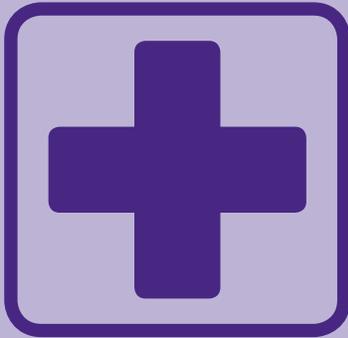


Bridging the Gap

Improving the Health of Justice-Involved People through Information Technology

FEBRUARY 2015

SUBSTANCE USE AND MENTAL HEALTH PROGRAM



Chelsea Davis • David Cloud

Executive summary

On September 17, 2014, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) convened a two-day conference in Rockville, Maryland called Bridging the Gap: Improving the Health of Justice-Involved People through Information Technology. The meeting aimed to address the problems of disconnected justice and health systems and to develop solutions by describing barriers, benefits, and best practices for connecting community providers and correctional facilities using health information technology (HIT).

The gathering, organized by the SAMSHA Health Information Technology and Criminal Justice Team and the Federal Interagency Reentry Council HIT Workgroup, included representatives from federal agencies; national advocacy organizations; and nonprofit, state, and local agencies providing health services to justice-involved populations.

The following proceedings give an overview of each session and a synthesis of the obstacles to instituting HIT solutions for information sharing detailed during the meeting. The proceedings address the importance of using emerging HIT to respond to the growing problem of people with mental health and substance use disorders involved in the criminal justice system and to articulate a vision of how HIT can facilitate ongoing connections between health and justice systems.

Several jurisdictions that are implementing new HIT programs—both those that connect community providers to correctional facilities during initial intake into the justice system and those that connect correctional facilities to community providers during reentry—are highlighted here. Common challenges emerged among jurisdictions despite their unique environments and systems. Conference participants discussed these challenges along with opportunities for overcoming them. An in-depth case study of new HIT initiatives in Louisville, Kentucky, is included, illustrating how to build and sustain collaborative cross-sector teams.

The conference coalesced around six key themes:

- > An underdeveloped HIT landscape makes it difficult for health and justice systems to communicate

and share data vital to the health of justice-system-involved populations.

- > Innovative programs from jurisdictions around the country can help others figure out how to successfully launch HIT programs intended to share data between community providers and correctional facilities.
- > Representatives from Medicaid agencies, corrections departments, and community providers need to be at the table together to develop solutions that advance common goals that promote public health and public safety.
- > Every locale must build a program based on its specific needs, infrastructure, and partners, but resources such as Justice and Health Connect, NIEM, and Global can guide jurisdictions looking to bridge the justice and health gap.
- > Privacy, security, consent, and technology adaptation are difficult but surmountable obstacles to providing healthcare to the justice-system-involved population.
- > Data-driven programs such as justice reinvestment seek to cut spending and reinvest the savings in practices that have been empirically shown to improve safety and hold offenders accountable. The trend toward evidence-based evaluation of justice programs, coupled with mounting evidence that current incarceration and recidivism rates are economically unsustainable, have galvanized diverse stakeholders to collaborate on developing better responses to justice-involved people who have substance use and mental health issues.

The conference was particularly timely: The Patient Protection and Affordable Care Act (ACA) has created opportunities to improve the health of low-income communities, including many people involved in the criminal justice system, who have historically lacked access to health care coverage. Information-sharing policies that promote intersystem communication can be used to identify eligible people who need treatment and to ensure continuity of care as they move between courts, jails, prisons, and healthcare settings in the community.

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Introduction

*HIT is the means
to an end—the
end being a better
healthcare system.*

Melissa Goldstein, associate professor,
Milken Institute of Public Health,
George Washington University

Developing collaborative, intersectoral approaches to address the high burden of disease among people involved in the justice system is both a public health and public safety imperative. People with serious mental illness are significantly overrepresented in correctional systems. An estimated 14.5 percent of men and 31 percent of women in jails have a serious mental illness (SMI) such as schizophrenia, major depression, and bipolar disorder, compared to 5 percent of the general population.¹ Speaking during the conference, Judge Steven Leifman, associate administrative judge for the Criminal Division of the Eleventh Judicial Circuit in Miami-Dade County, who serves on the Florida State Supreme Court's Task Force on Substance Abuse and Mental Health Issues, said that people in jail generally stay four to eight times longer if they have a mental illness, at about seven times the cost, compared to people without mental illness. Both Judge Leifman and Kimberly Jeffries Leonard, deputy director of the Center for Substance Abuse Treatment at SAMHSA, in her opening presentation, stressed that correctional health has become the only system in the country that cannot refuse treatment. Jails and prisons often are the first opportunity for treatment when they should in fact be the last resort. Too often healthcare services in correctional facilities do not reflect modern science, medicine, technology, or treatment.

A lack of health background information on the people involved in the criminal justice system diminishes the likelihood that jails will deliver properly targeted, often urgently needed care. Further, criminal justice agencies often lack health management systems, including systematized data-collection and information-management systems. According to the National Criminal Justice Association, most criminal and community healthcare information systems are disconnected for a host of practical, technical, and legal reasons. The disconnect between health and justice systems creates significant impediments to coordinating care for people while they are held in correctional settings and when they return home.

Increasingly, local health departments, corrections agencies, and community medical providers recognize the benefits of sharing information across health and justice boundaries. Improved communication can help agencies better identify, diagnose, and serve people with chronic health needs in justice settings. It can foster efforts to divert people with behavioral health needs from incarceration, improve the treatment that is available in jails and prisons, and increase the effectiveness of reentry services—all with the dual aims of addressing health disparities and increasing public safety.

The absence of effective, timely communication at critical points of transition for justice system-involved people as they move into and out of jails and prisons can have dire health consequences. Discontinuity in care raises their morbidity and mortality rates and leads to pointless duplication of services. Although health and justice-system practitioners along with advocates for

people with substance use and mental health problems recognize the benefits of sharing information, they historically have faced legal, cultural, and organizational obstacles that frustrate efforts to communicate about the well-being of those in their care.

Fortunately, in a number of jurisdictions around the country, health and justice actors are creating programs that can be used as models for overcoming these barriers and improving outcomes. The conference included representatives from the federal government, state governments, and local jurisdictions that have developed innovative approaches to breaking down barriers to coordination. The sessions included discussions of the significance and potential of linking community and correctional healthcare; the current HIT landscape; specific programs linking community health providers to corrections agencies around the country; challenges to creating health information exchanges (HIEs); opportunities for removing those roadblocks; and a detailed case study of how Louisville, Kentucky, created a comprehensive HIE.

The Patient Protection and Affordable Care Act (ACA) of 2010 has created opportunities to dramatically improve the health of low-income people, including those involved in the criminal justice system, who have historically lacked access to health insurance. Information sharing between justice and community health systems can help maximize the efficacy of the ACA by using people's contact with jails and other criminal justice settings as an occasion to assess and better manage their healthcare needs—such as enrolling those with complex behavioral health needs in Medicaid and connecting them to community-based health services upon release. The ACA also provides new opportunities to divert people with addiction or mental health problems from incarceration to more effective and cost-efficient treatment plans.

WHY HEALTH INFORMATION TECHNOLOGY?

HIT enables the electronic collection, storage, and exchange of patient information and includes a range of products and services, including software, hardware, and infrastructure. The goal of HIT is to increase the capacity for a patient's clinical information to flow between healthcare providers in different settings, enhance the coordination and continuity of care, inform clinical decision making by supplying timely access to accurate information, empower people by giving them better access and control over their own health information, improve workflow efficiency, and provide necessary clinical documentation for billing processes.

Conference participants stressed that the time is right to capitalize on the potential of evolving HIT to bridge the gap between criminal justice and community health systems. In her keynote address, Amy Solomon, senior advisor to the Assistant Attorney General of the U.S. Department of Justice, said that “given the scale, the complexity, and the variability of the population flow,

One of the important tools for moving forward is health information technology. Seamless continuity of care is crucial to the successful return of justice-involved individuals to their home communities.

Kimberly Jeffries Leonard, deputy director, Center for Substance Abuse Treatment, SAMHSA

electronic, automated, and secure information exchange is really the only way to go.” Some of the uses of HIT identified by presenters and participants throughout the conference included:

- > increasing access to healthcare and treatment in the community;
- > providing public health agencies with access to release dates, prescriptions, and other essential information for people leaving justice facilities;
- > sharing information on diagnoses and treatment needs;
- > performance monitoring;
- > collecting information on the services that people receive from multiple agencies; and
- > identifying people who are eligible for health coverage and enrolling them in Medicaid or qualified health plans through the Marketplace, improving access to care and cutting costs.

There are many programs around the country that demonstrate the benefits of leveraging technology to systematically improve conditions. For example, as Carl Wicklund, executive director of the American Probation and Parole Association, noted in his presentation, the National Information Exchange Model (NIEM), a community-driven, standards-based approach to exchanging information formally initiated in April 2005 by the chief information officers of the U.S. Department of Homeland Security and the U.S. Department of Justice and joined in October 2010 by the U.S. Department of Health and Human Services, has created a common language to facilitate data sharing between organizations using technologies that were not designed for interoperability.

David Cloud, senior program associate in the Substance Use and Mental Health Program at the Vera Institute of Justice, discussed the [Justice and Health Connect website](#), which provides advice on the benefits, challenges, and practical considerations for sharing information across health and justice agencies. The website includes a toolkit that community organizations and government agencies can use as a framework for developing an information-sharing initiative from the ground up and provides helpful counsel on goal-setting, governance, privacy laws, and technological solutions.

