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Two Model Practices for Correctional Healthcare: a conversation about Connecticut's Offender Reentry Program, uniform release of information consent, and pharmacy voucher programs with Dr. Robert Trestman

This summary is based on a conversation between Jim Parsons, director of the Justice and Health Connect Initiative at the Vera Institute of Justice, and Dr. Robert Trestman, executive director of Correctional Managed Health Care at the University of Connecticut Health Center. Dr. Trestman is a board-certified psychiatrist who has worked as the clinical chief of psychiatry at Mt. Sinai in New York and at the University of Connecticut's health center. From 1999 to 2002, he served as the director of mental health for all jails and prisons in Connecticut. Since April 2007, he has served as the executive director of Correctional Managed Healthcare, overseeing approximately 800 staff deployed throughout the jails and prisons in Connecticut, and managing a budget of close to $90 million dollars a year. Not only does he oversee care delivery within the correctional system, but he also interfaces with legislative and other relevant branches of state government, including but not limited to: the Department of Social Services (DSS: the Medicaid office), the Department of Mental Health and Addiction Services, and the Office of Policy and Management.

Jim Parsons: Please tell us about your experience working to improve coordination between the health and justice sectors. Are there any notable practices or opportunities evolving in Connecticut that use information sharing to improve the coordination of services?

Dr. Robert Trestman: Connecticut's Correctional Managed Health Care has been working for years with the Department of Mental Health and Addiction Services (DMHAS), both on the front-end as DMHAS clients become incarcerated and on the back-end preparing for discharge back to the community. Even going back to 1999 when I first came to work for the correctional healthcare program, we were already working with DMHAS, and our partnership has only grown over the years. Since 2005, we've worked closely with DMHAS on the Connecticut Offender Reentry Program, which has become a standard of practice. This program links anyone who is a DMHAS client and incarcerated to DMHAS services a full year prior to discharge back to the community. Using databases, staff at Correctional Managed Health Care identify DMHAS clients who are going to be eligible and enroll them in this program, so that they receive enhanced psychotherapeutic care and work directly with DMHAS clinicians who come to the Department of Correction for a year prior to discharge in order to ensure that DMHAS is prepared for the client when they are discharged and post-discharge care is properly coordinated. This has been a major program for us and has produced positive results, including substantial reduction in the reincarceration rates of people involved in the program, as demonstrated in a study that was published last year.

JP: Does the Connecticut Offender Reentry Program involve any actual exchange of information or is it more about coordinating services?

RT: Both information exchange and service coordination elements are in place. During intake to the correctional facility, we try to identify whether or not the individual is a DMHAS client, and on a monthly basis, we have a meeting with DMHAS during which we exchange information. To facilitate these processes, we have developed a comprehensive release of information form that spans all of the state agencies and allows information sharing across boundaries. Although it was possible to share information prior to developing these releases, they have drastically improved efficiency. Now, instead of using multiple different releases of information, we just have a single document. This is particularly important when we are working with emerging adults who have records in the Department of Children and Families; the Court Support Services Division of the Justice Branch that runs the juvenile detention programs; the Medicaid PSS service delivery; DOC; and, as they age out of the juvenile system, new records with the DMHAS. We can now get one release of information signed and use that across the board to coordinate all of these different elements and try to make someone's life experiences more coherent.

JP: What is the process for requesting information from all these different systems? And how does this new system change the experience of the person entering the system?

RT: When someone first enters a jail facility, we have them sign the initial release of information that is accepted by a number of agencies. We then send the release of information electronically to each of these agencies, which prompts the agencies to send us necessary information. At that point, if the individual is moved from that facility, we can make sure this information follows him and is made accessible to the appropriate people there, including psychologists, social workers, etc. Included in the information we gather would be any prior criminal record, including juvenile detention; information about foster care placements; and information about prior behavioral health treatments both in treatment facilities and during any prior incarcerations. With all of this information we can work to optimize current treatment and coordinate for reentry. I really think that this process has made improvements all along the criminal justice continuum—from helping us advocate for alternatives to incarceration programs when the case is first brought to court to improving provision of services upon intake to the correctional facility to ensuring continuity of care when individuals return to their communities.

JP: How did the development of consents and technology relate to one another? In some cases technology moves ahead of the consent issues, and sometimes it's the other way around. It sounds like Connecticut had the legal ability to share information prior to the development of a full capacity for agencies to actually communicate information in an automated way. Is that true?

