



**Health Care Behind Bars: A Key to Population
Health?
The Centene Corporation
Alliance for Health Reform
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ED HOWARD: The program concerns the health of people in prisons and other correctional facilities and the healthcare they need and the healthcare they receive which may be the same and may not be the same. If you're concerned about getting proper care to those who need it then how those behind bars have access to care should be important to you. And if you care about state budgets you need to care about prison health. States spent about 8 billion dollars on correctional healthcare in 2011, which was about 1 dollar in 6 of their entire correctional budget. And that level of spending shouldn't be surprising. This is not a healthy population. That includes a lot of folks with chronic conditions, with mental illness, with addiction disorders, and it's getting older as the population ages. So it's not surprising that states are trying a whole range of different strategies to get a handle on correctional health spending—everything from contracting with third parties to deliver the care to having more services delivered on site, to taking advantage of new health coverage opportunities for inmates, so today we're going to take a look at how well those strategies and some others are working and what kinds of policies changes might be helpful to improve both the quality and the value of the care that this population receives.

And as we examine these issues we're pleased to have, as a partner in today's program, the Centene Corporation, which contracts to provide Medicaid coverage in a dozen states, operates a number of related services and, later in the program you may hear from Dr. Asher Turney, who's a physician from a Tennessee joint venture that provides correctional healthcare and in which Centene is a partner.

I want to do a little housekeeping before we get started. If you want to Tweet, that's how you do it with the hash tag prison health. If you need Wi-Fi in order to Tweet or to do anything else, the credentials are on the screen. Feel free to make use of them. There's a bunch of good material in the packets that you received when you came in, including biographical information about all of the folks on our speaker list, and there's a one-page materials list that actually lists everything that you have copies of and additional material that you can go to for further edification. All of that is on our website, allhealth.org, and particularly that one-pager you should try on line because you can click on those things and you don't have to worry about copying a long URL.

There's going to be a video recording available of this briefing in a couple of days on our website followed by a transcript a day or two after that. And you can follow along with the slides that the speakers will be using today on that website. If you're watching on CSPAN you can find all these materials and the slides on our website and you can follow along if that is what you would like to do.

Word about question. At the appropriate time you can ask a question three ways. There's a green card you can fill out and hold up. There are microphones at either side of the room that you can use to ask it in your own voice, and you can Tweet us a question using the hash tag, and we will monitor and get that up to the dais.

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The only other thing I would ask is that as we go forward that you fill out the blue evaluation form that's in your packets so that we can improve these programs as we go along and cover subjects and have speakers that would be of the most interest to you.

So, let's get to the program. Our format is a little different than usual. There are going to be two panels, not just one. You'll have a chance to ask questions after each one. First we're going to get an overview of the issue and then turn to a view of these issues from some people who understand them from firsthand experience. And then, a second panel will address concerns about healthcare and the correctional system from the standpoint of some folks who are charged with delivering that care.

So, starting with our first panel, I'll introduce them all to keep the continuity of the conversation going. We're going to start with Steve Rosenberg, who is the president and founder of Community Oriented Correctional Health Services—is there a pronounceable acronym?

STEVE ROSENBERG: COCHS (Coaches).

ED HOWARD: Alright. Those of you who've been going to Richmond to watch the Redskins begin tryouts understand that coaches are important. Steve's been working to assure healthcare access to vulnerable populations for more than 40 years and provides technical assistance to correctional systems toward that end. Debra Rowe is the executive director of Returning Citizens United here in D.C. with 20 plus years of experience supporting and advocating for those reentering from incarceration. She holds a Masters degree in Human Services and spent several years incarcerated herself some time ago. And then finally we'll hear from Jacqueline Craig-Bey, who's a supervisor at a domestic violence safe house here in town and an advocate for inmates and former inmates among other vulnerable groups. She's the first paralegal hired by the University of DC Law School and before she "turned her life around," as she phrases it, she spent more than 20 years in prison herself. So we're really looking forward to hearing from you folks and we'll turn first to Steve Rosenberg. Steve.

STEVE ROSENBERG: Well, thanks, Ed. Thank you all, and welcome for joining us. I'm really appreciative to have the opportunity to talk about this relationship between public health and public safety because they're so closely tied. As Ed mentioned, I'm president of COCHS. We're a nationally based, philanthropically funded, nonprofit and our goal is to break down the barriers and build connectivity between our public health and our public safety systems.

Before proceeding, I just want to make a quick distinction between jails and prisons to make sure everybody understands what we're talking about. Jails are county- or city-based places where folks are held prior to trial or for being sentenced to a misdemeanor usually less than 1 year. Prisons are operated by state or federal governments and there where folks go for a longer sentence. With the data you have in front of you shows the

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point in time snapshot of who's in jail and who's in prison, but I'd like to turn your attention to the data below that which is that more than 11 million folks annually circulate through our nation's jails. Those folks are there for a very brief time and 4 percent of them, only 4 percent of them, end up in state prison. Ninety-six percent are released directly from jail back into the community. So when we look who's cycling in and out of jail what we see are these are our nations' most marginalized folks. They're largely young, largely nonwhite, largely poor, and suffering from diseases way in proportion to the rest of the population. So let me just give you some data that you can see that.