Amy Solomon noted that some of the highest stakes for people returning to the community from correctional institutions rest in health outcomes. People who are incarcerated have a constitutional right to healthcare while living in correctional facilities, and correctional healthcare currently amounts to a \$10 billion annual national investment in jail and prison health services. Without continuity of care to and from the community, that investment will be squandered. As Solomon stressed, every transition into or out of corrections is an opportunity to improve services.

The vision: no wrong door

In the conference's first session, Steve Rosenberg and Ben Butler of Community Oriented Correctional Health Services (COCHS) laid out COCHS's vision for health data sharing within correctional facilities and into the communities. It is rooted in "no wrong door"—the idea that while many of the conditions inside correctional facilities can be harmful to health, contact with the justice system opens opportunities for outreach to medically vulnerable people with the aim of getting them insured and connecting them with community-based care. Information sharing and HIT are vital for making these connections. As Rosenberg, COCHS's president, said, "Part of what we have is this new frame that says there's no wrong door through which people can access health care and health insurance."

HOW CAN HIT MAKE CONNECTIONS BETWEEN THE COMMUNITY AND CORRECTIONS POSSIBLE?

Brent Gibson, vice president of operations of the National Commission on Correctional Health Care, emphasized the importance of quality documentation, maintaining good records, and keeping the needs of community providers in mind. Catherine Devaney McKay, chief executive officer of Delaware's largest nonprofit, Community Support Programs, Inc., stressed that when using HIT, any point of contact is a potential opportunity for intervention and enrollment under the ACA. This may include initial contacts with law enforcement or public defenders, booking and receiving, pretrial detention, problem-solving courts, and reentry planning. McKay said that each of these points in the system allows criminal justice agencies to collect reliable information that can be shared with community providers to help promote continuity of care.

As described by Butler, while jails around the country employ myriad approaches to managing information on the people in their facilities, there are two main components of the correctional information technology landscape: inmate management systems (IMS) and electronic medical/health records (EMR/EHR). IMSs record information necessary for custody management, including intake, housing, sentencing, charging, and scheduling. EMRs and EHRs, though technically distinct, both contain a patient's medical history.² There are several types of EHRs, including those designed specifically for correctional facilities and those created for community providers and then adapted for jail settings, though most jails do not yet use EHRs. In most jails, interfaces between these two systems are limited to basic functions, including transferring demographic data entered into the IMS at jail booking to the EHR system; sharing medical appointment calendars from EHRs with corrections staff via the IMS; and sharing information on housing and dietary requirements.

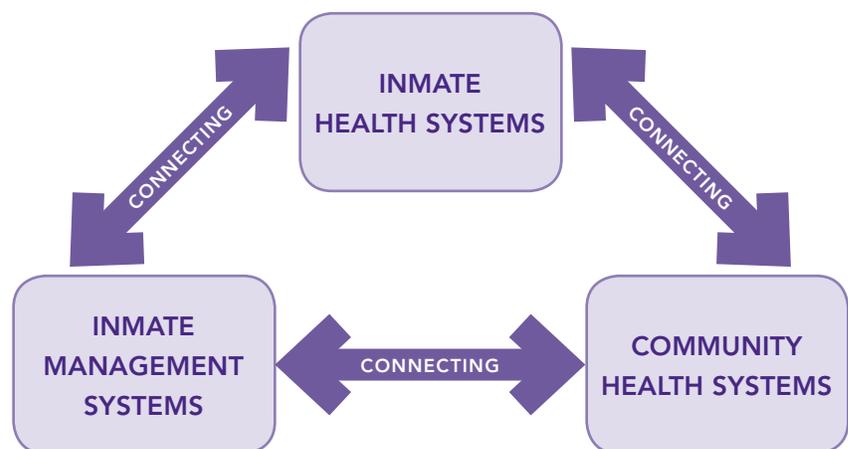
Since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 and the Affordable Care Act in 2010, the potential for enhancing connectivity between health and justice systems has

Corrections is just another transition in care.

Ben Butler, chief information officer, Community Oriented Correctional Health Services, Oakland, California

increased markedly. The HITECH Act creates financial incentives for community and correctional health providers that meet basic eligibility requirements to develop EHRs. The ACA expands eligibility for public and private coverage to people cycling in and out of correctional facilities at a time when more jails and prisons are interested in enrolling people in coverage and connecting them to services. HIT can play a critical role in bridging these two systems by determining eligibility, facilitating enrollment, and increasing engagement with and use of services by connecting people with community providers.

Emphasizing the need to connect the health and justice systems, Butler presented a three-pronged approach to managing HIT connectivity that incorporates inmate health systems or EHRs, inmate management systems, and community health systems.



Source: Benjamin Butler, chief information officer, Community Oriented Correctional Health Services, presentation at “Bridging the Gap: Improving the Health of Justice-Involved Individuals through Information Technology.” September 17, 2014. SAMHSA, Rockville, MD.

Butler described promising practices in a number of jurisdictions that are developing a technological infrastructure to increase connectivity.² For example, officials in the Multnomah County Health Department in Portland, Oregon, have developed an integrated system that may serve as a model for connecting community and correctional health systems. He highlighted the key components of Multnomah’s approach, including:

- > the county health department’s oversight and delivery of correctional health services;
- > leadership and a strong desire to establish connectivity between the jail health and community health systems; and
- > the selection and implementation of an EHR technology that is widely used in the community by hospitals and community health centers.

THE MEDICAID EHR INCENTIVE PROGRAM

According to Tom Novak, director of delivery system reform at the Office of the National Coordinator for Health Information Technology's (ONC) Office of Provider Adoption and Support, federal legislation has played a prominent role in the proliferation of HIT in the mainstream healthcare system. The adoption of EHRs in hospitals, community health centers, and among individual providers has expanded dramatically since the 2009 HITECH Act, which provides financial incentives for healthcare providers to adopt electronic health records. The expansion of EHRs has greatly enhanced the capacity of medical providers working in different specialties and settings to coordinate care for mutual patients. Novak emphasized the incentive to incorporate correctional health systems into the evolving HIT infrastructure.

The federal government's Medicaid EHR incentive program is an important opportunity to increase adoption of EHRs in jail settings and establish better data-sharing capacity with community providers, according to Novak. Under this program, providers can receive financial reimbursements if they adopt a certified EHR and show that they are clinically effective in ways that satisfy HHS's Center for Medicare and Medicaid Service's meaningful use standards.³ Medical providers working in correctional settings are eligible to receive reimbursements under the Medicaid EHR program if they can document that at least 30 percent of their patient population is Medicaid-enrolled.

HEALTH INFORMATION EXCHANGE IN NEW YORK CITY JAILS

Michelle Martelle, associate director of health information technology at the Bureau of Correctional Health Services (CHS) within the New York City Department of Health and Mental Hygiene (NYC DOHMH), gave an overview of the experience of implementing an EHR in a large urban jail that serves as many patients as a mid-sized hospital.

CHS oversees all healthcare delivered in the New York City jail system. In 2008, CHS decided to adopt e-ClinicalWorks, an ONC-certified EHR, as part of the city jails' health system. Since then, CHS has customized and implemented the EHR in all 12 of its facilities. Martelle also has played a critical role in helping CHS get federal reimbursements through the Medicaid EHR Incentive Program for its meaningful use of the EHR in the jail complex at Rikers Island—the first correctional health agency in the nation to do so.

According to Martelle, while implementation of EHRs in correctional facilities is a difficult process, the benefits are substantial and include:

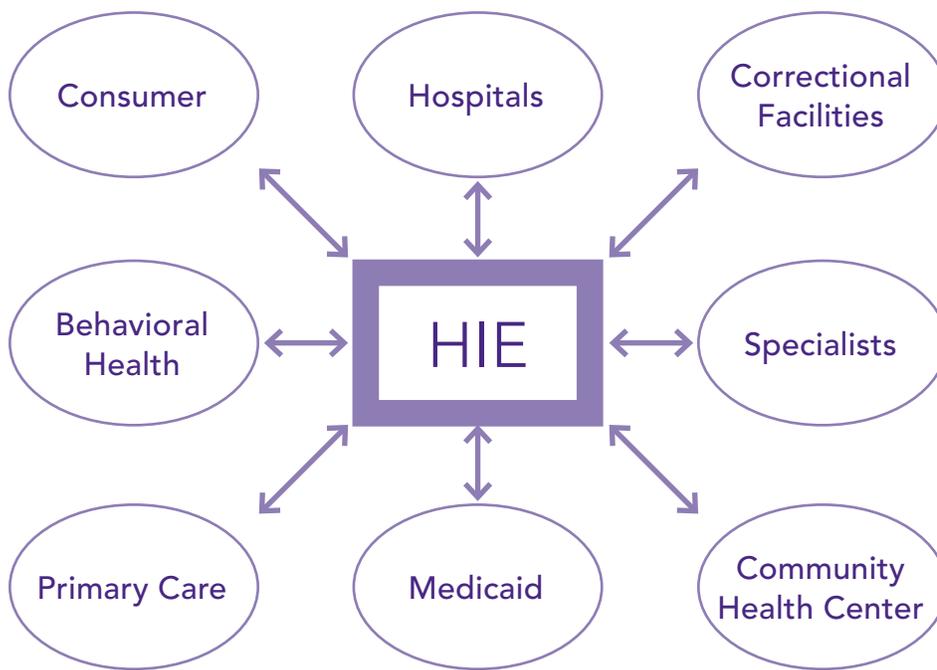
- > **More efficient medical intake.** Many people with behavioral health needs cycle through the jail several times a year. Having electronically available information on prior treatment, diagnostics, and medication at medical intake is critical for ensuring that people who need care receive it in a timely fashion.

