Leveraging National Health Reform to Reduce Recidivism & Build Recovery:
National Health Care 101 for Criminal Justice

GLATTC Webinar

September 7, 2011

The TASC Perspective

- Nearly 35 years of research, public policy involvement and direct service provision
- TASC serves more than 20,000 justice-involved individuals annually with substance use, mental illness, or both
- Designed and managed numerous programs connecting criminal justice with community-based care:
  - Statutory authority / state licensure around clinical case management for drug-involved probation and parole populations
  - Court advocacy and case coordination for specialty courts
  - Design and implementation of Cook County Jail treatment and re-entry program
- TASC participates extensively in national and state planning on health care reform and for people under criminal justice supervision

Goals of the Webinar

- Overview of the current challenges providing sa/mh services for justice populations
- Discuss how the Patient Protection and Affordable Care Act (ACA) can apply evidence-based practices and expand services for justice populations
- Recommendations for planning that should be happening ***NOW***
- Examines the financial and practical implications of health care reform for the criminal justice system
- Discussion / Q&A
- Additional resources

What is the Affordable Care Act?

Law enacted in March 2010 to:

- **Expand access to under-served populations**
- **Improve outcomes**
- **Maximize efficiency of public health expenditures**

What is the Affordable Care Act?

- We're focusing on one aspect:
  - **Expansion of access to care for low-income populations regardless of disability**
- Expansion shifts planning from program-level to system-level, linking criminal justice and community behavioral health

What is the Affordable Care Act?

- Status of Implementation
  - Federal and state govts currently in planning process, implementing early phases (e.g. pre-existing condition provisions)
  - Building health insurance exchanges, enrollment procedures
  - Federal "essential benefit" plan expected within the next year
  - Medicaid expansion takes effect January 1, 2014

Substance Use Disorders Are Nearly Universal in CJS

- Criminal justice populations include people who are addicted to drugs and/or alcohol as well as people who abuse and misuse these substances.
  - More than 70% of jail inmates test positive for drugs
  - 47.9% of state prison inmates and 43.7% of local jail inmates met criteria for substance dependence
    - This is over 7 times greater than in the general population.
  - Most of the remaining group demonstrate significant substance abuse that have serious consequences, including legal consequences
- Result of untreated substance use disorders
- Incredibly expensive especially to states and counties

Source: CASA, "Behind Bars II", February 2010; DOJ ADAM Report, Adams, Olson & Adams,, 2002

Other Chronic Conditions More Widespread Than In General Population

- Much higher rates of serious mental illness
  - **Over 10%**
- Higher rates of chronic medical conditions
  - **Diabetes, Heart Disease, Asthma, Cancer, HIV**
- <u>About 10% have insurance</u>
  - **Medicaid/disability, All Kids, Family Care**
  - **Private insurance**

Scope of the Challenge - Snapshot: Jails in Illinois

- Jail bookings (2008): 366,923
- Two-thirds report using drugs regularly (~241,000)
- 14.5% (~53,000) have psychiatric disorders
- Of those, 72% (~38,000) have co-occurring disorder
- Highly variable lengths of stay
- Difficult to coordinate care around case processing
- Little-to-no post-release care
- High likelihood of return if clinical needs aren’t addressed

