 2) to provide possible treatment, 3) to vaccinate against hepatitis A and/or B as appropriate [65% of HCCC inmates with hepatitis C infection are eligible for immunization against hepatitis A], 4) to provide counseling on behaviors that can be harmful to the liver, and 5) to provide counseling on transmission prevention, whether infected or not.

The hepatitis program at HCCC includes:

- Education for all inmates from the time of admission
- Hepatitis B vaccination for all individuals 30 years of age or under and for all others with negative test results for HBV
- Encouraging counseling and testing for HIV, Hepatitis A, B, and C
- Continuation of treatment for inmates who enter the jail on medication

The HCCC experience has resulted in a number of conclusions including:

- There is a high prevalence of hepatitis C at HCCC and the majority of cases are undiagnosed. A recent study conducted at the jail revealed that 86% of the inmates diagnosed with hepatitis C were unaware of their infection
- Most detainees have risk factors warranting testing for hepatitis C; the counseling and testing model used for HIV can be expanded to include HCV; hepatitis A and B testing and vaccination at the same time is likely cost-effective
- Only a fraction of detainees infected with hepatitis C meet the consensus criteria for initiation of interferon-based treatment but most need education, counseling and vaccination for hepatitis A and B
- Most detainees should be vaccinated against hepatitis B; the vaccination prevalence in the younger population is increasing and serology and/or better vaccine information retrieval could improve cost-effectiveness in delivering vaccination to inmates
- Today, most patients with hepatitis C have not begun treatment with interferon-based regimens either in jail or in the community, but the program structure and continuity does provide an opportunity for this; future experience should define how many patients will begin and complete treatment

### ***Sexually Transmitted Diseases (STD's)***

Surveys conducted at HCCC indicate that a significant proportion of inmates are at risk for STD's and are admitted to the jail with an STD. Over half of the inmates of both genders reported inconsistent and no condom use during sexual activity. Almost half of the male inmates and more than one-third of female inmates report more than one sexual partner in the previous 12 months.

Upon admission, all inmates are screened for:

- STD history
- STD symptoms
- Chlamydia via urine test
- Gonorrhea
- Blood test for syphilis

STD treatment is provided in accordance with accepted protocols through the Health Services Department.

All female inmates are provided with a Pap smear and pelvic examination within the first two weeks after admission by a Nurse Practitioner with special training in gynecology. In addition to the screening, female inmates are tested for trichomoniasis and bacterial vaginosis.

For any inmate found infected with an STD, partner notification and counseling services are available from the state public health department through the Disease Information Specialist in the STD Bureau.

Health education and risk reduction to prevent future re-infection and transmission are provided to each inmate diagnosed with an STD. Health services staff, including the Infectious Disease Coordinator and nursing staff, follow all guidelines and regulations regarding the documentation and reporting of communicable disease cases to the state public health department.

### ***Chronic Illness***

Overall, approximately 20% of the inmates at HCCC have a chronic disease requiring ongoing treatment, monitoring and management. For many inmates, jail is their initial experience with a primary health care system, with previous reliance primarily upon emergency rooms and self-care. The diagnosis of their condition in jail requires psychological adjustment to stressful information while away from family and community support. Inmates must also learn the specifics about their disease management quickly. The thorough assessment process at HCCC helps to detect a wide range of chronic medical conditions. Diabetes, hypertension, asthma, HIV, cardiac problems, disabilities, and developmental delays are some of the most commonly diagnosed conditions. Lack of access to care, years of neglected health needs and co-morbidity of drug addiction, poor nutrition and poverty frequently result in inmates presenting with serious cases of chronic diseases, many with advanced complications. Initiating treatment to control illnesses, and educating inmates about ongoing care are critical to improving the inmate's health status.

Upon diagnosis and initiation of treatment, inmates with diabetes or cardiovascular disease have access to frequent health education sessions with the Nurse Educator. She conducts one-to-one educational sessions on disease management issues as well as group education. In tandem with clinical care and treatment monitoring, inmates are informed of treatment schedules, follow-up visits, disease complications, and self-care techniques. When necessary, special accommodations are made for inmates including rigidly scheduled mealtimes and designated exercise time for diabetics.

A study conducted at HCCC showed that 2% of male inmates and 3.4% of female inmates had been told by a health care provider that they had diabetes. Almost half of the diagnosed diabetic inmates first learned about their condition while in jail. In addition to the education and support offered to the newly diagnosed diabetic inmate, family members are invited to meet the Nurse Educator, who is also a Certified Diabetes Educator, to learn more about disease management and to assist with care. Experience at HCCC has shown that intensive diabetes management and education have reduced complications. Among discharged inmates, the frequency of hospitalizations for extreme low blood sugar reactions has declined compared to a decade ago.

Inmates with chronic conditions are well known to their assigned treatment team and plans for post-release continuity of care are developed soon after diagnosis. The primary nurse in each treatment team monitors the medical progress of each inmate with chronic illness. Ongoing care plans and medical treatment decisions are based on approved guidelines and protocols.

The inmate with chronic disease presents a tremendous opportunity for intervention to improve individual health and prevent expensive medical costs down the road. A released inmate with well-managed diabetes, hypertension or asthma is less likely to need more costly invasive care or to overuse the emergency room. The continuity of care provided at the health centers ensures timely access to ongoing disease monitoring, health education and support for adherence to treatment regimens.

## ***Mental Health***

### **Contracted Community Vendor**

At HCCC, the mental health services are provided by a contracted, non-profit vendor, Behavioral Health Network. This provider delivers on-site outpatient and inpatient services at the jail in cooperation with and under the auspices of the health services department. The mental health services staff includes psychiatrists, social workers, clinicians, administrators and program managers. Outpatient services are provided during business working hours and there is a small inpatient unit for 24-hour care.

### **Evaluation and Delivery of Care for Acute Mental Health Needs**

A significant part of the operations of the mental health services is devoted to evaluating the status of each inmate. The clinical staff is charged with determining which inmates are in need of intensive treatment and which are displaying adjustment issues related to their incarceration. The methods of delivering mental health care mirror those of other clinical care. The triage and sick call system previously outlined are utilized to provide mental health services in the inmates' housing units. Clinicians are assigned to housing towers and respond to inmate requests and staff

referrals for counseling sessions. Clinicians see the inmates in the environment in which the behavior is happening and where the stressors are more evident. Emergency mental health needs are met on-site within an hour while non-emergency services are provided under the described triage system.

### **Chronically Mentally Ill Inmates**

Chronically mentally ill inmates require a great deal of staff time from both the clinician and correctional officers. These inmates can be difficult to stabilize on medications and can present serious behavioral and safety problems to staff and themselves. They must be monitored consistently and continually to ensure compliance with medications and treatment, which allows them to be maintained effectively with fewer incidents. The chronically mentally ill population has serious problems with recidivism and re-arrest due to non-compliance with medication and treatment planning in the community.

### **Discharge Planning**

A discharge mental health planner is dedicated to providing services for inmates. The mental health discharge planner meets with the inmate several times in the three months prior to release to establish a discharge plan. Inmates are connected to the mental health provider in their community linked to one of the four contracted community health centers. Inmates leave the facility with five days worth of medications, a prescription for renewal of medications and an appointment to see the identified mental health provider in the community. The discharge planner facilitates the first post-release appointment to maintain continuity of care.

### **Regional Evaluation and Stabilization Unit (ESU)\***

One unique feature of the mental health services at HCCC has been the Evaluation and Stabilization Unit (ESU). This 13-bed inpatient program on the grounds of HCCC provides intensive, short-term psychiatric evaluation and treatment on a regional basis. Separate units within the program are designated for female and male inmates. Patients are referred from the three other county jails in the region (Berkshire, Franklin and Hampshire counties). All of these regional correctional facilities are within a 90-minute drive of HCCC.

Once admitted to the ESU, patients undergo a thorough evaluation to clarify the diagnosis and/or treatment of an acute mental disorder. Patients with long-standing chronic mental illness are not appropriate for this program. The criteria for admission include:

- Inmate is considered to be a danger to him/herself or others
- Inmate is functioning so poorly he/she can not take care of daily needs
- Inmate presents with unclear diagnosis and a period of observation is required
- Inmate is acutely psychotic or suffers from a serious affective disorder but is not imminently dangerous to him/herself or others

Mental health staffs at the neighboring jails refer potential ESU patients to the supervisor of the HCCC Mental Health Services to determine eligibility. Each county jail facility in the region has

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*\* Note: In 2002, the ESU closed due to state funding cuts. The services described here depict operations before its closure. Efforts are currently underway to advocate for restored funding and reopen the ESU.*

a designated mental health liaison to make referrals to HCCC mental health services staff. Patients from the referring facilities are admitted and undergo the standard admission and intake procedure. The referring jail is responsible for all transportation to and from HCCC. The typical stay is 14 days. Patients may stay beyond the 14 days with the approval of the Behavioral Health Network Executive Vice-President; these patients undergo review every three days. Patients in the ESU are classified under special medical management which determines their range of privileges and required activities.