RT: The first step really was the joint release of information, and we are now working on meaningful electronic health information sharing. The Department of Children and Families still uses some paper records and, last time I checked, has about 80 different electronic databases, most of which do not interface with each other. As you can see, the system is very fragmented, so the first steps were really driven by the need to simplify getting information, even if it was no more high-tech than just sending inter-agency faxes. A meaningful electronic sharing program is

still a slow work in progress. Over the past months, DMHAS has been approved to purchase an electronic health record (EHR). They are now negotiating a contract with a vendor. We continue to negotiate with the Office of Policy and Management to be able to purchase an EHR for our use within the DOC. Although we're beginning the process now, it will still be years before it is implemented in either DMHAS or DOC.

JP: Changing gears a little bit, I am hoping you can tell us about the pharmacy program that you implemented in Connecticut.

RT: Conversations about the pharmacy program began in 2007, but it was not implemented until early 2011. Prior to the implementation of the pharmacy program, when an individual on medication left the DOC to return to the community, they were given a brown bag with two weeks' worth of medication in it. There were multiple problems with this, including that many people could not be seen by a clinician within two weeks, especially for individuals with mental health concerns, so there was a very clear need for a better system.

It took years of haggling by DMHSAS, DSS Medicaid experts, and even stakeholders from the courts to figure out exactly how the pharmacy program would work and convince the Office of Policy and Management to make it happen. But finally, in the last few years, a system was developed that ensures that, upon discharge, anyone who received general medical or psychiatric care from DOC or the courts while incarcerated, un-sentenced or sentenced, is enrolled into this pharmacy voucher program. Most individuals who utilize the program are enrolled in the weeks prior to discharge from the correctional facility. Sometimes, however, the courts end up filling out the vouchers when someone is released directly from the court without our prior knowledge. At the point that someone who has been enrolled into this program leaves the facility, he or she is given a piece of paper, which we call a voucher that explains to a pharmacist that the individual received medical care while incarcerated. The voucher also lists a phone number that the pharmacist can call to verify what medication the individual needs. This voucher can be taken to any pharmacy in the state of Connecticut that has a contract with Medicaid, which is essentially every pharmacy in the state. The pharmacists can then call our pharmacy, which is open 24/7 to have them send, either by fax or by phone, a list of all the prescriptions the individual is on. The individual is then given a full month of medication by that pharmacy, half of which is paid for out of the correctional healthcare budget and the other half of which is paid for by Medicaid. Sometimes individuals enter the system who are not already enrolled in Medicaid. In those cases, our staff liaises with staff at DSS who are responsible for Medicaid enrollment, and we try to help the inmate fill out necessary paperwork to expedite their enrollment process.

JP: What kind of privacy protections have been put in place in order to facilitate information sharing with DSS for Medicaid enrollment and pharmacies?

RT: Information sharing with the DSS is covered in the global release. However, information sharing with the pharmacies is not because pharmacies aren't a state agency, so we need individuals enrolled in the pharmacy program to sign a separate release of information which allows the pharmacy to notify DOC that the individual has tried to pick up medication and for DOC to release necessary medical information to the pharmacy. As more of this work is done electronically, the state had to purchase a secure e-mail system, so we now have an inter-

agency secure email protocol that enables us to share protected health information across agency boundaries. If someone, like the pharmacies, who needs to share information with us isn't affiliated with a state agency and doesn't have the same e-mail software, they can still log into the secure e-mail site.

JP: Do you have a sense of how widespread use of the pharmacy currently is?

RT: It has been difficult to determine and the numbers change each time we look at it. Currently only 50 to 70% of people who get the voucher are turning it in. Even though I say only, this is still a vast improvement over the percentage of people who previously got medication upon release. From speaking directly to clients, it seems that people have positive feelings about the program. Anecdotally, our staff says that they hear from people who are re-incarcerated, which sadly happens all too often, that the voucher program worked for them at least in terms of receiving necessary medication even if it did not help modify their behavior. But there are definitely still a lot of pieces that need to be in place. For example, if someone is only in jail for a few days, our staff may not know enough about the individual to be able to reach out. Other people are unable to take advantage of the pharmacy voucher program because they don't have proper identification. It is also important to note that this program is still only in certain jurisdictions and has not been rolled out statewide yet. This is still a very new program, and we are in the phases of educating people about it and getting all the necessary pieces in place.