Scope of the Challenge: Probation

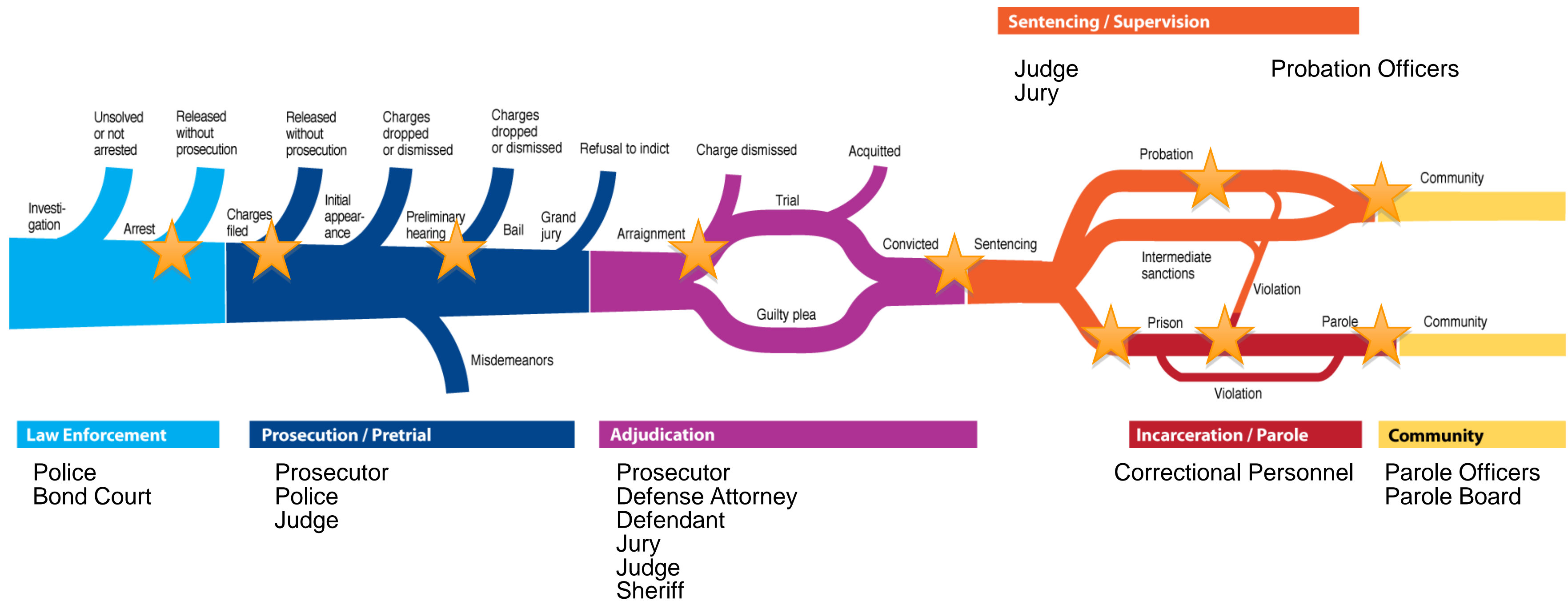
- Illinois (2009): 97,241
- Indiana (2009): 130,178
- Michigan (2009): 175,421
- Ohio(2009): 260,577
  - Special probation supervision, specialty courts, individual officer referrals

Scope of the Challenge: Parole

- Illinois (2009): 33,683
- Indiana (2009): 10,653
- Michigan (2009): 22,523
- Ohio (2009): 19,119
  - Special parole supervision initiatives, individual officer referrals
  - Recent Ohio initiative; Illinois Sheridan CC

Current Challenges in Providing and Funding Health Care Services for Justice Populations

Continuum of Interventions



Continuum of risk / need

	High Risk	Low Risk
High Needs	Accountability, Treatment & Habilitation	Treatment & Habilitation
Low Needs	Accountability & Habilitation	Prevention

Douglas B. Marlowe, J.D., Ph.D.

What is treatment?

- Evidence-based
- Behavioral therapies:
  - Counseling
  - Cognitive therapies
  - Psychotherapy
- Physician-prescribed medications
- Combination of one or more therapies
- Step-up / Step-down based on progress

Under current justice and health care structures…

- Multiple and interconnected barriers to providing coordinated and effective health care
- Especially pronounced with substance use and psychiatric disorders
- Specific challenges include:
  - Divergent system goals
  - Insufficient or fragmented funding
  - Lack of health insurance coverage
  - Insufficient or inadequate care
  - Lack of coordination

Divergent goals…

- Justice: Public safety and reduce recidivism
- Health Care: Protect or improve individual and community health
- Mutual objective of cost containment
- Justice systems not designed as providers of healthcare, but often obliged to assume that role
- Case precedents and constitutional safeguards compel a level of care within institutions

Insufficient/inadequate treatment…

- Demand for community-based treatment in most states exceeds availability
- Justice-based treatment programs rarely reach all individuals who are legal eligible (or legally entitled)
- Lack of resources to expand successful models

Fragmented funding streams…

- Public sa/mh supported largely by federal block grants & categorical Medicaid eligibility (MH)
- Federal Justice and Human Services funding streams / initiatives
- State and County-level funding
- Pursuit of non-block grant funding requires long RFA processes for only incremental increases
- Uncoordinated funding creates isolated pockets of service, not seamless continuums of care

Inadequate and truncated care…

- SA/MH are chronic – require ongoing, long-term treatment and management
  - At least 3 months in treatment to stop or curtail use
  - Durable recovery requires multiple episodes of care over many years
- Acute care treatment in justice settings can't address chronic conditions

Lack of insurance…

- Most people in justice systems don’t have health insurance
  - Only 10% of jail inmates
- State Medicaid rules may exclude most childless adults
- Those with Medicaid may get unnecessarily dropped while incarcerated
- Once released, little assistance reinstating benefits