Implementing an EHR in the New York City jail system, which serves as many patients as a mid-sized hospital, was challenging but has yielded substantial benefits.

- > **Improved Care Delivery.** By recording clinical histories, the adoption of e-ClinicalWorks has greatly improved clinical decisions and service delivery for people in custody who require medical or mental health treatment.
- > **Enhanced Triage.** The EHR has established a technological foundation for more effective and efficient communication between medical, mental health, and other clinical providers delivering care across the 12 facilities in NYC's jail system at points such as medical intake, admittance to an infirmary, and treatment in other clinics.
- > **More informed discharge planning.** The EHR also serves as an important tool for CHS staff who are responsible for discharge planning. Having reliable diagnostic information, medication history, and other personal health data has been invaluable for helping ensure continuity of care for people with serious mental illness and other chronic conditions who are transitioning from the jail to the community.
- > **Disease Surveillance.** The EHR's reporting system has allowed the health department to reliably track the incidence of diseases among the jail population and issue reports to the DOHMH executives and other city officials. Increased transparency about health conditions behind bars is critical for advancing programmatic and policy solutions for combating public health issues such as disease prevention, treatment, and reducing transmission to the community.
- > **More human rights protections through data analytics.** By tracking injury, self-harm, health outcomes, and disparities, EHR data analytics allow practitioners from both justice and health systems to discern potential patterns of abuse or systemic inequities.

Although customizing the city's EHR for the jail system required a considerable effort at the outset, it has greatly improved CHS's ability to make timely medical decisions, improve care coordination, track health trends, and monitor how different conditions of confinement affect health outcomes.

CHS is also on the frontier of connecting correctional and community health information systems. The agency's e-ClinicalWorks system has the technical capacity to exchange data with several community-based Regional Health Information Organizations (RHIOs)—virtual structures that connect healthcare stakeholders within a defined geographic area and govern the terms of HIE between providers to improve service delivery. Martelle described how, with the proper consents and privacy protections in place, connectivity between the jail EHR and community RHIOs has the potential to greatly improve communication, care coordination, and continuity of care for people transitioning to and from correctional facilities. RHIOs in New York City include information from both hospitals and community providers, allowing for efficient HIE, especially from the EHR.



Source: JHConnect.org, www.jhconnect.org/wp-content/uploads/2013/05/HIE-IMAGE.bmp.

Martelle offered additional lessons from the HIT work New York City has initiated:

- > Having correctional health services under the purview of the Department of Health and Mental Hygiene created an organizational capacity to connect the jail with other community-based clinics and providers that are also overseen by the health department.
- > Selecting an EHR product and customizing it to be interoperable with other community HIT networks, including the RHIOs, opened important communication channels between the jail and the community.
- > Forming specialized teams to work with administrators and frontline providers to map out clinical workflows at the outset was important for maximizing the utility of the EHR inside the jail and identifying opportunities to connect with external systems.

She also described the technical, policy, and operational hurdles her agency has encountered in connecting systems:

- > Implementing an EHR product designed for primary-care practices in a jail environment requires an intensive customization process.
- > Obtaining patients' informed consent to allow access to health records stored in community health databases (such as New York State's Psychiatric Services and Clinical Knowledge Enhancement System and RHIOs) at medical intake in the jail can be challenging.
- > Community healthcare providers and other potential consumers of this information needed to be educated about the existence, purpose, and benefits of correctional health records.

From correctional facilities to community providers

The purpose of this session was to discuss why it is critical for doctors, nurses, and social workers caring for patients in correctional facilities to share information with community providers when their patients are released. Gladys C. Taylor, assistant director of the Illinois Department of Corrections who oversees the department's technology and infrastructure, discussed how the Illinois Health Information Exchange Authority (ILHIE), set up by the governor's office, can increase information sharing for service planning and ACA implementation. The ILHIE will establish an integrated and shared adult and juvenile justice management system, use electronic health information to promote continuity of care, and facilitate enrollment in Medicaid in criminal justice settings in the state.

Experts who are leading efforts in Illinois, Alabama, and Washington, DC, described how information technology is helping correctional facilities more effectively communicate with community providers to improve care coordination and promote successful reentry.

WASHINGTON, DC: UNITY HEALTH CARE

Diana Lapp, deputy chief medical officer of Unity Health Care, described a program in Washington, DC that aims to promote continuity of care by using a community-oriented correctional healthcare model. Unity is a Federally Qualified Health Care Center (FQHC) and delivers comprehensive services to underserved populations in the District. As an FQHC, Unity qualifies for enhanced reimbursement from Medicaid. Originally formed as a healthcare provider for the homeless population, Unity was awarded a contract in 2006 to provide healthcare in DC's Department of Corrections (DOC) Central Detention and Central Treatment Facility. Unity began work with the correctional health system with the goal of improving information sharing, recognizing that people passing through the jail who needed medical care often had treatment histories in Unity's community-based system. All Unity providers are connected through an EHR system that permits communication across 30 healthcare settings, which include neighborhood and correctional health centers.

The Reentry Health Care Center (RHC) opened in 2008 with a patient-centered medical home team and social service integration to improve continuity of care. This model reduces service duplication and creates opportunities to arrange for follow up and referrals. Medical and behavioral healthcare are integrated, and patients are seen within one to two days of arriving at a halfway house. RHC receives electronic medical records from the Federal Bureau of Prisons—a critical advance, given that access to prison healthcare records is often difficult for community providers. Lapp reported that since opening the office Unity has reduced costs and enhanced continuity of care by reviewing

In Washington, DC, the Department of Corrections is working with community-based healthcare providers to ensure continuity of care for people involved in the justice system.

medical histories and diagnoses of people returning to the community, coordinating their care with community providers, avoiding duplication of laboratory and diagnostic testing, and continuing their medication regimens.

Lapp said that Unity’s EHRs are essential tools for staff working in the jail on discharge planning, because they document medications and whether the incarcerated person is enrolled in a health plan. Thus, the EHRs allow staff to design a discharge plan that will help a person returning to the community access and pay for healthcare services. Lapp reported that this program has increased care follow up and saved money, increased insurance coverage, and created lasting partnerships. She said that improved health outcomes for people leaving jail include reduced rates of asthma, diabetes, hepatitis, and HIV.

Unity’s partnerships are essential to information sharing between providers working in health and correctional settings, according to Lapp. Unity relies on “half-and-half” providers who spend two days in the jail and three days in the community per week and are vital to Unity’s reentry program. These “boundary spanners,” including psychiatrists and infectious disease practitioners, for instance, facilitate timely linkages to services because they are able to access and share information more readily across community and correctional health boundaries. The partnership between Unity and DOC enables correctional health providers to access community health records for patients who are seen in Unity clinics. It also permits half-and-half providers to access and use medical records created in the jail when they are treating formerly incarcerated people in community clinics.

Of people released from jail in 2012, almost a third (29 percent) sought and received services at a Unity site in the community. In 2008, Unity’s focus shifted to Federal Bureau of Prison (FBOP) returnees—a unique situation for the District, which is not a state and does not have a prison system. Inmates are housed in facilities across the country, disconnected from family and social networks.

Lapp stressed that the Unity Health Care model can help other jurisdictions understand how health and justice system partnerships and a robust EHR system for sharing information can lead to measurable gains in data connectivity and quality of care for people coming home.

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ALABAMA: ALABAMA SECURE SHARING UTILITY FOR RECIDIVISM ELIMINATION (ASSURE)

Richard Fiore, project sponsor of ASSURE, described a new program aiming to promote information sharing between health and justice stakeholders using a secure, web-based portal. Corrections and mental health commissioners formed a coalition that included the Alabama Department of Mental Health (ADMH), community mental health centers (CMHCs), substance use treatment providers, the Alabama Board of Pardons and Paroles, and the state Department of Corrections, to improve access to community-based service for high-needs populations who repeatedly cycle between corrections and community health systems.

Alabama is striving to use HIT to connect health and justice practitioners to more effectively respond to high-needs populations who repeatedly cycle between corrections and community health systems.

ASSURE's web portal is used to help correctional officials connect clients to one of the 25 CMHCs managed by ADMH. The portal is used to ensure people have their medications when they are released from custody; increase effectiveness and efficiency of intake and classification processes; reduce emergency room visits; and reduce recidivism. A community provider is now able to log into the portal and access information on the services received by their formerly incarcerated patient, for instance. So far, it has been successful in improving communication and continuity of care, raising awareness of the availability of CMHCs, and establishing more accurate and complete patient profiles. The system is low cost, requiring only a computer, Internet connection, user name and password, and printer for the consent registry.

