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Correctional Health Services

Reentry Planning During COVID
Presentation for the Board of Correction

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Core Tenets of CHS Reentry Services

Center Patient Autonomy

Focus on Continuity of Health Care

Be Resourceful and Flexible

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Centering Patient Autonomy

- All services are completely voluntary
- Respect patients' right to refuse services
- Refusal of services doesn't preclude future offers or availability
- Consents are obtained prior to sharing information

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Continuity of Care

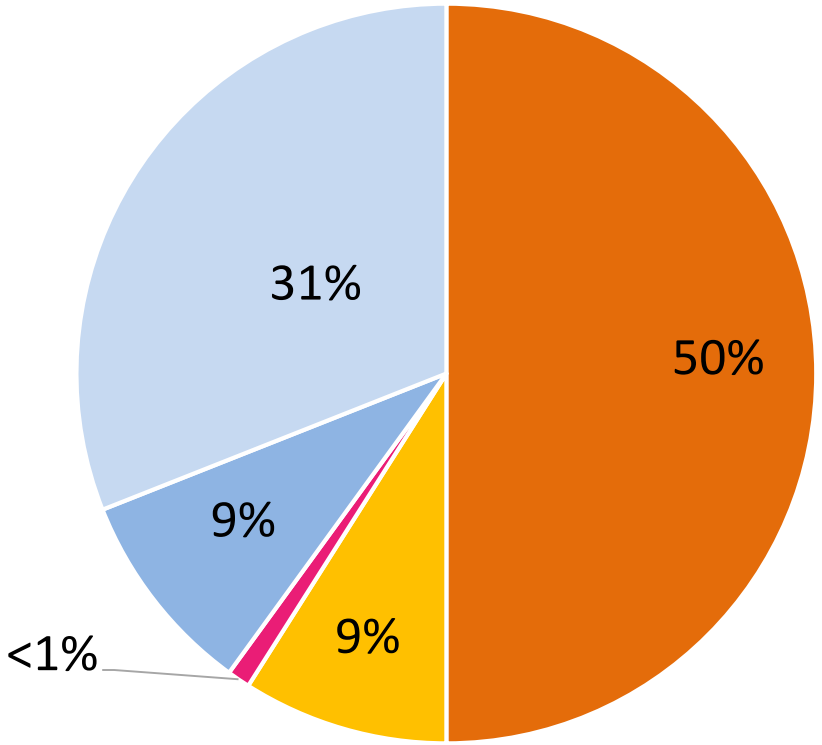
92% Of patients received core services, focused on ensuring access to care post-release

- Health insurance
- Medication
- Link to community health care

50% Of patients qualified for and received personalized discharge planning services (available to patients based on specific clinical criteria)

All figures provided throughout this presentation are based on data from calendar year 2020, unless otherwise specified.

Medicaid



- Existing Medicaid Coverage
- New Application by CHS
- New Application by CRAN
- Discharged within 48 Hours without Medicaid Coverage (Includes those with Unknown/Other Source of Coverage)
- No Medicaid Coverage (Other Source of Coverage, Refused Application, Unknown)

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Medicaid Continued

- Reactivation of coverage upon release is an automated process overseen by the State
  - CHS is in regular communication with HRA and NYSDoH about how to improve and expedite this process
- CHS' PORTline is available to assist with requests for manual reinstatement
  - Requested reactivation for **91** patients in 2020
- The Point of Reentry & Transition (PORT) Clinics and the Community Reentry Assistance Network (CRAN) are available to complete Medicaid applications post-release
- MOUs with HRA's Public Engagement Unit and MetroPlus support post-release outreach for Medicaid enrollment and recertification

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Medication

Implemented a discharge notification process to have patients produced to clinic

"Walking medications" were provided to **1,557** patients

Prescriptions sent to community pharmacies for **2,851** patients

1,016 Patients referred to community Opioid Treatment Programs (OTPs) for Methadone

Medication Continued

- PORTline made **448** calls to follow up with patients about their prescriptions and offer services.
- PORTline is available to assist with rerouting scripts. **161** Patients called for assistance.
- CHS provides Medication Grant Program (MGP) cards to eligible patients. **296** Patients were provided cards.
- CRAN is available as payer of last resort; covered cost of medication for **37** clients.

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Connection to Community Health Care

- PORT Clinics are available to all patients
  - Same day availability
  - Peer support
  - Staffed by CHS providers
  - Located at Bellevue and Kings County Hospitals
  - Primary care, connections to specialists (including BH)
  - 110 unique pts seen in 2020, 284 visits

- CRAN and PORTline are available to assist with identifying providers and making appointments post-release

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Connection to Community Health Care

- Patients who receive personalized discharge planning services are provided with referrals for care and assistance scheduling appointments
- Facilitate placements into residential treatment
- Actively collaborating with H+H to better facilitate transitions into community care (including behavioral health)

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Care Coordination & Case Management

- CRAN
  - Community Transitional Case Management
  - Assistance Network Services **(now available to all patients)**
- Partner Agencies and & Organizations
  - DOHMH
    - SPOA Applications
    - Hep C Navigators
  - Fortune Society
  - Health Home Care Coordination
  - Osborne Association (Elder Reentry Program)
  - Exodus

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Assistance Meeting Basic Needs

Food

Income

Shelter

IDs and Other Needs

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Need for Resourcefulness & Adaptability

- Unknown discharge dates
- Limited community contact information
- Homelessness/unstably housed

COVID Specific:

- Significant number of releases at one time
- Changing service landscape in the community
- Patients often rely on social networks which may be less accessible

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Advocating for Release

2,947 Letters sent to Defense Agencies supporting release on basis of clinical risk

1,709 Patients received Court Advocacy Services
(this includes support pursuing diversion placements)

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Successful Reentry

89%

Of patients released with a CHS discharge plan avoid reincarceration

Within a 3 month period, based on analysis of all those discharged to community between 1.120 and 10.31.20

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Supporting Patients in Need of Isolation Post-Release

- All patients produced by DOC are screened at discharge
- Isolation hotels are arranged for anyone who reports being unable to isolate in the community and is COVID + at the time of discharge, or reports new symptoms at time of discharge
- Arranged isolation hotels for 40+ patients

Figure includes January 2021

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Making Patients Aware of their Status

- CHS attempts to contact all patients who have a positive PCR test result returned post-release
- Patients are connected to a CHS doctor for disclosure of results and offered isolation accommodation and services (via PORT)
- All cases are reported to DOHMH and Test and Trace for follow up
- Patients can also call PORTline for test results

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Providing Information about Community Testing & Vaccination

- PORTline is available to provide information about community testing and vaccination sites

- PORT outreaches patients who have been discharged prior to receiving the second vaccine dose and makes arrangements for them to receive it

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To all those serving our patients, we are grateful and appreciate the opportunity to collaborate with you. Please feel free to reach out with questions or concerns:

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