While undergoing treatment at the ESU, the sending institution is responsible for any extraordinary costs which include outside medical treatment or any other medical or psychiatric care not usually associated with an ESU admission. A treatment plan is developed for each inmate in accordance with standard clinical practice at HCCC for all inmates.

If HCCC determines that it is unable to safely or effectively treat the inmate, or the inmate needs long-term psychiatric hospitalization, transfer to a state Department of Mental Health Psychiatric Unit or the state-funded Bridgewater State Hospital in southeastern Massachusetts is arranged. These transfer arrangements are discussed with and approved by the referring institution prior to enactment.

When an inmate is deemed ready for discharge from the ESU, HCCC mental health staff is in close communication with the referring facility to finalize arrangements. The referring facility receives a comprehensive Discharge Summary from HCCC. Mental health clinicians from both institutions have follow-up care consultations to determine the next steps in care for the inmate.

### ***Substance Abuse***

Due to the prevalence of alcohol and other drug addictions among the inmate population, substance abuse identification and treatment are high priorities within the public health model. Inmates are assessed for recent drug use and past history of addiction and treatment during the initial medical intake process. At HCCC, all substance abuse treatment decisions are guided by the philosophy that drug addiction is a treatable condition, that inmates benefit most when they participate fully in the program and that continuity of care upon release is critical to minimize the potential for relapse.

### **Acute Alcohol and Drug Withdrawal**

Inmates admitted to HCCC are assessed for acute alcohol and drug withdrawal during the initial intake process. HCCC health services maintain medical protocols for addressing alcohol and other sedative drug withdrawals as well as opiate/methadone withdrawal.

Based on an assessment of symptoms, amount of drugs used, time of last use, concurrent drug use, drug taking history, current vital signs and observations, health services staff determine the need for acute hospitalization or on-site detoxification treatment. Medication for on-site drug withdrawal management is administered only under the orders of a physician or nurse practitioner.

The criteria for hospitalization of a withdrawing inmate include:

- Delirium tremens

- Significant dehydration
- Fever over 101°F
- Documented seizure
- Head trauma with documented episode of unconsciousness
- Marked encephalopathy
- Previous difficult withdrawal with delirium tremens, psychosis or seizures
- Presence of major complications or associated disease: hepatic failure, respiratory failure, pneumonia, gastro-intestinal bleeding, pancreatitis, severe malnutrition, cardiac symptoms
- Significant agitation that does not respond to medication

### **Residential Substance Abuse Treatment Unit Programs**

At HCCC, a special on-site, residential unit is dedicated to providing substance abuse treatment in a number of program modalities. The unit has the capacity to house more than 150 sentenced male inmates at one time. For female inmates, the Substance Abuse Unit counseling staff delivers services to the women's unit at their separate housing location.

In the specialized residential treatment unit, the average length of stay is 60 days. Inmates with histories of substance abuse may be referred to this unit via a medical provider, mental health staff or self-referral. If an inmate participates in all phases of the program, he or she can receive substance abuse treatment for up to nine months.

The Substance Abuse Unit provides increasingly intensive psycho-educational treatment programs to meet the needs of inmates along a continuum of care. Multiple programs are available concurrently, so that inmates may progress through stages of programming while incarcerated.

#### *Beginner's Program*

The beginner's program provides introductory information and education on substance abuse. It is designed as preparation for more intensive programming and consists of 10 classes conducted by Unit counseling staff. This first step program is often valuable for inmates with shorter histories of drug use or those who may benefit from a refresher on basic drug education.

#### *"Boot Camp"*

A highly structured, 28-day "boot camp" program, based on Basic Life Skills training and drug/alcohol education is available within the Substance Abuse Unit. This program is recommended for younger inmates whose addiction has contributed to frequent arrest and subsequent incarceration. The program consists of daily physical exercise, drug education classes, individual and group counseling sessions. The highly structured day keeps inmates involved in numerous required sessions from 5 am to 10 pm over the 28-day cycle. Inmates in this program need to obtain medical clearance for participation; health services staff consults with substance abuse staff to ensure inmates are cleared for the program.

#### *28-day Intensive Program*

A 28-day intensive substance abuse educational treatment program is available primarily for inmates with long-term histories of drug use or those who have completed the beginner program.



It consists of educational classes, process classes, counseling, and health education. The typical day begins at 6 am and goes until 7 pm with multiple educational and supportive interventions. Health education classes focus on the health effects of drug use, the nature of addiction, anger management, the process of recovery from addiction and health risks associated with drug use including HIV, Hepatitis C and other medical conditions. Process classes are small groups of up to 10 inmates who attend group sessions three times per week to discuss what they are learning, their feelings about recovery and supports they need. Health services nursing staff conduct sick call in the Unit to assess the health status of inmates and treat medical illnesses that develop.

When inmates have successfully completed the 28-day program, they participate in a graduation ceremony and receive certificates of completion.

#### *After-Care Program*

Upon completion of the beginner program, boot camp and the 28-day intensive program, inmates are eligible for after-care support services to continue their recovery.

The aftercare program:

- Assists inmates with ongoing support in the residential Substance Abuse Unit
- Provides post-treatment interventions in the inmate housing units
- Prepares inmates for continuing recovery after release

For graduates of the 28-day program, 12 weeks of residential aftercare are available. Substance Abuse Unit staff assess who will benefit most from this support and refer inmates to the limited beds dedicated to this service. For inmates in the housing towers, 20 weeks of aftercare and transitional support are available. Substance Abuse Unit staff spends time in the “pods” to check inmate’s progress, provide support and begin the transitional process back to the community.

Substance Abuse Unit counselors also collaborate with in-house vocational programs by conducting educational sessions and support for inmates in recovery seeking job training skills. Counseling staff facilitates sessions on recovery and the work environment, job retention and maintaining recovery in the face of job pressures.

#### *Ongoing Support Groups for Recovery*

The Substance Abuse Unit coordinates the delivery of regular Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings in the jail. Meetings are provided four nights per week for female inmates and five nights per week for male inmates. Community representatives come on-site to oversee and facilitate the meetings. These meetings are utilized both by inmates who have undergone treatment while at HCCC and those who were attending community meetings prior to incarceration.

Finally, throughout the entire spectrum of substance abuse treatment services, staff from the Mental Health Unit is closely involved with the care of inmates who are dually diagnosed. The mental health staff assists with stabilizing inmates’ medications, providing consultation and evaluating progress in recovery. This internal collaboration enhances services and best meets the complex needs of inmates with addictions and mental illness.

## ***Oral Health***

Dental and oral health care are given high priority within the public health model at HCCC. Dental health assessment is incorporated into the initial evaluation and assessment process for each inmate upon admission. The inmate population is one for whom previous dental care is a rarity. Among the common dental complaints presented are periodontal disease, multiple non-restorable teeth, and difficulty eating due to multiple tooth loss. Adverse dental health has serious implications for overall health status. The dental care program is a priority-based system to meet the significant needs of inmates.

Because of the multiplicity of dental health problems presented by an inmate population, one goal of ongoing dental care is to reduce the need for expensive surgical and tooth replacement procedures. While at HCCC, the staff delivers oral health care designed to:

- Improve the oral health of inmates
- Reduce major complications
- Decrease the need for more costly, time-consuming procedures

### **Dental Care Program Operations**

The dental clinic at HCCC is staffed by a general dentist, one certified dental assistant and one registered dental hygienist. The dental clinic is located within the Health Services suite of offices and exam rooms to facilitate record-keeping, communication and referrals. HCCC contracts with Tufts Dental School for care and also serves as a training site for future dental professionals. Specialty services such as oral maxillary facial surgery, consultation and dental specialists are available on a regular basis.

A patient enters the priority-based system within 90 days of admission to the facility and upon evaluation by the dental team. Urgent and acute dental needs are detected by the same health personnel who conduct the initial medical intake, and are referred for dental care as soon as possible. Once the assessments are complete, patient treatments are prioritized and scheduled based on type of treatment needed, severity of condition, and length of incarceration. Upon completion of acute care, patients are placed into the routine recall system for ongoing care. The recall system allows for continued monitoring of all inmates' dental health status. Patients can be seen more immediately if oral conditions deteriorate or become more acute. Dental care emergencies are assessed for feasibility of treating on-site or for transport to the local hospital. No elective dental treatment is performed; necessary care decisions are based on severity of condition, pre-existing conditions, length of incarceration and type of treatment needed.