The program faces a few difficulties, said Fiore, including problems with interoperability with other data systems, different architectures and technologies, and multiple credentialing and access rules—which Alabama officials are trying to overcome using the National Information Exchange Model (NIEM), Global Reference Architecture (GRA), and the Global Federated Identify and Privilege Management system (GFIPM). ASSURE will begin mapping Alabama Department of Mental Health and Alabama Department of Corrections data elements to NIEM, conduct readiness assessments, and work on creating service specification packages of web services, NIEM, and security specifications. They will work with the University of Alabama Center for Advanced Public Safety to test real-time data to determine query performance and with the Georgia Tech Research Institute to develop new GFIPM attributes to support exchanges. ASSURE is an example of how jurisdictions can capitalize on the shared interest in cost savings to facilitate data sharing, using existing HIT structures like NIEM and GRA to improve interoperability.

From community providers to correctional facilities

On any given day, there are more than two million people held in U.S. prisons and jails who rely on these facilities for their healthcare. HIT can improve health services in correctional settings in similar ways that it does for many hospitals and community clinics. Presenters during this session provided overviews of emerging initiatives that are spanning the divide between health and justice, including programs in Delaware, Minnesota, and Arizona.

Catherine Devaney McKay, CEO of Connections Community Support Programs (CCSP), discussed CCSP's model for integrating healthcare services into Delaware's unified correctional system and described opportunities to identify people in criminal justice settings who need to be connected to services. A critical component of CCSP's initiative is a "living model"—in which discharge planning begins on the day of admission. When someone is

admitted to the jail, correctional health staff query the state HIE, the Delaware Health Information Network (DHIN) and if it exists in DHIN, access information on diagnosis, treatment needs, and other information important for determining appropriate care. Simultaneously, jail staff uses an electronic application process to link incoming people to health insurance. The homegrown EHR, iCHRT, and DHIN are used for creating integrated discharge summaries. When people leave the jail, educators and health coaches connect those in need to community-based care, and track a range of their healthcare and treatment outcomes. The EMRs allow sharing of information on services in correctional facilities and in the community. For example, the discharge module of the EMR can be updated at any point during incarceration and a person's discharge plan can be provided to the person leaving the jail on paper at discharge or transferred electronically.

Robert Bliese, project leader for IT and process management at Cermake Health Services of the Cook County Health and Hospital System (CCHHS), described three new initiatives that Cook County has implemented to address overcrowding and capacity. These programs all aim to ensure that electronic information held by the jail, health services, and juvenile detention agencies is compatible and can be shared to coordinate care. First, Cook County is implementing an interface that can be seen both by the jail management system (CCOMS) and the EMR, which is auto populated with booking data. Second, CCHHS is planning to implement an EMR at the juvenile detention center. Third, CCHHS is developing information-sharing infrastructure with the Illinois DOC.

PIMA COUNTY, ARIZONA

Amy Fish, administrative special projects coordinator at the Pima County Superior Court, described the county's HIT initiatives that aim to connect the different elements of IT infrastructure within the correctional system. Fish described her partnerships with the Health Policy Unit in the Office of Medical and Health Services on a number of initiatives: the development of an EHR at the Pima County Adult Detention Complex (PCADC); implementation of the statewide HIE at the PCADC; and a project to share information using NIEM guidelines and GRA architecture through Pima County's Justice and Health Collaboration.

Each year, Pima County has an average corrections census of 2,100, 39 percent with a chronic health condition and 51 percent with a mental health condition. Eighty percent of all prescription expenditures in the jail are for psychotropic medications, and nearly 8 percent of the total patient population is designated as having a serious mental illness. The high level of morbidity and growing correctional health services expenditures in the Pima County jail spurred the county to develop three HIT initiatives.

In partnership with the Arizona Health Care Cost Containment System, Pima County officials have developed an electronic data feed that is sent twice daily to inform state officials of the Medicaid status of people entering the jail

The high level of morbidity and growing correctional health services expenditures in the Pima County jail spurred the county to develop three HIT initiatives.

system. This data exchange is used to identify detainees' enrollment status and to suspend enrollment upon detention rather than terminating it, as is the common practice; suspension enables people to resume their Medicaid coverage upon release.

Pima County and state officials are working to connect the jail's correctional health system to Arizona's community HIE. Pima County was a partner in the formation and development of the Arizona HIE and from the start was able to include correctional health providers in the plans for connectivity. Connecting the jail to the HIE has involved a two-phase process.

Phase One included developing a protocol for allowing authorized providers in the jail to query, view, and download information on people's physical health needs at booking (information on behavioral health, substance use, and HIV are not included because of privacy rules). The information retrieved from the HIE is then placed in the EHR and used to verify health conditions against patient self-reports.

In Phase Two, the team is developing an interface between the EMR and HIE. Barriers to implementation included Arizona's opt-out statute, the development of privacy and security settings that meet each partner's privacy requirements, and meeting meaningful use standards. Full implementation of the HIE could improve safety and reduce costs associated with unnecessary prescription medication, adverse drug events, and redundant lab tests, while also providing accurate information, thus enhancing discharge planning efforts.

The third HIT initiative in Pima County is a pilot project to implement the Justice-Health Collaboration framework, which links disparate information systems to achieve faster identification of people with behavioral health needs who have been arrested and facilitate housing if necessary, as well as alternatives to incarceration. This framework will be used to reduce the time it takes to identify people who are eligible for diversion, increase the number of people released to the community for treatment, and help community providers create more informed treatment plans.

HENNEPIN COUNTY, MINNESOTA: HENNEPIN HEALTH

Jennifer DeCubellis, assistant county administrator of Hennepin Health in Minnesota, described efforts to establish a comprehensive shared patient record to improve coordination of care between a system that includes 100 network providers and four Hennepin County Accountable Care Partners who contract with DHS to provide services to Medicaid beneficiaries.⁸ Hennepin Health's HIT initiative uses a single patient health record that is shared by clinics, hospitals, jails, behavioral health providers, and social services in the network. The system also includes a team member dedicated to case management, and the creation of a shared care plan. Not all people in the network have access to the same information, as the type of clinical or demographic information a person sees depends on an employee's role. For example, the system allows confidential information on substance use needs and mental illness to

be managed securely by tailoring information access to the needs of each care provider in the network.

DeCubellis described how working toward a shared patient record improves care coordination and costs savings. For people preparing to reintegrate into the community, discharge planners make healthcare appointments within a week of release. All people entering the jail receive a standardized intake assessment and action plan that includes information on their needs related to welfare, housing, and employment services, in addition to healthcare. So far, this program has led to a number of benefits:

- > The number of primary care visits has increased and the use of emergency rooms has declined, resulting in a 52 percent drop in emergency room costs and a 72 percent drop in inpatient admissions.
- > Quality of care for formerly incarcerated people has improved, as evidenced by data describing chronic health conditions.
- > Total costs have dropped 55 to 75 percent, mostly in reductions of service use among people who frequently use health services and justice resources. Savings have been reinvested in systems improvements.

Challenges of using health information technology to improve the health of justice-involved people

As a number of the conference presentations illustrated, programs and initiatives set up to achieve meaningful interoperable exchange of health data across disparate systems face substantial but often surmountable difficulties. There are additional obstacles to creating systems that are sustainable in the long term. Though each jurisdiction's models and subsequent obstacles are unique, several common factors exist.

PRIVACY, SECURITY, AND CONSENT

Concerns about privacy, security, and consent often arise in information sharing. Tracie Gardner, director of state policy for the New York State Policy Legal Action Center, who moderated the session on challenges, said, "Confidentiality is a core component of creating a relationship with a provider, whoever the provider is." Kate Tipping, public health adviser for SAMHSA, concurred. "Privacy is not an area for compromise," she said. "Confidentiality should never be a shortcut. Security should not be an afterthought." However, regulations do not

Each of us brings a piece to the puzzle, not one of us really holds the solution for bridging this full piece between health and justice.

James Dyche, technical services manager, Pennsylvania Justice Network

prevent sharing health information as long as the necessary protections are in place. Jeanne Ocampo, chief of HIT at the Federal Bureau of Prisons (FBOP), said that the principle, common outside of prison and jails, that the patient owns her own personal and medical information should drive plans for information-exchange systems. That tenet, when applied to correctional health and built into these processes, can facilitate data sharing.

Both correctional and community providers alike may be confused about what is permissible when sharing behavioral health data because of the interpretations of regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Confidentiality of Alcohol and Drug Abuse Patient Records Regulations (42 CFR Part 2). For example, in Hennepin County, though healthcare providers can give information to jail and the welfare system, the welfare system is unable to share their information with the jail. It has been difficult to get consent for this bi-directional information sharing on an individual patient level. The CCSP program in Delaware described by Catherine McKay has had to address the problems arising from the fact that behavioral health records are not being entered into the DHIN because of concerns regarding privacy regulations, particularly 42 CFR Part 2. Medical histories, including information on methadone-assisted treatment in correctional settings, are vital for community-based providers. For example, bad outcomes such as overdoses can stem from the failure to connect people to community treatment providers at the time of their release or intake.

Kate Tipping provided an overview of HIPAA and 42 CFR Part 2; the former governs the release of private health information and the latter determines ethical and legal disclosure of information related to substance use disorders. These regulations are designed to encourage patients to seek substance abuse treatment without fear that their privacy will be compromised. 42 CFR Part 2 is not intended to prevent information sharing as much as set standards for how sharing should occur. Although exceptions such as medical emergencies and child abuse apply, patient consent must be obtained before a Part 2 program shares information and before information may be re-disclosed.⁹ A program may disclose information to those who need it for monitoring or supervision if participation is court-mandated, or with written consent of the patient.