Lack of capacity / recovery focus…

- Resistance to community-based services
- Lack of systems linkage between treatment, vocational, housing, educational services
- Lack of coordination between criminal justice and mental health systems
- Lack of capacity to engage families and other recovery allies

Lack of resources in rural areas…

- Rural jails/corrections have become default setting for health and social services that are absent in the community
- Health care in rural settings limited to screenings, medications management and crisis response
- Fewer pre-trial or post-release treatment programs
  - **In 2004, 91% of substance abuse treatment facilities were in or near a metro county**

Lack of resources in rural areas…

- As a result, behavioral health care falls largely on primary care providers
  - Few offer mental health services, and if they do, it's usually for less serious conditions (depression, anxiety, hyperactivity, etc.)
- Clients have to travel significant distances for services

The promise of health care reform

- Won't solve all challenges, but…
- Unique opportunity for significant change on a broad scale
  - Near universal coverage
  - Eliminate long waiting lists
  - Address gaps in services
  - Ending piecemeal approach to application of public funding

Preparing for 2014 Health Care Reforms: Applying What Works

Evidence-Based Practices (EBPs)

- Federal agencies articulate EBPs for service delivery to justice populations with SA/MH conditions:
  - NIDA – "Principles of Drug Abuse Treatment for Criminal Justice Populations"
  - SAMHSA – "Treatment Improvement Protocol 44: Substance Abuse Treatment for Adults in the Criminal Justice System (TIP 44)"
  - SAMHSA – National Registry of Evidence-based Programs and Practices (NREPP)
  - SAMHSA / GAINS Center – Six EBPs for mental health treatment in justice settings
  - NIC – EBPs to reduce recidivism
  - NIC – Guidelines for implementing EBPs in policy and practice in community corrections

EBPs Evolve

- New evidence, new conditions, new priorities:
  - E.g. Trauma-informed care
    - Childhood trauma common in justice population
    - Half of women in jail report past physical or sexual abuse
    - Trauma associated with high rates of psychiatric and substance use disorders
    - Un-addressed trauma can impede treatment and recovery
  - Trauma-informed care now one of SAMHSA's cross-cutting policy and program principles

Applying EBPs

- Align EBP with target population:
  - Phase of justice involvement
  - Behavioral need
  - Criminogenic risk
- Align EBP with goals
  - Reduction of costs
  - Corrections supervision
  - Improved clinical diagnosis
  - Stable, durable recovery
- Align EBP with system capacity and design
  - Don’t assume what works in one setting will work in another

The ACA and Cost Reduction

- Broad expansion of funding / eligibility in 2014
- More opportunities for diversion and intervention at each point in justice process
- Jurisdictions work with community providers to expand access to SA/MH services
- Bring to scale programs that are already in place
- Incorporate proven models (EBPs)

The ACA and Cost Reduction

- Expanded capacity as happened in 12 states that have already expanded Medicaid coverage
  - WA State results: 33% reduction in arrests after treatment WITHOUT CJS LEVERAGE

1. Specific Opportunities for Sheriffs/Jail Administrators:

- Reduce “frequent fliers” due to untreated substance use and psychiatric disorders
- Reduce jail health care expenditures related to chronic conditions
- Potential opportunity: Reduce incarceration through increased diversion to treatment with pre-trial/probation supervision

Potential Impact of Broad Reentry Programs

- Hypothetical county jail
  - **500 beds – 13,000 detainees/yr (ALOS 2 weeks)**
  - **Two-thirds (8,580) report using drugs regularly**
  - **Current capacity to only treat several hundred per year**
  - **14.5% (1,885) have psychiatric disorders, will benefit from treatment in jail or community**
- Even moderate reduction in detainees could result in significant cost savings.
  - **A 10% reduction in jail days would yield over $1M in savings annually**

What is needed to gain these results?

- Enrollment in Medicaid/Insurance during incarceration
- Universal screening
  - **Substance use & psychiatric disorders, chronic medical conditions**
- Matching to appropriate services
  - **Substance abuse treatment**
  - **Mental health treatment**
  - **Community medical care for chronic conditions**

2. Specific Opportunity for Probation:

- Reduce probation violations due to untreated substance use and psychiatric disorders
- Gain these results across all probationers, not just in smaller “demonstration” programs and specialty courts
- For specialty courts:
  - **Better access to timely treatment**
  - **Opportunity to focus on high risk/high need probationers**

What is needed to gain these results?