The system of prioritizing care is based on the following criteria:

#### **A. Symptomatic**

- Pain
- Swelling
- Infection
- Blunt trauma to oral structures
- Severely medically compromised



B. Asymptomatic

- Non-painful
- Periodontal recall
- Non-acute medically compromised

C. Inactive

- Refusal to submit to treatment
- Completed categories A and B

The dental staff also determines prosthetic cases that need attention based on:

- Fractured prosthesis affecting proper functioning
- When the health of the inmate would be adversely affected due to inability to masticate properly

In addition to lack of previous dental care, many inmates report fear and anxiety about dental care. At HCCC, the dental staff delivers care in a relaxed, comfortable environment designed to reduce fears. Patient education is a high priority. Staff provides information and hands-on training about routine care, proper oral management techniques and ways to reduce dental health risks such as tobacco use cessation. Many of the inmates have chronic medical conditions which can adversely affect oral health including diabetes, HIV infection, chronic tobacco and drug use. For most inmates, multiple dental health issues are common; it is rare to have a single dental complaint.

**Continuity of Care**

A major challenge for the public health care model and dental health care is the lack of affordable dental care in the community. In Massachusetts, there is an oral health care crisis at the community level with few dentists accepting Medicaid for care, fewer dental practices available for low-income patients and a severe lack of providers in rural areas. This lack of affordable dental care deters patients from seeking care in the community after release from jail and makes continuity of oral health care difficult. The availability of dental care is limited within local community health centers. Advocates and community leaders are working to fill this gap in services.

In order to provide a seamless continuum of care and reduce costs, HCCC is looking for ways to expand access to dental health care for inmates after release, and hopes to ultimately contract with local dentists to work dually within the jail and the community.

***Vision Care***

**History**

At HCCC, the history of providing vision care dates back to state-funded grants in the 1970's designed to reach underserved and institutionalized populations throughout the region. Based at Western Massachusetts Hospital, a state-sponsored health care facility, vision care and eyeglass services were originally available to HCCC inmates as part of the program.

### **Eye Health Care**

Currently, HCCC contracts with two local optometrists to deliver services to patients with medical conditions that require evaluation and treatment. The optometrists function as independent contractors and deliver care at the jail each week. The emphasis is on the detection and treatment of eye diseases, chronic conditions affecting eye health, and



managing eye injuries. Fewer of the services are for eyeglasses and traditional eye examinations. With the advancements in the profession of optometry, the majority of eye health care needs are met on site at HCCC. When a specialist or eye surgery is required, HCCC refers inmates to local providers contracted with the jail. The availability of in-house eye care services saves money and more fully integrates eye care into ongoing medical services.

The optometrist providing services at HCCC is also the Associate Director of the Eye Health Center at Brightwood Community Health Center, one of the three contracted centers. This provides additional continuity of care as inmates with ongoing eye health needs can see the same professional at a site in their community.

### **Eye Examinations and Eyeglasses**

Physicians or nurse practitioners make referrals for patients who need a full eye examination. Eyeglasses are made available for the inmates to purchase under certain circumstances.

Inmates who require glasses and who meet the following criteria will be allowed to purchase eyeglasses upon the order of the Optometrist:

- An inmate needs to be in the facility for at least three months in order for the optometrist to perform a proper examination, and for the purchase order process to be completed; inmates who will not be in the facility for three months receive referrals to community providers for post-release care
- Inmates are expected to pay for their eyeglasses according to a price schedule; inmates may use funds in their in-house account to cover this expense. Indigent inmates unable to pay for the costs of glasses will receive glasses only in those cases where the optometrist feels it is medically required; these inmates must be scheduled to remain at the facility for at least three months from the time of the examination

### ***Women's Health Care***

For incarcerated females, the rates of infectious and chronic disease are higher than male inmates, mental health issues are paramount and addictions are often used to mask the pain of severe trauma and sustained exposure to violence and abuse. Women require a wide array of services around reproductive health, pregnancy and childbearing. High quality pre-natal care for inmates has the potential to save money as high-risk pregnancies often result in infants requiring

costly intensive care. Mental health counseling, supportive therapeutic environments and on-site intensive substance abuse treatment are essential to provide female inmates with the range of quality care they need.

### **Reproductive Health**

At HCCC:

- A nurse practitioner with expertise in HIV and women's health evaluates all female inmates within two weeks of intake. The session includes: a medical history and physical, including gynecological examination. The approach incorporates education, empowerment and harm reduction in a manner designed to diminish the impact of prior trauma on each woman's self-care and interaction with the health care system
- A weekly sexually transmitted diseases (STD) screening session is conducted in the female inmates' residence or health services clinic by Nurse Practitioners
- All female inmates admitted to the facility receive a pelvic examination including a Pap smear, cultures for gonorrhea, chlamydia and other infections; the frequency of follow-up exams is determined by the Nurse Practitioner
- Inmates may request an appointment for an acute or chronic gynecological concern through the usual daily sick call process
- Specialty gynecological services are made available on-site and through linkages with local hospital care providers
- Pregnancy tests are conducted on all inmates at the time of admission; HIV counseling and testing is offered to all inmates
- Comprehensive counseling is offered to pregnant inmates in keeping with their expressed pregnancy outcome
- About 25 female inmates per year come to the jail pregnant; prenatal care is provided by staff from the Wesson Women's Clinic at Baystate Medical Center
- An inmate who begins her labor at the jail is transported to Baystate Medical Center for delivery and immediate post-partum care
- Post-partum follow-up care is provided at the Women's Clinic at Baystate Medical Center
- The jail does not provide birth control services due to the separation of male and female inmates at the facility

HCCC offers mammography to inmates who meet the following criteria:

- Unless clinically indicated, mammograms are not routinely conducted for inmates under the age of 40; a baseline mammogram for inmates between the ages of 35-40 may be ordered if a physician feels the patient may be at high risk for breast cancer
- Inmates age 40 and older receive a mammogram every two years unless clinical conditions require it more frequently
- Inmates age 50 and older receive an annual mammogram
- Mammograms are performed at Baystate Medical Center and are read by a board-certified radiologist

### **Women's Substance Abuse Treatment**

For female inmates, the confluence of drug addiction and mental health issues requires the development of health care programs tailored to their unique needs. At HCCC, the scope of programming is comprehensive, integrated, and multi-tiered. Programs contain affective, cognitive and behavioral elements. They provide information, teach skills, permit an application of new information to inmates' own personal lives and, for those who are ready, provide an opportunity for in-depth healing and treatment of trauma scars. Program elements are practical and concrete and are aimed at matching social skills with existing community resources. Group work encourages attention to dynamics that promote meaningful affiliation and connection.

HCCC has created a treatment program open to all female offenders. The program offers a mandatory 28-day women's addictions program followed by series of eight-session psycho-educational and treatment groups. These sessions are offered in a developmentally appropriate sequence. The program was designed to address the jail population with an average stay of about nine months. A major feature of the program is the need for women-only groups and classes. Research has concluded that women experience more growth in this format, share more feelings and issues about key relationships, explore identity issues more easily and receive more validation. Groups are run by staff who are trained and knowledgeable in women's' treatment issues.

At HCCC the environment is adapted to allow women to explore their vulnerable concerns in a safe, nurturing, relational and self-esteem-building climate. Although significant learning and healing takes place in structured program sessions, the milieu is a supportive environment that is responsive to women's emotional and behavioral needs. The milieu depends largely on the quality of interaction with staff, constant communication, and the quality of role definitions and boundaries. The interactions in the unit are designed to create maximum safety and meaningful connection among peers and staff.

### **HCCC Program Model: Women's V.O.I.C.E.S**

#### *Program Overview*

HCCC's program model is comprised of four progressive phases. At the end of each phase, inmates complete a personal growth plan. This plan permits inmates to clarify their needs with increasing specificity.

#### Phase I - Exploration/Discovery

The first phase begins with a series of initial explorations of the program, of one's own current

needs and circumstances, and of general women's issues. Women begin to identify and prioritize their own problem areas and strengths. This phase provides skill development in problem-solving. Specific topic areas include:

- “My Journey Begins Here” 28-day addictions program (part-time)
- Overview of Women's V.O.I.C.E.S. core curriculum
- Who am I?
- Introduction to Family Services
- HIV/AIDS Education
- Creating Safety
- Staying out of Jail: Effective Choices

### Phase II - Information and More

This phase introduces a more detailed approach to the various topics. The Intensive 28-day program applies factual information about the addictions process and its consequences to the inmates' personal lives. More intense group interactions encourage women to “tell their stories” within a supportive psycho-educational setting. Other groups offer information and education about skills or topics related to women such as domestic violence and parenting. Specific topics include:

- 28-day addiction program (full-time)
- Anger Basics Group
- Women's Health Issues
- Independent Living Skills for Women
- Love and Violence I Group
- Mother-child Connection Group
- Problem-solving Skills: New Options

### Phase III - Treatment/healing

This phase engages participants who are screened, motivated and appropriate for in-depth healing. Participants are divided into closed-membership treatment groups led by staff. Participants learn to identify earlier hurts and recognize how they can resurface in adult behavior and emotional expression in a distorted manner. Specific topics include:

- Relapse Prevention
- Love and Violence II
- Channeling Your Anger (for women with violent crimes only)
- PlayCare project
- Breaking the Silence- Trauma Survivors group
- Relationships Group

### Phase IV- Community Integration

In this final phase, inmates are provided with specific information and skills about accessing community services in accordance with their formalized action plan for return to the community. Specific groups for release planning and coping with fear and transition are elements of this phase.