Currently, HIPAA does not require consent for disclosures or uses that are necessary to carry out treatment, payment, or healthcare services. HIPAA also permits disclosures for certain activities, including but not limited to public health activities, help for victims of abuse, law enforcement purposes, threats to health or safety, court-ordered examinations, correctional facilities, and allowing justice and health agencies to gather and share health information for research and treatment. Both HIPAA and 42 CFR Part 2 permit intra-agency exchanges in many situations.

Michael Boticelli, acting director of the Office of National Drug Control Policy, addressed the concern that 42 CFR Part 2 restrictions contribute to the discrimination they are supposed to protect against. He indicated that, while privacy and security are important concerns, there is a tremendous amount of misun-

derstanding about the regulations. If the regulations are a barrier to community and corrections information sharing, changing them might be necessary to treat addiction and mental illness as health conditions. Privacy concerns should not diminish the larger goal of looking at substance use disorders and mental health disorders as mainstream medical issues that belong in a public health framework.

IMPORTANCE OF BEHAVIORAL HEALTH ISSUES

In this session, panelists discussed how some agencies use the privacy regulations as an excuse to avoid the possibility of data sharing. Dean Johnson, policy, compliance, and programs director of Maricopa County, Arizona, discussing interagency partnering to share information, said, “It comes down to that they don’t want to do it, because of the accountability issues, the transparency, the data quality, the funding, the relationship. Those are the real reasons but they throw up HIPPA, Part 2, no it’s this, I can’t do it.” Although a few states such as Rhode Island do include behavioral health data in HIEs, some have experienced problems connecting behavioral health providers into HIE networks because of concerns about protecting sensitive information. Catherine McKay, describing why this information isn’t included in DHIN, said, “I think they’ve just made a decision that the behavioral health information is too complicated because of the protections that they perceive. And also...I think they think it isn’t important.”

PROCUREMENT

Several conference participants identified procurement processes as a major roadblock to building connectivity between agencies. People involved in procurement rather than those involved in care or information sharing often select the information technology that corrections systems use. As a result, institutions end up buying HIT solutions that are incompatible with other systems and reinforce isolation. According to Dean Johnson from Maricopa County, “It is either so restrictive that you have to go with the lowest bidder that went off the letter or the word you put in the RFP and you don’t get what you need, or somebody has gone on the far side and started all procurement processes and said, ‘You’re going to implement system X.’ Whichever...you end up in the same place. It’s most likely not going to meet your need.” To address this widespread concern, the Integrated Justice Information Systems (IJIS) Institute is developing a standardized procurement process, and the Department of Justice’s Global Initiative has a procurement guide for purchasing automated case-processing software. According to David Cloud, in his presentation on Justice and Health Connect, it is no longer necessary to purchase specialized software to facilitate interoperability. There are several web-based options for storing and sharing data electronically that build on agencies’ existing technology infrastructures.¹⁰

Procurement processes that exclude HIT experts and healthcare professionals can result in choosing systems that impede information sharing.

SPONSORSHIP AND GOVERNANCE

Dean Johnson discussed the tension between the need to have sponsorship within the government and governance structures within leading organizations and teams in place to build data-sharing initiatives and the fragile nature of public-private partnerships. Many organizations are concerned about how their data will be maintained by other agencies. Cross-sector collaborations can be challenging to develop and sustain unless goals are aligned from the outset. However, relationships between actors in the private and public sectors become incredibly important and require communication and negotiation of procurement processes. Acquiring funding and making the case for costs and return on investment requires effective uses of internal skill sets, particularly when advocating for budget or resource allocation.

Overcoming challenges: opportunities and solutions

While conference participants agreed that barriers to achieving HIE persist, they were generally optimistic that resources and strategies exist to foster successful outcomes. Government incentive programs, regulatory changes, and state/local/private-sector partnerships increasingly support electronic data exchange. For example, Jeanne Ocampo described the flood of interest and innovation generated by the HITECH Act. She also described low-tech strategies for improving communication, including simply streamlining processes through which information gets to outside healthcare providers.

Ahmed Haque, director of the Office of Programs & Engagement at ONC and senior adviser to the CMS Innovation Center, described federal incentives to fund HIT for connecting justice and health systems. He said that the use of interoperable HIT allows providers to make real-time decisions based on shared information, reducing redundancy and saving money. Between 9 and 30 percent of correctional funding is currently directed to health expenses. This focus aligns with CMS priorities to ensure better care, better health for populations, and reduced expenditures. The first component of the federal incentives to fund HIT is the Health Care Innovation Awards (HCIA) program, which focuses on workforce development and training and looks at new models of care and payment. HCIA funds the Transitions Clinic Network, which links high-need Medicaid patients returning from prison to community primary care. Second, the State Innovation Model project provides each recipient state with between \$25 and \$45 million over a four-year period to develop multi-payer healthcare delivery system models. Arizona and Connecticut are using their awards to focus on correctional health, facilitating integration, care coordination, and payment reform.

MARICOPA COUNTY, ARIZONA

Dean Johnson described the strategies and steps that his office used to implement its HIE and how the county has responded:

- > The county selected a vendor that produces EMRs specifically for the correctional environment.
- > Johnson's office has been working with multiple exchange partners. Fourteen vendors or internal departments and entities are interested in the HIE data, affecting costs and data quality and necessitating several exchange methods. This complex interchange involves dealing with 30 to 50 people on a monthly basis, establishing roles for each agency and person and creating communication plans.
- > Disparate leadership in a mix of appointed, elected, and judicial professionals who don't always have similar views and often need resources.
- > Security and privacy concerns often arise, "and the things that people try to pass off as HIPAA-protected are amazing." There is no formalized HIPAA implementation for infrastructure aimed at sharing data between justice and health systems.

Johnson's office has sought to handle this multifaceted information exchange by forming a partnership with Health Information Network of Arizona (HINAZ) to build an interface geared toward providing health services. Maricopa County also created the Health Care Integration Group, bringing together public health, medical, adult probation, human services, and juvenile justice professionals. Three subgroups emerged, dedicated to billing, data sharing (to identify and streamline internal data-sharing opportunities), and enrollment in the ACA. They collaborated with the county's Integrated Criminal Justice Reform System (ICJRS) to assist with technical solutions.

Maricopa County provides a potential model for other jurisdictions looking to manage several groups of stakeholders with diverse kinds of leadership in order to implement a comprehensive HIE.

Resources for finding solutions

JUSTICE AND HEALTH CONNECT

The Bureau of Justice Assistance funded the Justice and Health Connect project in 2013, recognizing the importance of information sharing between these two systems. David Cloud, who managed this project and built the website, described its mission: to educate practitioners and policymakers about the benefits of information sharing, identify common problems, and outline solutions. Cloud emphasized that health and justice systems must realize that despite their different cultures and institutional priorities, their missions overlap significantly. Justice and Health Connect was designed to appeal to both systems in various jurisdictions by focusing on that overlap. The website was developed with the guidance of an advisory board that included leading experts in both health and justice sectors.

The website, www.jhconnect.org, contains interviews and podcasts featuring experts from both fields; literature and policy reviews including white papers and academic literature; and practical tools such as consent forms, examples of information-sharing agreements, and technical guidance on developing information-sharing systems. Papers on topics such as HIPAA and 42 CFR and the epidemiology of health disparities are in the website's resource section.

Cloud also described the JH Connect toolkit, which helps jurisdictions think about information sharing from the ground up. The first module of the toolkit offers guidance on the agencies and stakeholders that need to be brought to the table to design and build support for a new information-sharing initiative. The second module focuses on governance, including policies, MOUs, project charters, privacy agreements, and other templates. The third module deals with privacy and legal and ethical regulations, including universal consent forms. The fourth module features technology, describing the continuum of options for sharing information—from paper-based systems to sophisticated HIT—including meaningful use-certified EHRs.

GLOBAL JUSTICE INFORMATION SHARING

Carl Wicklund provided an overview of the Global Justice Information Sharing Initiative (Global), whose primary mission is to advise the DOJ on justice information sharing and integration initiatives, including a comprehensive technological platform and set of tools to help agencies navigate the legal, technological, and policy considerations of connecting systems. Global has also created a framework for privacy policy, including essential questions for ensuring ethical information sharing.

James Dyche described how to use Global as a resource. Dyche said that the Global model has helped to develop solutions applicable to courts, corrections, law enforcement, information technology, planning, and management

at various levels. For example, the Global Justice & Health Services Task Force created two key business documents that could be used by jurisdictions working to implement HIT. One is a current list of known key data exchanges and the other is a prioritized list of exchanges as defined by the Global Strategic Solutions Working Group. He stressed that the Global model aims to promote trust between systems and partners—an essential prerequisite for information sharing, because neither the justice nor the public health system can have ultimate control of service specifications. Global templates for privacy policies, procurement procedures, and information-sharing processes have helped foster connectivity and data flow between corrections agencies and community stakeholders.

FLORIDA SUPREME COURT'S TASK FORCE ON SUBSTANCE USE AND MENTAL HEALTH

Steven Leifman has overseen the development of an HIT initiative that aims to reduce the fragmentation of Florida's community mental health systems. In his presentation, Leifman described efforts to address the overrepresentation of people with mental illness in the criminal justice system. He said that between eight and 10 new prisons would need to be built to accommodate projected increases in the number of people with mental illness entering the justice system over the next eight years. This overrepresentation often results from a lack of community capacity to treat people with mental health problems.¹¹ An analysis of mental health system use in Miami-Dade County showed that 97 people cost Miami-Dade almost \$13 million in a five-year period.

