Coming Home: Transforming the Community Health Care System to Effectively Serve Individuals Returning from Incarceration

An emerging funding opportunity for primary care clinics in California to implement the Transitions Clinic Network program.

APPLICATIONS DUE:

FRIDAY, SEPTEMBER 20TH at 5pm

California Health Care Foundation

TRANSITIONS CLINIC

PARTICIPATION AT A GLANCE

What is the Transitions Clinic Network?

Transitions Clinic Network (TCN) is a national network of community-based primary care clinics that serve individuals recently released from incarceration with chronic health conditions. TCN has supported over 30 clinics in 11 states and Puerto Rico in implementing the TCN program, an evidenced-based model of care shown to improve health and reentry outcomes among formerly incarcerated individuals. TCN programs have served over 7,000 patients recently released from incarceration.

What is a Transitions Clinic Network Program?

Founded on the belief that the people closest to the problem are also closest to the solution, each clinic that implements the TCN program dedicates a multi-disciplinary team that includes a community health worker (CHW) with a prior history of incarceration to work with eligible patients. TCN programs are bolstered by strong relationships with correctional partners and community organizations that address the social determinants of health. The TCN teams and CHWs are specially trained to promote healthy reintegration into the community, provide care coordination, behavioral health services, chronic disease management, prevent unnecessary emergency department utilization and hospitalizations, and reduce parole and probation violations.

Why Implement a Transitions Clinic Network Program?

The United States incarcerates more people than any other nation in the world. The vast majority have a chronic physical or behavioral health condition. Our prisons and jails have become warehouses for the ill, many of whom have never received care within the community. Transitions Clinic Network programs help mitigate and prevent the long-lasting harms of mass incarceration. By hiring individuals historically excluded from employment in the health system and providing client-centered, holistic services to individuals returning from incarceration, TCN programs improve health and reentry outcomes. In a randomized controlled trial, the program was shown to decrease its patients' emergency department visits by 50%, compared to patients receiving expedited primary care services. TCN programs also reduce ambulatory care sensitive hospitalizations and parole and probation violations.

TCN program sites become members of TCN's national network of healthcare professionals, dedicated to amplifying the voice of individuals impacted by mass incarceration to create systematic change. TCN membership provides an opportunity to share best practices and collaborate with colleagues from programs across the

"My goal as a medical professional is to provide people with the tools they need to feel empowered to take control over their health and their lives, and it is a tremendous gift to get to do that work with a population that has so often been marginalized and subject to discrimination. Working side by side with a community health worker who has had a direct experience of incarceration and substance use continually broadens my perspective and keeps me accountable to the needs of the patients we serve. Growing our Transitions Clinic has been a creative process as we learn from the experiences of our patients, identify gaps in services, and build our skills and our networks to fill those gaps."

Ann Finkelstein, MD, MPH
La Clínica de la Raza, Vallejo
Transitions Clinic Network
Program Director

nation. Members participate in annual conferences; ongoing webinars; and have access to the online cultural humility manual and toolkit.

Who is Eligible to Participate?

This opportunity is made available through the generous support of the California Health Care Foundation. Federally Qualified Health Centers (FQHC's), FQHC look-alikes, community health centers and behavioral health centers with primary care programs throughout California are eligible to participate. **Sites must currently employ or be willing to employ a community health worker (CHW) with a history of incarceration as part of the primary care team.** Each site must have demonstrated support from at least one high-level administrator and clinician. Sites that are: located in a neighborhood disproportionately impacted by incarceration, have integrated behavioral health care services onsite, offer medication assisted treatment (MAT) onsite, and/or have demonstrated commitment to employing and sustaining CHWs will be prioritized.

What is the Time Commitment?

All participating sites are required to have at least two dedicated staff attend monthly technical assistance/training calls (1 hour), quarterly liaison calls (2 hours) and participate in two in-person meetings over the course of a 12-month period: one daylong meeting (with an optional tour on a second day) and one two-day meeting. The CHW, once hired, is also expected to participate in daylong CHW Kick-off Meeting, and complete TCN's online CHW training, which is a time commitment of approximately 2 hours each week over a period of 12 weeks. Sites are expected to participate in program evaluation and quality improvement activities.

How Much Will it Cost

California Healthcare Foundation will support all training and technical assistance costs and travel. Sites must be able to offer in-kind clinician support (MD, NP or PA) as well as a CHW supervisor (such as a LCSW or MSW) and have a funding mechanism to support the employment of a CHW.

Each site will receive up to $28,000 across the project period. Funds may be used to offset team travel expenses to the in-person meetings, to support participant focus groups and/or to utilize for incentives for Transitions Clinic Network patients. If your site is interested in participating, but does not have funding to support a CHW, feel free to contact anna.steiner@ucsf.edu; 415-502-2441.

How Does a Clinic Apply to Participate?

Each clinic is required to complete an application. Applications are accessible on our website: http://transitionsclinic.org/tcn-ca/

Interested sites must complete an online site assessment and submit a proposal by September 20th, 2019. Sites must also participate in a brief follow-up call in late September or early October.