### *Program Staffing*

All of the staff in the women's unit are Sheriff's department staff. The Unit Director and Unit Manager have advanced social work degrees. Counseling staff is trained in social work, therapy and case management. Graduate students in social work from nearby Springfield College serve as interns. All staff receives weekly clinical supervision from licensed social workers.

### *Evaluation*

HCCC uses pre-tests and post-tests to assess progress in mastery of program content. Client satisfaction surveys are administered upon group completion. Instruments to measure empowerment using the plans created by inmates are currently in development. Future outcome measures will examine participants' abilities to make effective choices and avoid repeat offenses. Women need to be empowered to engage in ongoing addictions treatment, make improved choices about partners, select new positive social supports and be able to create a stable home and financial base for themselves and their children. All of these issues are potential subjects for additional research and program evaluation at HCCC and other correctional facilities.

## ***Pharmacy and Laboratory Services***

### **Pharmacy**

HCCC has an in-house pharmacy that has allowed for local control and decision-making on pharmacy issues. In 2002, HCCC entered into a new contract with the statewide Commonwealth of Massachusetts Office of Pharmacy Services (OPS). This resource provides comprehensive pharmacy support to public sector healthcare organizations and has been providing pharmacy services to 22 Department of Correction facilities since 1998. As part of this new contract, OPS will provide non-emergency and non-narcotic medications and pharmacy support. Some aspects of the pharmacy will remain local while others will be off-site.





### *Pharmacy Operations and Costs*

As is the case with most health care organizations, pharmacy operations and costs are significant concerns for HCCC; costs continue to increase dramatically throughout the country. Financial savings are a key consideration, but maintaining high quality care comparable to the community standard with few restrictions and security are also priorities. HCCC dispenses more than 100,000 medications annually.

With its new contract, HCCC can take advantage of cost-savings while maintaining high quality care. The OPS offers state-of-the-art pharmacy delivery; current clinical practices; assures full regulatory compliance; implements and maintains the latest pharmacy software; and provides support for all aspects of budgeting, purchasing and forecasting. They assist with monitoring costs and adverse drug reactions, updating drug treatment guidelines, and evaluating medication usage. As part of a larger statewide system, HCCC can compare its medication and pharmacy management with other facilities including correctional sites and other state-supported institutions. HCCC will continue to use an in-house pharmacy under this new contract and anticipates streamlined administration and improved data collection.

### *Pharmacy Formulary and Storage Procedures*

HCCC uses a formulary that is reviewed and approved by the Director of Health Services and the Pharmacy and Therapeutics Committee, a standing committee of the overall departmental quality assurance program. The Committee includes the Health Services Director, Director of Nursing, Director of Pharmacy, all physician staff and all nurse practitioner staff. The main function of the group is to update the formulary and provide educational materials to the staff.

The formulary includes the names and strengths of all medications, including over-the counter medications, stocked in the facility. The formulary is reviewed, updated and distributed to staff annually or as the need arises. Copies are made available in the nurses' station and the Pharmacy. Medications available in generic form are used unless the physician orders no substitution. The Director of Health Services or his designee must approve prescriptions for any non-formulary medications.

In order to maximize safety and efficiency, the Health Services Department ensures that there is proper management of pharmaceuticals at all times. The Director of Pharmacy is accountable for the receipt, storage, dispensation, administration and distribution of medications by properly trained staff according to physician's orders and in a timely manner. Controlled substances are dispensed according to state and federal laws and regulations. Psychotropic medications are prescribed only when clinically indicated as one facet of a therapeutic program.

The Pharmacist provides maximum security storage of controlled substances with all security and storage of syringes and needles provided by the Central Supply Nurse. All inventories are conducted on a continuing basis. When the pharmacy is not open, an Emergency Medication Cart is available to qualified health services staff. The cart contains emergency over-the-counter drugs, up to 10 3cc syringes and prescription medications. When the cart is accessed, all supplies used are properly signed out and inventoried. The Central Supply Nurse conducts a weekly inventory of all medication and syringes contained in the Emergency Medication Cart. Nursing staff conducts shift counts of all narcotic medications and syringes.

*Resources Needed*

In 2000, the pharmacy installed an automated computer (CIPS) system for tracking all pharmacy activities. This was part of an overall effort to update and computerize medical records for inmates. The Health Services Department maintains a full-time information technology specialist to address the needs across the department.

**Laboratory**

HCCC contracts with Baystate Reference Laboratory (BRL), a division of Baystate Medical Center in Springfield, Massachusetts and with specialty labs for specific tests for its laboratory services.

The contract with BRL provides HCCC with:

- Cost-efficient laboratory work 24 hours per day, seven days a week
- Daily courier service for the transportation of specimens from HCCC to BRL
- A dedicated computer result printer and terminal for exclusive use of lab results
- Supplies and lockbox needed for specimen collection, preservation and transportation from HCCC to BRL
- Reporting of STAT test results within one hour after receipt of specimen
- Results of tests reported by phone, fax or dedicated computer printer; written test results are delivered to HCCC on the day after the test was completed
- Custom requisitions as required by HCCC
- Lab work in accordance with a fee schedule set by BRL



As part of the contractual agreement, HCCC staff conducts phlebotomy and provides BRL with patient demographic and identification information. Lab work and BRL facilities comply with all required federal, state and local regulations and licensure requirements.

BRL bills HCCC for all of the laboratory work as a group account based on an established fee schedule. Tests that are not included in the fee schedule are billed at a 50% discount rate from the BRL price list.

## **VI. ADMINISTRATIVE ISSUES**

### ***Accreditation***

The public health model of care at HCCC is fully accredited by the National Commission on Correctional Health Care (NCCHC). The NCCHC 's mission is to improve the quality of health care provided in jails, prisons, and juvenile confinement facilities. NCCHC develops and maintains nationally recognized standards for correctional health care used to accredit jails, prisons, and juvenile confinement facilities, and to assist public and private agencies in monitoring the quality of medical services provided in these settings.

The accreditation process provides a clear framework for ongoing operations and an administrative structure that supports the public health model. For any correctional facility considering replication of the HCCC model, the NCCHC standards and guidelines provide an important foundation. Planning for and implementing the public health model of care automatically helps the host institution to meet the accreditation standards. The NCCHC standards serve to inform the planning of services, the development and implementation of protocols, the structure and function of health care delivery systems and program documentation procedures.

*For more information about NCCHC, see section VIII, part 4.*

### ***Utilization Review***

In order to comply with State requirements, HCCC has developed a Utilization Review program. The goal of the utilization review process is to prevent unnecessary medical care in the jail environment. It concentrates on preserving the inmate's current health status, stabilizing and treating emergencies until more extensive medical backup arrives, if necessary, and improving inmate's self-care. HCCC also ensures that the facility remains free of infectious disease through a comprehensive screening process.

Utilization review looks at the current patient problem, physician assessment, reason for referral, length of time the inmate has had the problem and whether or not the problem can wait until he or she is released back into the community. *All necessary care is given.* Elective procedures are not performed during incarceration.

In deciding about care, there are many individual factors for consideration. Security issues and length of incarceration play major roles. Staff must evaluate an inmate's care with the following in mind:

- Whether the inmate is pre-trial or sentenced; if sentenced, for how long? If an inmate is pre-trial, when is the court date, expected length of time before trial, etc?
- Can the treatment wait until after release without putting the inmate at risk?
- Can we ensure follow-up with good release planning?
- If longer rehabilitation is needed, what are the implications for security to protect the inmate, staff and other inmates while treatment is provided?

A registered nurse serves as the full-time Utilization Review Nurse. It is her responsibility to be aware of all procedures ordered by medical providers. If a procedure seems unnecessary or can safely wait until a later time, it is delayed until it is reviewed by the Utilization Review Committee, which meets monthly. If an immediate decision is required, the Utilization Review Nurse brings the situation to the attention of the Medical Director and the Director of Nursing. The Utilization Review Committee is comprised of Physicians, Nurse Practitioners, and Nursing staff. The Utilization Review Nurse chairs the committee and attends weekly jail classification meetings to provide important input into their proceedings. He or she consults regularly with the Director of Classification and the Superintendent about medical cases requiring unusual security measures or to determine if an illness cannot be properly cared for in a jail environment. In addition, the Utilization Review Nurse is responsible for the discharge planning for patients with a chronic or severe illness or who have unusual medical needs post-discharge.