As a result of the task force's establishment in 2010 and reconstitution in 2012, the county has implemented more than 20 reform initiatives focused on community integration and diversion. By creating a new system of care, developing continuity for the community, and working in a public-private partnership with Otsuka Pharmaceutical and IBM with an investment of \$30 million, the jail census has dropped significantly. Overall recidivism has dropped from 75 percent to 20 percent, and one Florida jail closed last year. The key HIT component of Miami-Dade's initiatives is an electronic management system.

The task force's term has been extended to 2016. Judge Leifman described this system's four goals:

1. It will decrease system fragmentation and support a no-wrong-door approach to providing care. For example, a person who frequently uses the community mental healthcare and correctional health systems can be connected to community health services through criminal justice involvement as opposed to requiring multiple and redundant assessment and referral processes.
2. Treatment protocols and assessments for mental illness will be informed by data collected from multiple sources. All 58 public care providers in the system have agreed upon such an assessment for both mental health and substance abuse, thus increasing continuity and quality of care.

3. This system will create accountability by showing which providers are achieving good outcomes. A board will assess the data collaborative's work in order to protect privacy and security rights.
4. Predictive analytics focused on behavioral health issues will be used to predict a person's risk of decompensation, prior to an arrest or hospitalization. Prevention is the goal of these predictive analytics, which can identify those who are at risk of a psychiatric emergency, send a report to the South Florida Behavioral Health Network, and dispatch a case manager to see them, all before they are rearrested and returned to jail.

Leifman described his group's approach to getting district attorneys and judges to support this new response to behavioral health issues in the justice system. For example, they established a Judge's Leadership Group, which works in consort with the Psychiatric Leadership Group. These groups educate and partner with judges and DAs, overcoming potential opposition to the program. Judge Leifman said that law enforcement re-training has also been an essential component of the initiative, stressing that 21 people have died over the past 10 years at the hands of police who were not trained to handle people with mental illness. Since training and implementation of crisis intervention teams, 10,651 mental health calls were made to police, and only nine arrests were made. Miami-Dade County demonstrates how technical solutions facilitating data sharing can be used both to build support from stakeholders for an initiative and to overcome large-scale systemic problems.

Case study: creating a health ecosystem in Louisville, Kentucky

Linda Mellgren, a senior social science analyst at the U.S. Department of Health and Human Services, led a discussion of a novel approach to information sharing that has been adopted in Louisville, Kentucky. In Louisville, as in other jurisdictions, many people with complex health and social issues have high rates of emergency room use, hospitalization, and justice involvement. Although each jurisdiction is unique, Louisville's experience provides a promising example of planning and implementing the exchange of health data between communities and corrections to respond to this phenomenon of high utilizers—people who cycle through the justice and health systems, using a disproportionate amount of various social-service safety-net resources.

Mellgren conducted the discussion with four leaders of the Louisville project, who described in detail the development, implementation, and sustainability of the HIE they built, which specifically targets high utilizers. The panel included Tom Walton, system director at of KentuckyOne Health Partners, an accountable-care organization; Karyn Hascal, president of The Healing Place,

an addiction treatment facility; Mark Bolton, director of the Louisville Metro Department of Corrections (DOC); and John R. Langefeld, chief medical officer of the Kentucky Cabinet for Health and Family Services at the Department of Medicaid Services. These healthcare, corrections, and governmental agencies and organizations worked together and with the state of Kentucky to create and launch the HIE. According to Walton, the multi-agency approach was a vital component of the program from its inception, “baked into the DNA of the work and community.”

Though Medicaid agencies are not traditionally involved in justice-oriented partnerships, Langefeld said that he recognized the need to deal with high utilizers. Kentucky has made gains in Medicaid services, moving from a state-wide 20 percent uninsured rate to around 11 percent in less than a year. The Kentucky HIE creates connections internally and externally to the major state stakeholders. There are more than 1,000 providers enrolled through the HIE, and as of January 2014, one correctional facility. The HIE is working with SAM-HSA to understand and map unique consent needs of and regulations pertaining to populations with behavioral health issues. With Langefeld, the team identified the local agencies and care providers that need to communicate with one another to increase care coordination, patient-centered care, and the ability to deliver actionable information in real time.

The University of Louisville Hospital conducted a pilot project in which it identified a group of six people who met the criteria of high utilizers. The hospital convened a community-wide complex-treatment planning conference, at which an interdisciplinary team addressed how they could more effectively treat the six people. The teams developed treatment plans for the six and specified what three actions they should take when a practitioner next saw one of these six people. By developing consistent and comprehensive care models, this pilot project reduced the emergency department use and led to better care models.

Walton described how the Louisville team, chaired by the mayor’s director of policy and the executive director of the Metro Criminal Justice Commission, functions. Partnering organizations include the Jefferson Alcohol and Drug Abuse Center, Coalition for the Homeless Administration, the DOC, a residential transition center, and a dozen additional agencies representing a broad spectrum of the community.

The discussion highlighted aspects of the work in Louisville that may be instructive to other jurisdictions:

- Identifying organizations in various fields—such as mental health, supportive housing, criminal justice, substance abuse, medical, and dental services—has led to the creation of a community-wide definition of high utilizers who disproportionately use resources across various systems. A basic cost analysis showed that managing an initial cohort of 24 high utilizers over the course of the pilot project saved \$700,000, much of which was related to the use of supportive housing and decreased emergency services.

Integration is baked into the DNA of the community.

Tom Walton, system director,
KentuckyOne Health Partners

Louisville's engagement with the city's business community helped to build a collaborative focused on solving the challenges presented by super utilizers: those who consume high amounts of healthcare resources across systems.

- > The Louisville team overcame concerns about privacy and consent by developing a shared consent form that allows data to be loaded into a state-wide case-management system called Service Point.
- > Increasing opioid use and overdoses drove Bolton and the DOC to reach out to Karen Hascal and The Healing Place—the only provider of open-access detoxification and recovery beds in the Louisville community.¹² Hascal said that she sees the same community members rotating through her organization's services as through the jail and hospital. The Healing Place wanted to work with DOC, which needed to treat people more efficiently in order to deal with overcrowding.

The Louisville team members explained how they responded to a number of common obstacles to justice and health collaborations:

- > Bolton responded to pushback against using the jail as a venue for Medicaid enrollment by reiterating internally that healthcare costs in corrections institutions were approaching 25 percent of the total budget. Although Medicaid does not cover healthcare costs of people in jail, Bolton persuaded those in the corrections system averse to the program that mitigating those costs by improving the health of people who frequently spend time in jail would allow DOC to use these funds for other purposes.
- > The brainstorming process fostered working relationships based on shared understanding. Hascal mentioned the significant strides on the universal release of information, allowing the most basic information to be shared. She described how, when faced with the daunting task of fixing an entire system, focusing on making it work for one person can lead to better systemic solutions. Universal sharing of basic information is a huge step in this direction, she said. She added that engaging the business community, specifically the health collaborative with representatives of Ford, GE, Anthem, Humana, and major pharmaceutical companies, helps identify new partners interested in addressing the phenomenon of super utilization—the consumption of high amounts of resources across systems by a relatively small number of people—and building new programs such as social impact bonds or systems based on predictive analytics for this population.
- > Corrections professionals welcomed outside agencies into jails and prisons so that they could see the problems firsthand.
- > Because hospital administrators and lawmakers often view people facing reentry as an inconvenience, the DOC informed medical professionals and legislators about corrections environments.

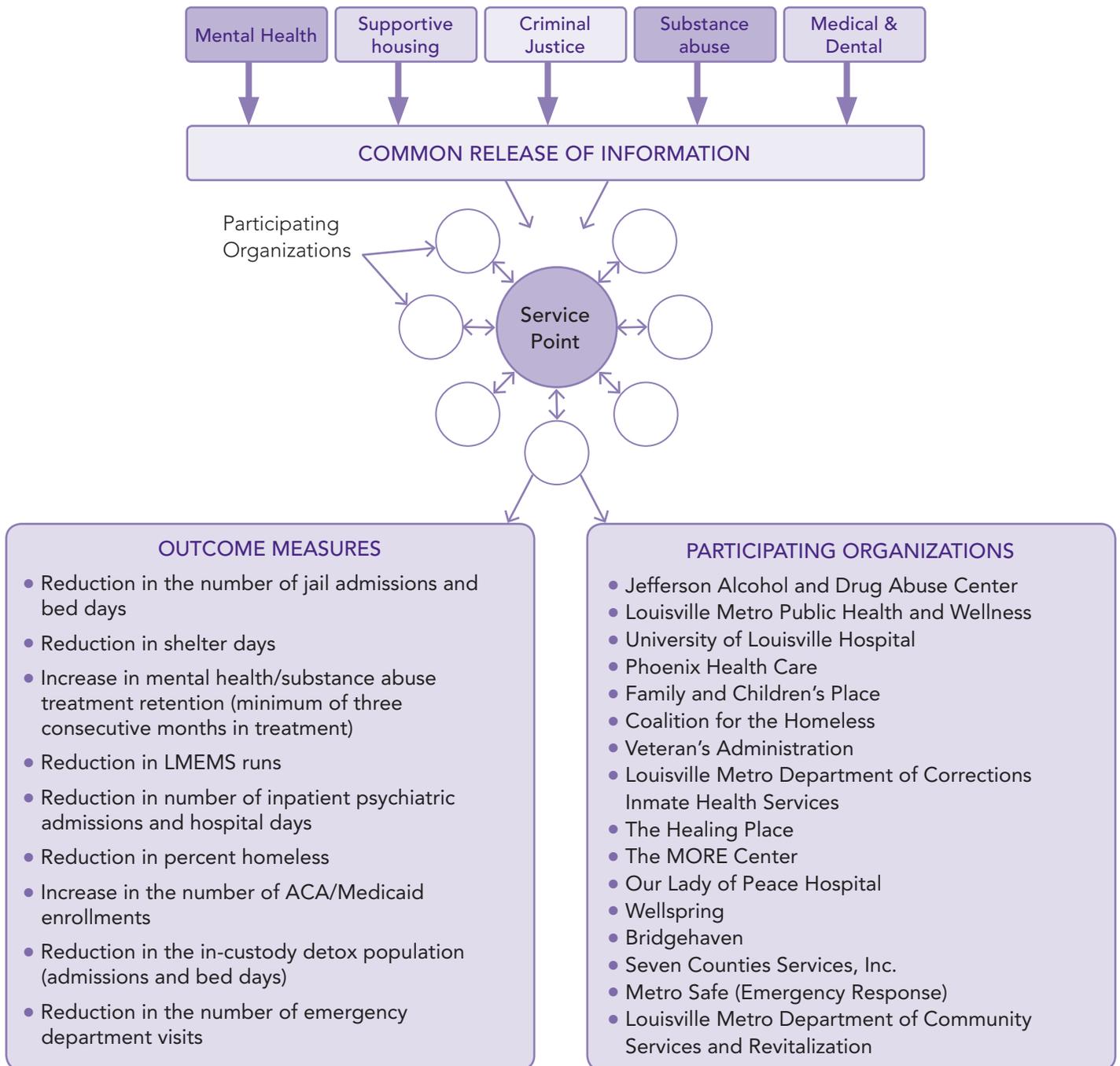
Walton stressed the importance of knowledge dissemination to foster health and benefits literacy. The value of health systems navigators in this public information process is significant, he stressed.