- Timely enrollment in Medicaid/Insurance
- Universal screening early in the CJS process
- Matching to appropriate services
  - **Drug Education**
  - **Outpatient, Intensive Outpatient, Residential Treatment**
  - **Expanded capacity will be needed**
- Universal reporting and sanctions process
  - **Must avoid net widening**

3. Specific Opportunity for Parole:

- Develop reentry services for parolees who have had treatment inside correctional centers
  - **Research shows that pre- and post-release treatment together have the greatest impact**
- Reduce parole violations due to untreated substance use and psychiatric disorders
  - **Increased access to community based treatment as an alternative to re-incarceration**
- Gain these results across all parolees, not just in smaller "demonstration" programs
  - **Universal access to sa/mh services on release**

What is needed to gain these results?

- Timely enrollment in Medicaid/Insurance
- Universal screening early in the CJS process
- Matching to appropriate services
  - **Drug Education**
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What Will Change: Benefits and Impact of Health Care Reform for Justice Populations

Change #1: Funding & Billing Mechanisms

- Medicaid funding rules will govern how SA/MH is structured, reviewed and approved
- State Medicaid authority – primary funder and overseer
- Providers must implement Medicaid-compatible, fee-for-service billing structures
- Medicaid certification requirements
- Electronic health records

Change #1: Funding & Billing Mechanisms

- Providers receiving block grant may be required to shift funding sources
- State may use block grant for “non-medical” services (e.g. recovery homes, recovery support, trauma-informed care) or may be substantially reduced

Change #2: Reimbursement Based on Necessity

- Medicaid billing requires authorization based on medical necessity
- Each state Medicaid authority puts in place processes for "medical necessity" determination
  - **Medicaid managed care**
- SA/MH providers will need to understand Medicaid provisions
  - **Ensure categorization of SA/MH as necessary**

Change #2: Reimbursement Based on Necessity

- "Medically necessary" in justice context:
  - Incarceration suppresses use
  - Substance dependence is chronic – symptoms may disappear temporarily – likely to reappear
  - Disconnect with how medical necessity is traditionally determined
  - Clinical treatment still necessary to manage illness and build recovery

Change #3: Increased Demand

- Potentially dramatic increase in number of patients requiring SA/MH services.
- NASADAD review of utilization expansion:
  - **+20% in Massachusetts**

    (had low uninsured population prior to their coverage expansion)
  - **+32% in Maine**
  - **+100% in Vermont**
- Need to build community treatment capacity

Change #4: Supply of services will shift

- Supply of services dictated by what will be covered by Medicaid
- Depth of care may be reduced
  - Residential treatment less available
  - Reorganize away from acute care and toward long-term recovery support
    - Recovery Oriented Systems of Care
- Less expensive services may expand:
  - E.g. Brief interventions; outpatient; day treatment; medication-assisted treatment

Change #5: Integration of SA/MH with Primary Care

- Integration of specialized care with primary care is a priority under ACA
  - **Improve access**
  - **More coordinated care**
  - **Fewer acute care episodes**
- Collaboration and partnership will be expected
  - **Federally-qualified health centers**
  - **Community health teams**
  - **Home health care providers**
  - **New referral networks**

Change #5: Integration of SA/MH with Primary Care

- Planning efforts focus on practical systems changes that facilitate access to a continuity of care
  - Transfer of prescriptions b/w corrections and community
  - Integrating electronic health records
  - Increasing public health education
  - Centralized care facilities offering SA/MH alongside primary care

Change #6: New workforce issues

- Workforce issues in ACA oriented around primary care access and medical homes, not specialty care
- Providers required to employ staff who meet Medicaid-defined professional standards.
- Shortages of credentialed clinicians must be addressed
- Staff trained how to operate in Medicaid environment:
  - **Language / terminology**
  - **Billing**
  - **Use of technology (e.g. telemedicine)**

Increased Opportunities for Justice Interventions that Combine Supervision with Clinical Care

Opportunity #1: Earlier interventions / sustained services

- Broad-based screening will identify larger pool of individuals in need of services
- Screen all individuals coming into justice system provides opportunity to intervene before condition becomes chronic
- Overall expansion of resources for SA/MH services should expand access and promote adoption of EBPs

Opportunity #2: Implement protocols for screening

- Justice system will need to employ screening tools to determine eligibility for covered services
- Can / should be done at intake to assess clinical need and criminogenic risk
- Tools may already exist:
  - SAMHSA TIP 44
  - Texas Christian University Drug Screen
  - National GAINS Center
  - SBIRT Model
- Early screening also informs participation in treatment alternatives

Opportunity #3: Justice system as Medicaid enrollment partner

- Identify and respond to barriers to enrollment
  - **Lack of identification and documentation**
  - **Substance use and psychiatric disorders may interfere with ability to make healthful choices**
  - **Unfamiliarity with procedures and processes**
- State Medicaid directors play a critical role in establishing procedures