### ***Quality Assurance***

At HCCC, the goal of the Quality Assurance program is to ensure a system of care that is ethical, responsible and accountable. It achieves and maintains established standards of health care as required by accrediting organizations with which HCCC has a relationship. The program consists of a Quality Health Council (QHC) that oversees standards of care, problem identification, problem resolution, ongoing quality improvement, and overall program monitoring. The Quality Health Council provides a systematic approach to identify and resolve problems that impair the delivery of quality health care.

Members of the QHC include the Health Authority, Responsible Physician, Director of Nursing, Director of Forensics, Nurse Supervisor, Director of Pharmacy and Clerical Supervisor. Additional work teams are assigned to address specific problems identified by the Council. The full Council meets at least quarterly, while teams meet as needed to resolve the identified problem and continue monitoring until an acceptable level of correction has been maintained for one year.

### **First Step: Problem Identification**

A major function of the Quality Health Council is to identify health care delivery issues that require further evaluation. Priority is given to services that are high volume, high-risk, problem-prone or essential. The following outlines the priority services issues for the Council:

#### *High-volume Services*

For all of the following, the Quality Health Council is concerned about timeliness, completeness, accuracy and appropriateness:

- Receiving screenings
- Initial health assessments
- Dental health assessments
- Mental health assessments
- Initial and annual tuberculosis tests
- Periodic health assessments
- Inmate health education programs
- Direct orders

#### *High-Risk Services*

The following are regularly reviewed by the Council:

- Invasive procedures
- Emergency department visits
- Detoxification procedures
- “Keep on Person” medication programs
- Access to care and consultation referrals
- Consent form signatures
- Refusal form signatures
- Diagnostic and laboratory tests
- Nursing treatment protocols
- Nursing triage of sick call requests
- Local hospital admissions and discharges

### *Problem-Prone Services*

The following situations undergo in-depth review by the Council for indicators of significant quality assurance issues:

- Deaths, including suicides
- Injuries
- Inmate grievances
- Health-related incident reports
- Chronic Care: seizure disorders, diabetes, chronic obstructive pulmonary diseases, tuberculosis, HIV/AIDS, coronary heart disease

### *Data Sources*

To conduct its work, the QHC has access to numerous data tools including: medical records, inmates’ grievances, staff suggestions, surveys, observations, monthly statistics, and disaster drill summaries. Reports of incidents, accidents, environmental monitoring, infection control and inmate deaths are readily available to the Council. In addition, each member of the medical staff reviews at least five inmate charts a week for appropriateness of care.

### **Second Step: Problem Resolution**

Once the QHC and its working teams have selected an area for review, indicators are developed to collect data, develop goals and monitor the improvement process. The indicators are objective, measurable, define a single element to be evaluated, contain a time and frequency designation, relate closely to the specific aspect of care, and include a percentage compliance goal. Corrective action steps are developed and the corrective action continues until goals are met. The Quality Health Council approves all projects submitted by the teams prior to implementation of any corrective action.

### **Third Step: Monitoring**

Once the corrective action plan has been initiated, the program is continually monitored to obtain feedback on the change process. Compliance thresholds established by the Council include 100% for procedures which the Council determines to be critical to high quality health care and 0% for preventable events. When full compliance has been achieved and maintained for a specified time, the problem is considered resolved by the Council.

***Staffing: Recruitment, Training, Retention, and Capacity***

Staffing for the health services department includes the entire range of health professionals needed to deliver a comprehensive spectrum of care. Contracting with outside providers and vendors allows HCCC to realize cost-savings while delivering high quality care, since it reduces the need for full-time health services staff. Most provider positions are supported by contracts with outside vendors including physicians, dental care providers, mental health staff, laboratory personnel, and pharmacy services.

The staffing pattern and plan is revised as needed based on a census of inmates and resources. All clinical staff, nurses, physicians and mental health staff are licensed and credentialed based on state law, facility policy and program standards.

Initial employee orientation and continuing education are provided for all staff. Newly hired health services staff is required to attend an orientation within 90 days of hire; this orientation is staffed and delivered by the Nurse Educator. All applicable policies and procedures are reviewed and outlined for new staff members. Forty hours of annual in-service training and continuing education are required for all staff.

All health services staff positions have job descriptions that are reviewed annually. (See attached samples and organizational chart.)

As with most health care facilities faced with finite resources, it is a challenge to maintain optimal staffing levels to address the intense level of needs among jail inmates. This may be particularly true in the mental health arena, where recruitment of clinicians to work with incarcerated populations is difficult. The same factors leading to a nursing shortage in the region and around the country affects nursing recruitment at HCCC. Health care delivery in a correctional facility is a unique specialty for nurses, physicians and other clinicians. Recruitment of qualified staff with an interest and commitment to this population can be a formidable obstacle.

In addition, the goal of assembling a linguistically and culturally competent staff is a challenge for all non-profit health organizations. In western Massachusetts, there is a shortage of nursing and mental health clinicians who are bilingual in English and Spanish; competition among local employers for such candidates is fierce.

Contracts with local community health centers provide a significant number of culturally and linguistically representative personnel to HCCC. Individuals from the African-American and Latino communities staff the health centers serving the surrounding areas. Their ability to communicate more effectively with inmates enhances trust, communication, and the overall patient-provider relationship.

Despite the barriers of nursing shortages and competition for culturally competent staff, the public health model of care may actually *reduce* staff turnover at HCCC. Medical staff is able to continue caring for patients after they are released and the model provides for intensive education and support under community standards of care. For many practicing clinicians,

especially nursing professionals, this type of care is precisely what attracted them to the field. Many of the clinical staff at HCCC have been employed for more than five years and have developed relationships with inmates and their families. The close coordination of services through a team approach and the delivery of care to an overwhelmingly high-risk population often results in significant health improvement. This is rewarding to the health care providers, the patients and their families. Clinical care of an inmate population requires intense and well-developed assessment and clinical judgment skills. Many professionals find it a very stimulating and challenging environment in which to practice medicine.

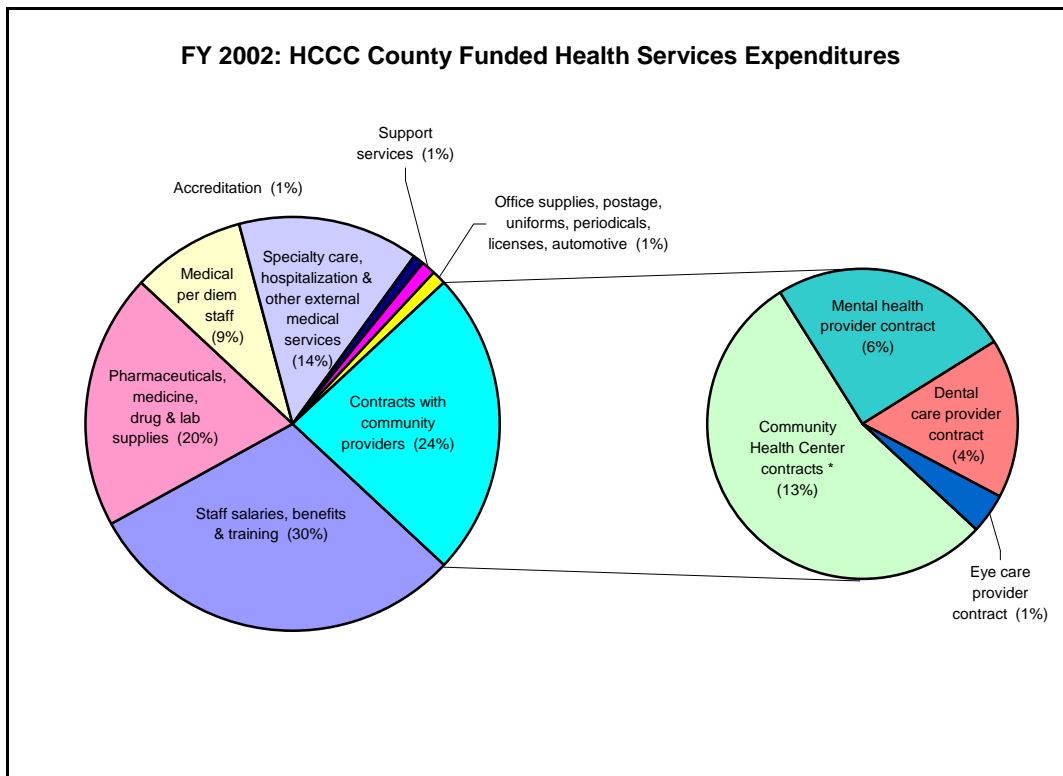
**Budget and Cost-Effectiveness**

**Overall Operating Budget**

The fiscal year 2002 annual budget for the HCCC Health Services Department was approximately \$6.8 million. Outside grants made up about \$440,000 of this amount. HCCC realizes significant cost savings by contracting out many services to local non-profit community providers, resulting in health services costs that are very similar to national averages.