Where Can I Find More Information

You can watch a recording of our webinar about this opportunity from fall 2018 for more background on the TCN program. We also plan on holding a webinar in September – we'll post that on our website once scheduled.

You may submit any questions to Liz Kroboth at elizabeth.kroboth@ucsf.edu or 415-514-4918.

INVITATION TO PARTICIPATE

Coming Home: Transforming the Community Health Care System to Effectively Serve Individuals Returning from Incarceration is a joint effort of the California Health Care Foundation (CHCF) and the Transitions Clinic Network (TCN).

Program Background

In 2016, over 34,000 people incarcerated in state prisons and thousands more incarcerated in federal prisons and jails returned to under-resourced communities in California.[1] This population is sicker than the community, with higher rates of chronic physical and behavioral health disorders, and death. [2] These individuals also face additional barriers to care: homelessness, unemployment, and low literacy. Previously, most individuals cited the emergency department (ED) as their primary source of care.[3] While the Affordable Care Act offers increased enrollment in Medi-Cal, community clinics still struggle to engage patients into care and provide medical care that adequately addresses the needs of individuals returning from incarceration. Active recruitment, culturally competent providers, and patient-centered services are essential to engage people returning from incarceration in care[4]. While engagement in care can impact recidivism, health outcomes and costs[5], most health systems have not aligned financial mechanisms and practice delivery to provide services that successfully engage people returning from incarceration.

"They [Transitions clinic staff] don't judge you – they treat you like a human being, like you're still a person. That's something that prison takes away from you, and when you get out, society takes that away from you… I think that's what makes Transitions clinic so successful."

--SF Transitions Clinic patient

Overview of California Transitions Clinic Network

The Transitions Clinic Network (TCN) supports a consortium of community-based primary care clinics that provide evidence-based, community-driven health care and reentry services to individuals recently released from incarceration with chronic health conditions. Using a set of specialized tools and trainings, TCN has provided 25 clinics nationwide with technical assistance (TA) on program implementation, evaluation, CHW integration, and sustainability planning.

In an effort to improve the health and reentry outcomes among Californians released from incarceration with chronic health conditions, TCN, in collaboration with California Health Care Foundation, will support TCN program implementation in up to 25 primary care sites statewide.

Program Objectives

1. Improve capacity of California health systems to effectively serve individuals returning from incarceration with chronic health conditions.
2. Enhance primary care provider and systems knowledge, skills and attitudes regarding care provision for communities impacted by the criminal justice system.
3. Create employment opportunities in the health care field and ongoing professional development for individuals impacted by the criminal justice system.
4. Develop sustainable funding models to support TCN programs statewide.

5. Create statewide advocacy network focused on reducing the collateral consequences of incarceration and improving continuity of care between corrections and the community.

Program Structure

Program will begin November 2019 and end October 2019. Participants will receive structured, comprehensive technical assistance customized to their specific needs in order to achieve objectives stated above.

TCN will provide comprehensive technical assistance and implementation support to up to 25 primary care clinics, including:

- Two daylong in-person meetings.
- Monthly structured case-based technical assistance calls.
- Quarterly all-site liaison calls.
- Individual site visits and introduction to the model.
- Access to online toolkit and cultural humility manual.
- Online training for community health workers.
- Access to experts in health policy and fiscal sustainability.
- Evaluation and research support.

Participating sites must be committed to sending at least two people per site to in-person convenings, participating in monthly TA calls, allocating time for their CHW with a history of incarceration to complete the TCN online CHW training, and collaborating with existing and new TCN sites as well as correctional systems, policy and advocacy groups and reentry service organizations. Participating sites must also be committed to maintaining support for the Transitions Clinic Network program at their site beyond the period of this grant.

Technical assistance content to include:

- **Assessing Clinic Strengths and Gaps:** Sites will complete a TCN asset and needs assessment to identify strengths and address potential gaps in services needed for this population.
- **Health System Transformation:** Support and coaching related to transformation of current primary care practice to meet the needs of chronically ill individuals returning from incarceration.
- **Hiring and Integration of CHWs:** Best practices in hiring, supervising, and integrating a community health worker with a history of incarceration into the primary care team.
- **Team Based Care:** Defining roles and assuring that all team members are working to the top of their professional capacities and addressing patients' needs.
- **Social determinants of Health (SDOH):** Promote understanding of SDOH particular to individuals returning from incarceration and best practices in addressing these from within the primary care setting.
- **Collaborations with Correctional Systems:** Training and technical assistance in best practices related to collaborating with correctional agencies as well as improving continuity of care between corrections and community health systems.
- **Cultural Humility Training:** Provide cultural humility training to sites as well as specialized training for CHWs in best practices in working with individuals with history of incarceration.
- **Data Collection and Evaluation:** Assess what standardized data sites should be collecting to measure impact, promote ongoing quality improvement and define evidenced based model of health care provision for this population in California.
- **Sustainability:** Best practices in leveraging existing funding and finding innovative opportunities to support sustainability of TCN programs.