Opportunity #3: Justice system as Medicaid enrollment partner

- Kaiser Family Foundation Survey
  - **Lack of awareness among newly eligible**
  - **Difficulty communicating through conventional strategies**
  - **Failure to complete forms**
  - **Periodic incarceration / cessation of eligibility**
- Justice system can be an active partner in enrollment
- Development of electronic enrollment records must be explored
  - **Identify potentially eligible detainees**
  - **Automatically enroll / leave jail/prison with valid Medicaid card**

Opportunity #4: Balance clinical intervention and public safety

- At each point in the CJS (jail, probation, parole):
  - **Develop legal eligibility criteria**
  - **Develop community supervision requirements**
  - **Both of above inform scale and scope and likely population**
  - **Employ validated risk assessment tools**
  - **NIC EBPs for community corrections**

Opportunity #5: Patient choice in justice settings

- Patient choice of providers is a condition of Medicaid
- Justice system can have processes in place to recommend levels of care, but…
- Client will have access to a network of approved providers
- Similar process used in Access to Recovery initiative
- Justice practitioners and community providers need to collaborate to develop the network

Need to avoid net-widening

- “Net-widening” – expansion of intervention program actually leads to increased numbers in the justice system:
  - More technical violations
  - Lower risk offenders placed into more intensive supervision to ensure access to care
  - Medicaid may recommend less-intensive levels of care, judges may be reluctant and impose harsher sentences
- Criminal justice partners need to be involved in planning for ACA expansion

Leveraging ACA and Justice Mandates to Increase Recovery

Take a Systems Approach

- Incorporate essential elements of recovery
- Balance sanctions and rewards of justice system
- Promote client recovery from SA/MH conditions
- Involve the community where offenders come from / will be returning to

Components of Care Continuity for Justice Populations

- Screening for SA/MH and medical needs
- Comprehensive clinical assessment leading to course of care
- Placement in community SA/MH services and with medical care provider
- Ongoing care management to support engagement and retention in services
- Ongoing care management to facilitate access to recovery support services
- Regular reporting on compliance and progress (including drug testing)

Infrastructure for coordinated care

- Recovery-focused continuity of care
- Follow individuals from institution to community
- Shift framework from acute episodic treatment to sustainable chronic disease management
- Support long-term, durable recovery, not just cessation of use

Community recovery capacity

- Recovery happens in context of community, where people live, work and engage in relationships
- Communities must have capacity to support ability to live in healthful ways
- Based on systems partnerships involving justice practitioners, community providers, recovery support services, and peer support

Realizing the Potential of ACA Reforms: A Call to Action for Stakeholders

Behavioral Health and Medical Care Providers:

- Expand treatment capacity
- Integrate primary care and specialty care
- Integrate community services with justice-based services
- Expand capacity to enroll clients in Medicaid/insurance
- Improve treatment through use of EBPs
- Cultivate new partnerships with other stakeholders

County Government Officials:

- Maximize diversion and re-entry initiatives
- Minimize costs and risk of litigation
- Assess potential benefits and risks
- Convene planning processes to develop local action plans
- Investigate reallocation of funding from county corrections to community health services

State Medicaid Directors:

- Collaborate with criminal justice, medical & behavioral health care providers to reduce barriers to coverage for Medicaid-eligible population
  - **Expedite enrollment from jails & prisons**
- Facilitate strategic planning of capacity expansion
  - **Special attention to rural / underserved communities**

State Insurance Directors:

- Collaborate with health care providers to reduce barriers to coverage for insurance-eligible population through exchanges
- Address integration of this population in managed care

Jail / Corrections / Probation / Parole Officials:

- Partner in systems integration efforts that provide continuity of care between community and justice settings and support practices to reduce recidivism
- Maximize Medicaid/insurance enrollment among justice population
- Partner in diversion initiatives / community treatment alternatives

Judges:

- Partner with correctional and community / behavioral health care providers and funders to bring diversion and re-entry initiatives to scale
- Represent the concerns of public safety and behavioral health intervention from criminal justice perspective
- Advocate for treatment resources needed to reduce recidivism

resources

COCHS Conference Papers

http://www.cochs.org/health_reform_conference_dc/papers

SAMHSA Presentation on HCR from the treatment provider/system perspective

http://www.saasniatx.net/Presentation/2011/HCRforProviders-NIATX-Julyl2011-RitaVandivort.pdf

Council for State Governments FAQ on HCR

http://consensusproject.org/announcements/new-csg-justice-center-faq-on-health-reform-legislation

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