*County-Funded Health Services Expenditures*

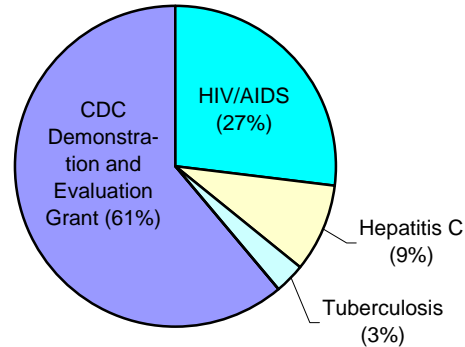
In FY 2002, approximately \$6.4 million of HCCC’s county-funded operating costs were spent on health services.



*Grant-Funded Health Services Expenditures*

In FY 2002, HCCC received approximately \$440,000 from external grants. The Centers for Disease Control and Prevention provided one-time funding for a “Public Health Model Demonstration and Evaluation Project” and the Massachusetts Department of Public Health funded HIV/AIDS, hepatitis C, and tuberculosis projects.

### FY 2002: External Grants



#### Comparison with Other Jail Facilities

The 2001 edition of *Correctional Health Care*, published by the US Department of Justice, reported data on 1998 health care costs from a national survey of the 30 largest jails. Seventeen of the 30 jails responded and survey results showed great variability in a number of measures.

##### *Annual Health Care Costs per Inmate*

The 1998 data from the 2001 USDOJ study found a range of health care costs per inmate per year, from a low of \$1,097 in Hamilton County, Ohio to a high of \$6,821 in Washington DC. The median cost per inmate per year was \$2,660. **HCCC 1998 data shows an annual health care cost per inmate of \$2,639.**

##### *Total Health Care Costs*

The total expenditure for health care in the 17 reporting jurisdictions ranged from a low of \$2.1 million in Hamilton County, OH to a high of \$52.3 million in Los Angeles, CA, with a median total health care expenditure of \$13.2 million. **At HCCC, total health care costs for 1998 were almost \$4.3 million.**

##### *Percent of Total Jail Budget Spent on Health Care*

On average, these county jails spent 15% of their total budget on health care. These figures range from a low of 7.8% in Hamilton County, OH to a high of 34.6% in Wayne County, Michigan. **In 1998, HCCC spent 9.6% of the overall jail budget on health care.**

For data comparison purposes, it is important to note that not all 17 of the 30 jails reporting included all service costs. For example, some counties did not include mental health costs and specialty care costs were not consistently included. However, the 1998 figures reported for HCCC include costs for mental health services, all hospitalizations, all pharmaceuticals, equipment/supplies and all other operating costs.



When compared to the 17 jails studied by the US Department of Justice, HCCC would rank third lowest in total health care expenditures, third lowest in the percent of its overall budget devoted to health care costs and ninth lowest in annual health care cost per inmate. *These comparative figures demonstrate that the public health model of correctional care need not be a high cost venture and can be established at a reasonable amount.*

### **Sources of Funding for the Public Health Model**

Funding to support many of the specialized initiatives at the jail are obtained from grants and contracts with the state public health department, private foundations and national organizations such as the federal Centers for Disease Control and Prevention. These linkages have resulted in substantial dollars for 1) HIV care, medication reimbursement, and education; 2) hepatitis C screening and case management; and 3) STD and TB detection and care. In fiscal year 2001, more than \$700,000 was obtained through grant funding. Additional dollars and support are obtained from pharmaceutical companies for health education materials, glucometers, medication timers and reminder systems for inmates after release. Research studies to evaluate the effectiveness of the overall public health model and specific program interventions has also been supported by private and public grants.

### *Strategies to Pursue Sources of Financial Support*

HCCC has sought financial support for their public health model of correctional health care from numerous sources. For any correctional facility exploring ways to adopt the model, it is recommended to investigate potential funding from all of the following sources:

- State Department of Public Health for services related to: HIV/AIDS, hepatitis C, substance abuse treatment, sexually transmitted diseases, tuberculosis, and other infectious diseases
- State Department of Mental Health
- State Department of Education
- Federal Centers for Disease Control and Prevention (CDC)
- Private foundations, particularly for HIV/AIDS, substance abuse, women's health, program evaluation, public safety initiatives, and initiatives to reduce health disparities
- Pharmaceutical companies
- County and local health departments
- Linkage with local university schools of public health, medicine, dentistry, and social work for ongoing research and evaluation

### *Innovative Ways to Obtain Funding:*

#### **Staff Support**

HCCC has dedicated significant resources to seeking and securing outside grant funding to support their public health model of care. A full-time Sheriff's Department staff position which manages community outreach and advocacy activities is used to research information about funding sources, write grant applications and assist with grant oversight. At HCCC, the fiscal department provides support for monitoring grant expenditures and budgeting. The intensity of the support needed varies with the requirements of each grant.

### In-house 501c3 Non-profit Entity

HCCC has established an in-house non-profit entity that serves as the fiscal conduit for grant funding. Based on the number of persons served annually, HCCC is the largest human service provider in the county. The establishment of a tax-exempt, non-profit organization within the Sheriff's Department administrative structure creates eligibility for grants from public and private foundations. This innovative strategy maintains clear boundaries from state government but opens up avenues of support that otherwise may not be available to HCCC.

### Importance of grant-writing and community collaborations

At HCCC, grant applications are frequently developed in collaboration with community partners. Since numerous non-profits are eligible for grants, collaboration reduces duplication and increases the likelihood of procurement of funding. For many public and private funders, community collaboration is a key component in successful grant applications. The local community health centers with whom HCCC works closely are often eligible for these same public and private dollars.

### ***Electronic Medical Records***

HCCC uses multiple computerized systems during the course of treatment for offenders. On-site medical staff uses an electronic medical record (EMR) system to enter, track, and review an offender's medical data – such as medical history, problems, diagnoses, medications, counseling, dental care, and vision care. Data analysis is performed to show outcomes within the facility as well as the local community.

HCCC uses an automated pharmacy system. Providers enter medication orders into the EMR and the information is electronically sent to the pharmacy software system. The pharmacy software verifies the medication order. Drug interactions and duplicate therapy warnings are reported back to the provider through the EMR. This reduces the duplication of data entry and the potential for data entry errors.

The physicians at HCCC are affiliated with local area hospitals. While at HCCC, a physician can connect to their outside hospital records system using an ISDN line and review any medical treatment an offender may have received prior to or during their incarceration.

Newly hired staff undergoes extensive onsite training on how to use the electronic medical record system, performed by a health service supervisor. Resources, such as user guides and internal help desk support, are available for additional support.

The on-site Information Systems and Technology department provides the primary line of support for all systems. Critical problems may be elevated to customer support staff at the various product vendors.

### ***Transportation***

The location of the Hampden County Correctional Center in western Massachusetts provides for nearby access to community services when necessary. The four contracted community health centers are within a 30-minute drive of the jail. The major hospitals utilized for emergency care and other needs such as surgery are equally accessible in the region. Transportation of inmates

for health care at local and regional agencies is provided by the in-house Sheriff's Department vehicles and correctional staff. Transport of inmates is coordinated between the health care service staff and the transport staff. Strict procedures and guidelines are followed to ensure inmate medical confidentiality while maintaining a safe and reasonable transport for the inmate and staff. In fiscal year 2000, the health services department arranged for nearly 1,000 transport trips for inmates.

### ***Challenges in Adopting the Public Health Model***

There are numerous challenges faced by institutions and communities in adopting the public health model of correctional care.

Some general concerns include:

#### **Different priorities between public health and corrections:**

In the United States, inmates are the only designated population group for whom health care is a legally mandated right. For most correctional facilities, the provision of health care to inmates is a major ongoing function. However, the **provision of health care is not the primary function** of the correctional system and may differ greatly in its degree of priority within each institution. It is important to acknowledge the primary functions of the existing correctional institutions including jails, prisons and youth detention facilities. Correctional institutions exist for the purpose of ensuring public safety, incarceration of individuals deemed dangerous to society and carrying out sentences for conviction of criminal conduct. Public health exists for the purposes of education, disease control, health promotion and improving the well being of individuals and communities. These purposes may be at odds with each other in any given community.

#### **State vs. county system structures:**

Although definitions may vary from state to state, in general, jails and houses of correction exist for the detainment of individuals charged with a crime prior to sentencing and to house those persons generally sentenced to shorter terms; prisons generally house inmates with longer sentences. At year-end 2000, the combined facilities of local and county jails, state prisons, federal prisons and other correctional facilities in the US managed more than 2 million inmates.