Participation Requirements

This project will support primary care clinics invested in fully implementing a Transitions Clinic Network program.

Primary care sites will agree to: develop integrated behavioral health and substance use disorder treatment, collaborate with correctional systems and reentry service providers, hire and integrate a community health worker with a history of incarceration into primary care team to address the social determinants of health.

Preference will be given to sites that are located in communities impacted by incarceration, have team-based care models, have electronic health records and quality improvement capacity, and those that have demonstrated institutional buy-in from their administration.

Each team must include:

- A clinician champion
- CHW supervisor

Preferred key stakeholders:

- Administrative staff
- Human resources staff
- Correctional partners
- Social service or community based organization partners

Transitions Clinic Network Team:

Shira Shavit, MD, Executive Director. Shira has been providing health care to patients and families impacted by incarceration for over a decade. In addition to acting as Executive Director, Dr. Shavit locally directs the Transitions Clinic Network program at Southeast Health Center in San Francisco's Bayview Hunter's Point neighborhood and the Medical Discharge Planning clinic at San Quentin State Prison. She worked as a consultant to reform healthcare systems in California State prisons with the California Department of Corrections and Rehabilitation from 2006-2011. Dr. Shavit is also a Clinical Professor of Family and Community Medicine at the University of California in San Francisco and received the Robert Wood Johnson Community Health Leader Award in 2010. She received her MD at Rush University in Chicago and completed her residency in Family Medicine at the University of California, San Francisco.

Liz Kroboth, MPH, California Program Manager. Liz Kroboth joins TCN as the California Program Manager, and is leading TCN's 25-site California expansion. Liz's wealth of experience includes managing training programs at the San Francisco Department of Public Health, teaching research and writing courses at San Francisco State University, and working as a curriculum developer and project manager within health-focused nonprofits and market research organizations. Liz has a strong commitment to reducing mass incarceration and law enforcement violence and to promoting health equity among communities most affected by these issues.

Anna Steiner, MSW, MPH, Program Manager. Anna is TCN's Program Manager. Before joining TCN, she served as Program Advisor for the Office of Viral of Hepatitis Prevention as well as the Correctional and Women's Health Coordinator for the Sexually Transmitted Diseases Control Branch at the California Department of Public Health. Throughout her career, she has worked to promote health equity and build capacity among those facing systematic and institutional barriers to accessing health care, including people who inject drugs, formerly incarcerated and homeless individuals.

Joseph Calderon, Lead Community Health Worker. Joe is a tried and true TCN CHW who has served a navigator, mentor and advocate for countless formerly incarcerated individuals and their families. Joe's life work reflects his strong commitment to social justice and empowering the formerly incarcerated community. In addition to his work as a CHW, Joe served two terms here he sat on the SF Reentry Council and currently sits on the council's sub-committee for policy. As the CHW Lead, Joe lends his vital perspective to program planning, works to expand organizational partnerships, and mentors and trains formerly incarcerated CHWs, including those joining the Transitions Clinic Network as part of the California expansion project.

Emily Wang, MD, MAS, Evaluation Director. Emily is an Associate Professor in the Yale School of Medicine and directs the Health Justice Lab, a collaborative, innovative, interdisciplinary team focused on improving the health of individuals and communities who have been affected by mass incarceration. Dr. Wang has cared for thousands of individuals with a history of incarceration and is Co-Founder of the TCN. She has served on the National Academy of Sciences/Institute of Medicine's Health and Incarceration Workshop, Means of Violence Workshop, and the Steering Committee on Improving Collection of Indicators of Criminal Justice System Involvement in Population Health Data Programs. Her work been published in the Lancet, JAMA, American Journal of Public Health, and Health Affairs, and showcased in national outlets such as the New York Times, NPR, and CNN. Dr. Wang has a BA from Harvard University, an MD from Duke University, and a MAS from the University of California, San Francisco.

Jenerius Aminawung, **MD, MPH**, **Evaluation Manager.** Jenerius is a Research Associate and the Evaluation Analyst for the Transitions Clinic Network working alongside the Evaluation Team located at Yale University. Dr. Aminawung's work includes health services research projects at Yale University, studying cancer treatment effectiveness, chronic disease management and outcomes in disadvantaged populations, ambulatory care services and drug safety. Dr. Aminawung received his medical training abroad at the University of Yaounde and earned an MPH in Epidemiology and Biostatistics from Tufts University School of Medicine.

Citations

[1] The U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Prisoners in 2016. January 2018, NCJ 251149. Accessed at https://www.bjs.gov/content/pub/pdf/p16.pdf on May 10, 2018.

[2] Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. J Epidemiol Community Health. 2009; 63(11):912–9.

[3] Frank JW, et al. Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey. J Gen Intern Med. 2014; 29(9): 1226–1233.

[4] Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. Am J Public Health. 2012 Sep; 102(9):e22-9. PMID: 22813476

[5] Morrissey et al. Medicaid enrollment and mental health service use following release of jail detainees with severe mental illness. Psychiatr Serv. 2006;57(6):809–15.