The Louisville example demonstrates that creating effective cross-sectoral

collaborations requires a broadly inclusive approach: an entire health ecosystem, not just healthcare narrowly defined, is at stake. That means including systems such as housing and transportation, as well as the traditional justice and public health systems and actors.

The Louisville Model

Dual Diagnosis Cross-Functional Team
Community Care Management Network



Source: Tom Walton, director of business development, KentuckyOne Health Partners, presentation at “Bridging the Gap: Improving the Health of Justice-Involved Individuals through Information Technology,” September 18, 2014. SAMHSA, Rockville, MD.

Conclusion

...[W]e have an unprecedented opportunity to treat substance abuse, mental health, chronic, and communicable health problems while people are incarcerated and especially upon release. If we do that, if we can deliver the right treatment to the right people at the right time, then we can improve public health, we can improve public safety, and we can save taxpayer dollars. The HIT bridge is a critical part of this opportunity, and this conference couldn't be more timely.

Amy Solomon, senior adviser to the assistant attorney general, Office of Justice Programs, U.S. Department of Justice

As Michael Boticelli said in his keynote address, the ultimate goal of HIT is to divert people away from the criminal justice system while connecting people who are leaving jails and prisons with quality care. The recent progress in reentry services and a new HIT workgroup connecting several federal partners can reduce the current role of jails and prisons as society's de-facto behavioral and mental health institutions. The high prevalence and public visibility of drug overdoses has accelerated these conversations and partnerships between public health and justice systems. Boticelli urged attendees to work toward shifting the national paradigm from substance abuse as a public safety problem necessitating arrest and incarceration to a public health problem requiring care and treatment.

Conference participants raised questions that merit further scrutiny in future conversations about HIT:

- > What happens before people reach the correctional environment?
- > What are the major differences between pre-sentence and post-sentence jail populations?
- > To what extent are judges making treatment decisions without the guidance of healthcare professionals?
- > What are the roles of health literacy and training, as well as access to education and technology, for people who are incarcerated?
- > How do we increase people's access to their own EHRs both while they are inside facilities and post-release?
- > What role do housing professionals and justice reinvestment collaborators have to play in conversations about HIT?

The health of the justice-system-involved population is intertwined with the health and safety of the general population. Connecting healthcare in the criminal justice system to healthcare in the community through the use of HIE, electronic health records, and improved access to insurance preserves the investments jurisdictions make in their justice-involved populations and improves health and safety outcomes for everyone. To expand understanding of the value of information exchange across agencies and organizations, stories with outcomes from specific jurisdictions about bridging public health and public safety, like the many described at this meeting, are vital for other groups to hear.

Resources

Center for Medicare and Medicaid Services (www.cms.gov)

- EHR Incentive Programs and Meaningful Use (www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/)
- CMS Innovation Center (www.innovation.cms.gov/index.html)
- CMS Health Care Innovation Awards (www.innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/) and the State Innovation Models Initiative (www.innovation.cms.gov/initiatives/state-innovations/)

Community Oriented Correctional Health Services: COCHS (www.cochs.org)

FAQ regarding the Substance Abuse Confidentiality Regulations (www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs)

Global Federated Identify and Privilege Management system (www.gfipm.net)

Global Justice Information Sharing Initiative (www.it.ojp.gov/global)

Global Reference Architecture (www.it.ojp.gov/GRA)

IJIS Institute (www.IJIS.org)

Justice and Health Connect (www.jhconnect.org)

Justice and Health Connect HIT toolkit
(www.jhconnect.org/toolkit#module-4-develop-technological-solutions)

National Information Exchange Model (www.NIEM.gov)

National Commission on Correctional Health Care (www.ncchc.org)

SAMHSA (www.samhsa.gov/health-information-technology)

Appendix A

CONFERENCE SPEAKERS AND PANELISTS

Robert Bliese

Project leader information technology and process development, Cook County Jail & Juvenile Detention Center, Cermak Health Services, Illinois

Mark Bolton

Director, Louisville Metro Department of Corrections, Kentucky

Michael Botticelli

Acting director, National Drug Control Policy at the Office of National Drug Control Policy

Ben Butler

Chief information officer, Community Oriented Correctional Health Services, Oakland, California

David Cloud

Senior program associate, Vera Institute of Justice, New York City

James Daniel

Public health coordinator, U.S. Department of Health and Human Services

Jennifer DeCubellis

Assistant county administrator, Hennepin County, Minnesota

James Dyche

Technical services manager, Pennsylvania Justice Network

Richard Fiore

Project sponsor, Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE)

Amy Fish

Administrative special projects coordinator, Arizona Superior Court

Traci Gardner

Director of State Policy, Legal Action Center, New York

Brent Gibson

Vice president of operations, National Commission on Correctional Health Care

Melissa Goldstein

Associate professor, Milken Institute of Public Health, George Washington University

Ahmed Haque

Director, Office of Programs & Engagement, Office of the National Coordinator, U.S. Department of Health and Human Services

Karyn Hascal

President, The Healing Place, Louisville, Kentucky

Larke Huange

Senior advisor, Administrator's Office of Policy Planning, SAMHSA

Dean Johnson

Policy, compliance, and programs director, Maricopa County, Arizona

John R. Langefeld

Chief medical officer, Kentucky Cabinet for Health and Family Services, Department of Medicaid Services

Diane Lapp

Medical director of correctional medicine, deputy chief medical officer, vice president for medical administration, Unity Health Care, Washington, DC

The Honorable Steven Leifman

Florida State Supreme Court's Task Force on Substance Abuse and Mental Health Issues, Mental Health Committee for the 11th Judicial Circuit of Florida

Kimberly Jeffries Leonard

Deputy director of the Center for Substance Abuse Treatment,

Substance Use and Mental Health Services Administration

Michelle Martelle

Associate director of health information, Bureau of Correctional Health Services, New York City Department of Health and Mental Hygiene

Catherine Devaney McKay

Chief executive officer, Connections Community Support Programs, Inc, Delaware

Linda Mellgren

Senior social science analyst, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Thomas Novak

Director of delivery system reform, Office of Programs and Engagement, Office of the National Coordinator, U.S. Department of Health and Human Services

Steven Rosenberg

President, Community Oriented Correctional Health Services, Oakland, California

Amy Solomon

Senior adviser to the assistant attorney general, U.S. Department of Justice

Gladys C. Taylor

Assistant director, Illinois Department of Corrections

Kate Tipping

Public health adviser, SAMHSA

Tom Walton

Director of business development, KentuckyOne Health Partners

Carl Wicklund

Executive director, American Probation and Parole Association

Appendix B

CONFERENCE AGENDA

Bridging the Gap: Improving the Health of Justice-Involved Individuals Through Information Technology