The differences between the types and functions of correctional facilities have implications for the delivery of health care to inmates. Variations in length of sentences, demographics of the inmate population and geographic distance from inmates' home communities must all be taken into account when planning and implementing health care services. In Massachusetts, while most inmates in county jails come from the surrounding communities, this is not the case for state facilities. For public health and health care professionals, understanding the needs and operations of each type of facility is crucial to informed, effective, and sustained collaboration.

#### **Stigma & politics:**

The incarcerated population is greatly stigmatized and often deemed undeserving of high quality health care. Especially during difficult fiscal times, this stigma and the political ramifications of negative public sentiment can create significant internal and external challenges to the delivery of comprehensive health care to inmates.

**Specific challenges:**

All of the following are frequently cited as specific potential barriers to establishing the public health model in correctional systems:

- Negative public attitudes about crime and corrections; resentment over whether inmates deserve health care; providing health care and other social services to inmates that are not consistently available to the general public in the community can be perceived as special privileges, another means to “coddle criminals”
- Limited dollars to support health care in jails; concerns about the costs and sources of funding to provide comprehensive health care to inmates, especially for tax-payer supported institutions
- Administrative and security staff concerns about facility safety, transporting inmates for care, and on-site storage and management of medications and medical devices
- Adversarial system intrinsic to corrections
- “Closed-system” thinking on the part of correctional administrators that jails and prisons function better when they are “out of sight and out of mind”
- Public policy-makers and legislators’ fear of appearing “soft on crime”; reluctance to support funds or regulations dedicated to inmate health care
- Public health and health care communities’ lack of familiarity with the criminal justice system and the severity of health needs “behind the walls”
- Public health and medical provider attitudes that assume “we know best what is needed” from a medical perspective, with limited understanding of the priorities and culture of jails and prisons
- Elected officials response to their voting constituents’ demand to “get tough on crime” resulting in overcrowded facilities with fewer resources for health care
- Expansion of health care services perceived as exacerbating the staffing, especially nursing, shortage; high correctional health care staff turnover; difficulties in recruitment and retention of health care staff in correctional facilities
- Challenges in bringing mental health care and substance abuse treatment together with primary care; limited community mental health care and substance abuse treatment services for post-incarceration collaboration
- Lack of inmate advocacy for improved access to health care and continuity of services
- Lack of community and institutional advocacy for correctional health care services

- Lack of a rehabilitative approach to corrections
- Alienation of the inmate who does not trust “the system” and its providers.

### **Overcoming Challenges to Implementing the Public Health Model**

There is growing interest in the fields of corrections and public health for the replication of the public health model. We believe that the program is adaptable to many settings and types of facilities. While the model is designed for a county correctional facility, the core elements of the program can be implemented in any adult or juvenile facility with the collaboration of correctional administrators, community-based medical and social service providers, and public health agencies.

The following have been essential in overcoming challenges to implementation of the public health model of care at HCCC:

- Secure strong support and commitment from leaders at the correctional facility and influential community health care providers; at HCCC, Sheriff Michael Ashe, Jr. and his vision of providing comprehensive health care to inmates was a key stimulant to the development of the program; this vision of health care as part of an overall inmate rehabilitation and community re-entry philosophy was crucial to the establishment of the public health model; at Brightwood Health Center, Director Dr. Jeff Scavron and his health care staff were already working with jails and were strongly supportive of community collaboration to provide the highest quality health care to inmates during and after incarceration
- Identify support from the health care provider and public health communities
- Identify a correctional center willing to accept ongoing collaboration with outside providers and an inclusive style of care delivery
- Educate public policy-makers and local leaders about the demonstrable benefits and positive outcomes of the model, such as improved public health and safety
- Identify community-based human service agencies and health care providers willing to dually deliver care on-site at the jail and after inmate release; HCCC works with local community health centers and numerous other social service providers including AIDS service organizations, substance abuse treatment centers, mental health care providers, and social services such as housing, vocational training, faith-based organizations, etc. Many of these providers initiate the relationship with an inmate while he/she is incarcerated and continue service delivery after release
- Explore creative use of funding and solicit funding from local, state and national sources including departments of public health, education, and mental health; apply for research grants; solicit correctional, criminal justice agencies and private foundation grant sources; utilization of an in-house grant writer to seek out grant sources and develop proposals for submission

- Develop memoranda of agreement and/or contracts for the delivery of free or low-cost services with local agencies and social service providers; for example, AIDS service organizations funded to provide HIV prevention services to at-risk populations see the jail as an appropriate venue for their services; recovery organization such as Alcoholics Anonymous (AA) use community volunteers to lead meetings at the jail
- Establish a willingness on the part of both correctional and public health personnel to accept a new paradigm of correctional health care and the need for integration of services with community health care and social services; willingness to learn each other's "language", professional perspectives and current developments in their respective fields
- Participate in on-site visits to correctional facilities using the public health model to experience "hands-on" learning about the planning, implementation, evaluation and adaptations of the model or elements of the model
- Review national correctional health care accreditation standards and guidelines to assess applicable elements of the public health model currently implemented as part of accreditation; for many facilities, adoption of the public health model would be a matter of expanding services and linkages, not re-inventing the entire health services program
- Establish and sustain extensive communication between in-house departments and stakeholders during the program planning, development and implementation phases; ongoing cross-departmental communication between health services and correctional security staff; clear definition and understanding of the roles related to health care delivery; commitment to a team approach in health care services with the active participation and input from jail security staff, mental health providers and community agencies; extensive planning for community re-integration through collaboration with local social service and health care systems

## **VII. FUTURE DIRECTIONS IN CORRECTIONAL HEALTH CARE**

Although medical services in correctional facilities and outside institutions may resist new paradigms, it is imperative that the field of correctional health expands its scope to embrace a public health agenda. For correctional health care to take its rightful place in the nexus of medicine, public health, and corrections, the following ideas are offered for serious consideration and debate:

### ***Enhance Public Health and Corrections Collaborations***

Correctional health care programs are, in fact, an extension of local public health systems. Jails and prisons represent one of the largest target populations for public health services in America. Individuals admitted to correctional facilities are sicker than the general population and require a more intensive level of health services, from illness assessment to health education to appropriate treatment and follow-up. Thus, the corrections and public health communities must form stronger ties. By jointly committing resources, public health and corrections can significantly improve communicable disease surveillance, prevention and management.

With all that correctional health and public health share in common, integrating services and developing collaborations should be major goals. Working in tandem, corrections and public health have the opportunity to address major public health challenges faced today. A community-focused and community-based model of correctional health care provides the system by which public health and corrections can be strategically linked and fully integrated. Ideally, a public health model of correctional health care would exist in all correctional facilities.

### ***Address the Needs of Special Populations***

Too often correctional health systems are designed for the white, male, English-speaking population, regardless of the variations in the populations that may be served by the facility. In order to be effective, programs, materials, and interventions must be gender specific and culturally appropriate. While contracting with community health centers to provide health care for the inmates who come from these communities helps to reach this goal, additional efforts to attain culturally competent and gender appropriate information, staffing, and programming at correctional facilities must be continually assessed and enhanced.

### ***Increase Focus on Chronic Health Conditions***

Correctional health efforts often focus primarily on infectious diseases. While it is crucial that communicable diseases be addressed in the inmate population, chronic health conditions such as asthma, diabetes, and heart disease must also be included in correctional health efforts. Chronic illnesses affect a significant portion of the correctional population and account for a large share of health care expenses. Individuals admitted to correctional facilities today have a high rate of chronic mental and physical conditions, which have often gone untreated or undertreated. Inmate health assessments must be comprehensive and screen for infectious disease, chronic illness, oral health problems, mental health disorders, and substance abuse problems. Once identified, correctional facilities have a mandate to address those conditions that require treatment and are not elective

### ***Promote Comprehensive, Integrated Mental Health Services & Substance Abuse Treatment***

Many inmates suffer from mental health and substance abuse problems. These problems are often inextricably linked, especially among female inmates who frequently have histories of physical and/or sexual abuse. In many cases, diversion into mental health and/or substance abuse treatment programs – instead of incarceration – is the most effective way to address these problems and will reduce expensive incarceration costs. We must promote increased use of diversion programs and support funding for the community programs necessary to appropriately address the mental health and substance abuse needs of this population.

For those who are incarcerated, mental health and substance abuse problems must be comprehensive, integrated, and gender-specific. Discharge planning that promotes holistic care and continued treatment of these issues is crucial to a healthy transition back into the community.

### ***Advocate for Increased National, State and Local Funding of Correctional Health Care***

Most correctional health care systems do not have sufficient funds to meet the health and mental health care needs of the incarcerated population. Chronic under-funding is compounded by significant annual increases in medical care and pharmaceutical costs. Too little money means understaffing and inadequate services.