September 17–18, 2014

The Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Rockville, MD 20857

DAY 1

- 8:00–8:30 Registration
- 8:30–8:40 Welcome
- **Kimberly Jeffries Leonard**, PhD, deputy director, Center for Substance Abuse Treatment, SAMHSA
- 8:40–9:15 Keynotes
- **Kimberly Jeffries Leonard**, PhD, deputy director, Center for Substance Abuse Treatment, SAMHSA
 - **Amy Solomon**, senior advisor to the Assistant Attorney General, Office of Justice Programs, DOJ
- 9:15–10:45 Session 1 – **The vision**
- As community providers implement health information technology (HIT) to improve continuity of care, we look at other areas where we could strengthen our data sharing capabilities. In this initial session we will discuss the vision for health data sharing and re-use from behind and beyond the bars of correctional facilities. Key areas we will discuss include:
- > Why information exchange between corrections and the community is critical
 - > How health information technology can make connections between the community and corrections possible
 - **Steve Rosenberg**, president, Community Oriented Correctional Health Services (Moderator)
 - **Tom Novak**, director of delivery system reform, ONC
 - **Michelle Martelle**, associate director of health information, Correctional Health Services, New York City Department of Health and Mental Hygiene
 - **Ben Butler**, chief information officer, Community Oriented Correctional Health Services
- 10:45–11:00 Break
- 11:00–12:30 Session 2 – **From correctional facilities to community providers**
- Keeping the vision in mind, this session focuses on how HIT can make the connection between corrections and the community possible. Through the adoption of HIT, correctional facilities are beginning to electronically collect health data on their inmates which can help community providers in post-release care. Key areas we will discuss include:
- > What are the emerging practices for using technology to provide information from correctional facilities to community providers
 - > What are the emerging practices for using technology to provide information from correctional facilities to other correctional facilities (i.e., jails to prison; intra-prison system transfers)
 - > How are correctional facilities and other providers working together to meet transition of care needs

- **Brent Gibson, MD, MPH, CCHP**, vice president of operations, National Commission on Correctional Health Care (Moderator)
- **Diana Lapp**, family physician, Unity Health Care
- **Gladys C. Taylor**, assistant director, Department of Corrections, State of Illinois
- **Richard Fiore**, project sponsor at Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE), State of Alabama
- **Carl Wicklund**, executive director, American Probation and Parole Association

12:30–1:30 Lunch (available for purchase)

1:30–3:00 Session 3 – **From community providers to correctional facilities**

As people move into the justice system it is important that their health information move with them. Risk avoidance is an important consideration as inmates are assessed for treatment and care needs. Having knowledge of an inmate’s health history allows the facility to understand any emergent medical needs to reduce risk and prevent unnecessary testing and inappropriate medications and treatment. Key areas we will discuss include:

- > What are the emerging practices for using technology to provide information from community providers to the correctional facility
- > How has health information exchange (HIE) played a role in data sharing
- **Larke Huang**, director of the Office of Behavioral Health Equity, SAMHSA (Moderator)
- **Shane Hickey**, director, Health Information Technology Support, National Association of Community Health Centers
- **Amy Fish**, administrative special projects coordinator at Superior Court, Pima County, AZ
- **Jennifer DeCubellis**, assistant county administrator, Hennepin County, MN
- **Catherine Devaney McKay, MC**, president and chief executive officer, Connections Community Support Programs, Inc.

3:00–3:15 Break

3:15–4:45 Session 4 – **Challenges to health information exchange across health systems in the community and in corrections**

There are challenges to achieving meaningful interoperable exchange of health data across disparate systems. This session discusses those challenges and ways of overcoming barriers that exist in both community provider settings as well as in correctional environments. Topics to be discussed include:

- > 42 CFR Part 2
- > Privacy, security, and consent
- > Standards and Architecture
- **Tracie M. Gardner**, co-director of policy, Legal Action Center (Moderator)
- **Kate Tipping**, public health adviser, SAMHSA
- **James Dyche**, information technology manager, Office of Administration Justice Network, State of Pennsylvania
- **Dean Johnson**, policy, compliance, and programs director, Office of the Deputy County Manager, Maricopa County, AZ

4:45–5:00 Day 1 wrap up

DAY 2

- 8:00–8:15 Welcome – SAMHSA
- 8:15–8:45 Day 2 Keynote – Michael Botticelli, acting director of National Drug Control Policy
- 9:00–10:30 Session 5 – **Opportunities to increase health information exchange across community and correctional systems**
- Just as there are barriers to overcome to achieve HIE in both community and correctional settings, there are also resources and strategies that can contribute to the successful exchange of data. These opportunities have been made possible through government incentive programs as well as regulatory changes that increasingly support the interoperable exchange of data. In this session we will discuss:
- > The Patient Protection and Affordable Care Act (ACA)
 - > Vera Institute of Justice’s Justice and Health Connect project
 - > Health Information Technology (i.e.: electronic health records, state/regional health information exchanges)
 - > Funding (i.e.: CMS Innovation Center, HITECH Act)
- **Jim Daniel**, public health coordinator, Office of Provider Adoption Support, ONC (Moderator)
 - **Clare Wrobel**, team lead, State Innovation Models Initiative, CMS Innovation Center, CMS
 - **Jeanne Ocampo**, chief, health information, Federal Bureau of Prisons, FBOP
 - **Robert Bliese**, project leader IT and process management, Cermak Health Services, Cook County Health and Hospital System, IL
 - **David Cloud**, Justice and Health Connect, Vera Institute of Justice
- 10:30–10:45 Break
- 10:45–11:45 Session 6 – **Fitting all of the pieces together – Promoting the exchange of health data between community and corrections**
- In this session of the conference, we will look at how one community, working together with the state, has begun to tie all the pieces together with the goal of creating greater continuity of care for justice involved individuals. Although each community and state is unique, the experiences of Louisville, Kentucky, provide an illustrative roadmap for planning and implementing the exchange of health data between community and corrections.
- **Linda Mellgren**, senior social science analyst, ASPE (Moderator)
 - **Tom Walton**, system director, Healthy Communities and Academic Relations, KentuckyOne Health
 - **Karyn Hascal**, The Healing Place, Louisville, KY
 - **Mark E. Bolton**, director, Louisville Metro Department of Corrections
 - **John Langefeld**, chief medical officer, Kentucky Cabinet for Health and Family Services, Department of Medicaid Services
- 11:45–12:15 Closing Keynote
- **Melissa Goldstein**, associate professor of health policy, Milken Institute School of Public Health, The George Washington University
- 12:15–12:30 Day 2 wrap up and meeting adjournment
- 12:30–1:30 Lunch (available for purchase)

ENDNOTES

- 1 H. J. Steadman and M. Naples, "Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders." *Behavioral Sciences & the Law*, 23(2) (2005): 163–170; Henry Steadman, Fred Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of serious mental illness among jail inmates," *Psychiatric Services* 60, no. 6 (2009): 761–765; Ronald C. Kessler, Christopher B. Nelson, Katherine A. McGonagle, Mark J. Edlund, Richard G. Frank, and Philip J. Leaf, "The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization," *American Journal of Orthopsychiatry* (66)1 (1996): 17-31.
- 2 EHRs are inclusive of patient care more broadly by containing information from all clinicians involved with a patient's care.
- 3 To read more: Benjamin Butler, *Jails and Health Information Technology: A Framework for Creating Connectivity*, (Oakland, CA: Community Oriented Correctional Health Services, 2013).
- 4 For more information, see www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl
- 5 For more information on meaningful use standards, see www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html
- 6 This criterion applies even when the Medicaid-eligible population would be subject to the payment exclusion for inmates of public institutions as provided for in Section 1905(a)(29)(A) of the Social Security Act.
- 7 For more detailed information on NIEM, GFIPM, and GRA, see Resources, page 29.
- 8 Ann Carson and Daniela Golinelli. "Prisoners in 2012." Bureau of Justice Statistics, December (2013): 1.
- 9 Accountable Care Partners includes Hennepin County Medical Center, Human Services and Public Health Department, Metropolitan Health Plan, and the NorthPoint Health and Wellness Center.
- 10 The regulation applies to any federally assisted person or entity that "holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or treatment referral."
- 11 For example, as shown on the Justice and Health Connect website, Paul Wormeli from the IJIS Institute recommends that jurisdictions with limited capacity to build data systems and develop interoperability use Cloud Computing, which stores information on remote servers that can be accessed online. The NIEM model, which can be downloaded from www.niem.gov, also aids in overcoming these technical challenges.
- 12 According to Judge Leifman, Florida's total community mental health budget is \$40 per capita compared to the national average of \$120. He said that Miami-Dade County has the highest prevalence of mental illness of any county in the United States.
- 13 They do not charge fees to clients, are open 24 hours a day, seven days a week, and they will detox anything but benzodiazepines. People using that class of drugs are referred to the University Hospital, where they are stabilized and sent back to The Healing Place.

About the Substance Use and Mental Health Program

There are three times as many people with serious mental illness in jails and prisons than in hospitals, and about two-thirds of people in prison report regular drug use. Justice systems around the country, however, are ill-equipped to provide behavioral health services, and individuals often fail to get the help they need. This has serious implications for people involved in the justice system, their families, and the communities in which they live. SUMH research helps jurisdictions design policies that increase access to treatment, reduce reliance on the criminal justice system as a response to these problems, and improve public safety.

For more information on SUMH's work, please visit www.vera.org/centers/substance-use-and-mental-health-program, or contact Chris Weiss at cweiss@vera.org.

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An electronic version of this report is posted on Vera's website at www.vera.org/bridging-the-gap.

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Vera Institute of Justice
233 Broadway, 12th Floor
New York, NY 10279
Tel: (212) 334-1300
Fax: (212) 941-9407

Washington DC Office
1100 First St. NE, Suite 950
Washington, DC 20002
Tel: (202) 465-8900
Fax: (202) 408-1972

New Orleans Office
546 Carondelet St.
New Orleans, LA 70130
Tel: (504) 593-0937
Fax: (212) 941-9407

Los Angeles Office
707 Wilshire Blvd., Suite 3850
Los Angeles, CA 90017
Tel: (213) 223-2442
Fax: (213) 955-9250