Increased funds must be allocated to correctional health in order to address the needs of this population appropriately. Such an investment will ultimately save money in reduced incarceration, improved public safety, improved public health, and more appropriate use of the health care system. Correctional health supporters must advocate for greater commitment on the part of federal, state and local governments to fund health care in correctional settings adequately.

### ***Improve Data Collection Capacity and Outcome-Based Research***

There is great variation in the data collection and medical record tracking systems at correctional facilities throughout the nation. Many facilities lack a computerized medical records system and, if they do have such a system, it may not be similar to other facilities or community health providers. Standardized computerized medical records systems within corrections would promote efficient transfer of inmate health data to other correctional and health care facilities, allow for broad data collection on inmate health conditions, and would help in gathering information to educate the public, policymakers, and others about the immense need for resources and partnerships to improve inmate health.

Improved data collection and sharing would also allow for expanded research in the correctional health care field. The full potential of comprehensive correctional health care will not be realized or appreciated until further research studies are conducted. Conclusive outcome studies demonstrating the cost-efficacy of expanded disease surveillance, treatment, health education, and re-entry services for inmates are essential. For correctional health to obtain support from health care professionals, corrections personnel, policy-makers and the general public, more substantive research is needed.



***Establish a Federal Level Office of Correctional Health Care***

One of the challenges facing correctional health is the lack of widespread advocacy at the local, state and national levels. There is no specific position within the federal government's health care infrastructure officially representing correctional healthcare, despite the fact that it provides services to more than 2 million Americans. The field of correctional health is diverse, decentralized and often lacks a unified national voice in policy-making and collective action. A federal level office on correctional health care within the US Department of Health and Human Services (DHHS) would help to advocate for, support, and coordinate programs on a national basis. It could also examine issues such as government funding and the use of Medicare and Medicaid funds for correctional health care.

***Strive for Minimum Standards of Care***

In order to achieve a minimum standard of correctional health care in the U.S., there must be strong incentives and sufficient resources for all correctional facilities to meet nationally recognized protocols and standards of health care. Currently, only 10% of America's jails and prisons are accredited by the National Commission for Correctional Health Care (NCCHC) or the American Correctional Association (ACA). At a minimum, all correctional facilities should strive for NCCHC accreditation. Additionally, the NCCHC should increase their emphasis on *mandatory* prevention and health promotion standards in correctional facilities.

## **VIII. CORRECTIONAL HEALTH RESOURCES**

The following resources are available to assist with the adoption of the public health model and to provide additional information about correctional health care issues:

### ***The Hampden County Correctional Center (HCCC)***

HCCC has served as a resource for correctional facilities exploring the public health model since establishing the model in 1990. Correctional professionals and public health leaders are encouraged to visit the facility, network with staff members, and utilize the website developed in conjunction with this manual at:

**[www.mphaweb.org/HCCC](http://www.mphaweb.org/HCCC)**

Many facilities have found it useful to speak directly to the management and leadership involved with developing the model. The Health Services Director at HCCC can be reached at:

Dr. Thomas Conklin  
Director of Health Services  
Hampden County Sheriff's Department and Correctional Center  
627 Randall Road  
Ludlow, MA 01056-1079  
Phone: (413) 547-8000 extension 2344  
E-mail: tom.conklin@sdh.state.ma.us

### ***The Massachusetts Public Health Association (MPHA)***

MPHA is the state affiliate of the American Public Health Association. In 2001, the MPHA received multi-year funding from the Jessie B. Cox Charitable Trust to focus its efforts on improving the health of inmates as they move through the criminal justice system in Massachusetts. Several components of their correctional health campaign include:

*Educational programs:* MPHA sponsors seminars and other events to increase understanding of the importance of the links between public health and corrections. The target audience includes corrections staff, public health practitioners, advocates, and community service providers.

*Public Health Model of Correctional Care:* MPHA is working with HCCC to promote replication of their Public Health Model of Care nationally.

*Support of legislation:* MPHA advocates for state funding and public health policies that will improve correctional health in Massachusetts and the U.S.

*The Public Health and Corrections Connection:* MPHA works to strengthen relationships between corrections and public health. MPHA's Correctional Health Advisory Committee includes representatives from the Department of Public Health, Department of Mental Health, Department of Correction, Sheriffs' Association, Parole Board, County Jail Health Administrators, Office of Community Corrections, Federal Department of Health and Human Services, faith community, former inmates, and criminal justice advocates.

*Co-Chairs of MPHA's Correctional Health Campaign:*

Alfred DeMaria, Jr., MD  
Assistant Commissioner, Communicable Disease Control  
Massachusetts Department of Public Health

Rachel Wilson, MPH  
Director of Advocacy and Education  
Massachusetts Public Health Association

*For more information about MPHA's Correctional Health Campaign, contact Rachel Wilson at (617) 524-6696, extension 102 or [rwilson@mphaweb.org](mailto:rwilson@mphaweb.org). For information about your state affiliate, contact the American Public Health Association ([www.apha.org](http://www.apha.org))*

### ***Centers for Disease Control and Prevention (CDC) Community Corrections Working Group***

As part of the CDC's National Center for HIV, STD and TB Prevention, the Community Corrections Working Group (CCWG) seeks to improve community health through improved access to HIV, STD and TB health care and prevention services within correctional settings and transitional programs in communities. Their objectives are to:

- Provide a database for decision-makers to improve disease prevention services for incarcerated populations
- Promote the availability of transitional services and continuity of care through partnerships
- Establish opportunities for information and technology transfer between corrections and public health

The CDC Working Group has established a website with additional resources and links to databases, state and national organizations and facts sheets relevant to correctional health issues. The mission of the Public Health and Corrections Web page is to disseminate information on correctional health care issues to the public and to foster collaboration between public health organizations and corrections.

The website can be reached at: <http://www.cdc.gov/nchstp/od/cccwg/>

### ***National Commission on Correctional Health Care (NCCHC)***

The National Commission on Correctional Health Care's mission is to improve the quality of health care provided in jails, prisons, and juvenile confinement facilities. NCCHC develops and maintains nationally recognized standards for correctional health care. These standards are used to accredit jails, prisons, and juvenile confinement facilities, and to assist public and private agencies in monitoring the quality of medical services provided in these settings.

The National Commission on Correctional Health Care is a not-for-profit organization offering a wide range of services and programs designed to help correctional health systems provide efficient, quality health care. Services provided include:

- Health Services Accreditation
- Educational Conferences and Seminars
- Quality Assurance Reviews
- Technical Assistance and Consultation
- Professional Certification
- Reference Publications

#### *Contact Information:*

National Commission on Correctional Health Care  
P.O. Box 11117  
Chicago, IL 60611  
Phone: (773) 880-1460  
Fax: (773) 880-2424  
Email: [ncchc@ncchc.org](mailto:ncchc@ncchc.org)  
**[www.ncchc.org](http://www.ncchc.org)**

### ***Additional Professional Organizations Supporting Correctional Health***

There are numerous national organizations that serve as resources for technical assistance, information, data, professional education opportunities and research on correctional health.

**Academy of Correctional Health Professionals**

<http://www.correctionalhealth.org>

**American Correctional Association**

<http://www.corrections.com/aca/>

**American Correctional Health Association**

<http://www.corrections.com/achsa/>

**American Jail Association**

<http://www.corrections.com/aja/>

**American Public Health Association**

<http://www.apha.org>

**Center on Crime, Communities and Culture**

<http://www.soros.org/crime>

**Correctional Industries Association**

<http://www.corrections.com/industries/index.html>

**Council of Juvenile Correctional Administrators**

<http://www.corrections.com/cjca/>

**Federal Bureau of Prisons**

<http://www.bop.gov>

**Juvenile Justice Center (American Bar Association)**

<http://www.abanet.org/crimjust/juvjus/>

**National Institute of Corrections**

<http://www.nicic.org>

**National Institute of Justice**

<http://www.ojp.usdoj.gov/nij>

**National Juvenile Detention Association**

<http://www.corrections.com/njda/index.html>

### ***Additional Sources of Correctional Health Information***

The following websites provide additional research and statistical information on correctional issues.

**The Bureau of Justice Statistics**

<http://www.ojp.usdoj.gov/bjs/>

**Corrections Healthcare Network**

<http://www.corrections.com/healthnetwork/>

**Health Issues Specific to Incarcerated Women**

<http://www.med.jhu.edu/wchpc/pub/prison.pdf>

**HIV & Hepatitis Education Prison Project**

<http://www.hivcorrections.org/>

**National Library of Medicine: Prisons/Prisoners**

<http://sis.nlm.nih.gov/HIV/HIVPrison.html>

Visit  
**[www.mphaweb.org/hccc.html](http://www.mphaweb.org/hccc.html)**  
for website updates and additional resources

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