These are the rates of hepatitis for justice-involved individuals compared to nonjustice-involved individuals and you can see, as we get older down the age spectrum the gap widens largely. This is the data on HIV compared to justice-involved individuals compared to nonjustice-involved individuals. This is the data on substance use disorder, and there was a recent study that was completed—it's known as the Adams Study—which looked at the incidence of substance disorder and what it found, between 60 and 80 percent, depending upon the jurisdiction, of individuals who are incarcerated in jail had an illegal drug in their body at the time of arrest. So we obviously can see that much of our criminal justice system is inherently a public health challenge of folks have substance use disorder and it's that disorder that's having them end up in the correctional system.

Similarly, folks with serious mental illness—look at that data. National population compared to local population. And, for women in particular, this is a much greater challenge. More than 30 percent of women who have incarceration or justice-involved experience had a serious mental illness. So, obviously, what we're depicting to you is, is that this is a challenging population.

But what I want to show you are their insurance status. Prior to January 1, 2014, 90 percent of individuals leaving jail were uninsured. So we made this investment in stabilizing their healthcare because we are required to under the Supreme Court's ruling of *Estelle v. Gamble*, which said that public jurisdictions have a responsibility under the 8th Amendment to not be deliberately indifferent to the citizens that are under their charge. So we make this investment in stabilizing them and then the minute they leave the street typically we lose that investment. But it's the bottom dot point I think should be of more concern to all of us. A study showed that of individuals incarcerated who had a chronic disease 80 percent of them did not receive treatment for that chronic disease in the year prior to their arrest. So, if you have an untreated behavioral health disorder—I just showed you the data on substance use disorder and mental illness—you're not receiving treatment for that disorder in the community, the likelihood of your ending up exposed to the criminal justice system becomes fairly high.

So, what do we know about what happens when we treat the underlying substance use disorder? Washington State in 2003 ran a national science experiment. Their data system allows them to organize the jail booking data, Medicaid claims data, and mental health

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utilization data. And the state provided 30 million dollars of general funds to its five largest counties for them to go ahead and treat, as they saw fit, individuals with substance use disorder. And the results were startling. Notice this is not completion of substance abuse treatment, this is exposure to substance use treatment. Well, the first thing you want to notice is the arrest rate went down by 33 percent. Simply by exposing folks to substance use disorder treatment the arrest rate went down by a third. For every dollar that the state spent on treating folks with substance use disorder it saved a hard \$1.16 in criminal justice costs, the cost to victims of crime are included. The savings was \$2.87 for every dollar saved. That's on the justice side. Now let's look on the healthcare side.

As you've seen, folks with justice experience have very high morbidity. Prior to 2003, their healthcare costs were increasing at a rate of 5.5 percent annually. Once they were exposed to substance use disorder treatment, all of a sudden their cost dropped to 2.2 percent annually. So, you know, here in D.C., folks are always talking about bending the cost curve. Well, what you have in front of you is a perfect example of a cost curve that was bent simply by providing access to substance use disorder treatment.

ED HOWARD: Bent out of shape.

STEVE ROSENBERG: Bent out of shape. That's right. Bent way out of shape. So, I think where that leaves us are recommendations for you as policymakers in going forward, and I really want to give you four things to consider.

One is, these are folks who are not mothers with kids with earaches who are going to bang on the door of the welfare system saying give me a Medicaid card. So, a study in 2009 in Massachusetts showed that, while there are only 3 percent of individuals in the state were uninsured, 22 percent of individuals showing up at publicly funded substance abuse treatment programs, whose demographic parallel is exactly that of justice-involved individuals—largely male, largely poor—those folks had an uninsurance rate of 22 percent. So the very first thing I want to make sure you all understand is that targeted outreach for enrollment will be necessary. This is going to be a complex and difficult population to enroll, and that the use of the Medicaid Administrative Claiming program by public safety entities can facilitate their enrollment. Most folks within the public safety world know nothing about the Medicaid Administrative Claiming program and that is a great opportunity for use for states and localities to bring in resources to enable them to enroll this challenging population. And, as you just saw, enrolling this population will save everyone funds.

The second is that we need to understand the relationship between substance use disorders and the criminal justice system and how healthcare providers, both in the corrections and in the community, can work together to increase public safety. That's the second take home.

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The third take home is wanting to talk a little bit about how it's important that we understand that we have, on our books going back to Medicaid program, this thing called the IMD exclusion, or that is, people who are patients in an institution of mental disease cannot receive Medicaid. The purpose of that goes back to the desire when Medicaid was started to not have the state hospitals suddenly become financed by the federal government. Well, our science and vocabulary have advanced since then. We now understand things like traumatic brain injury, TBI, criminogenic behavior—these are not vocabulary words that we had in 1965 so I want to urge you to give very careful consideration as policymakers to make sure that statutory folks that are 50 years old that may not be relevant in today's world that we don't fail to meet this juncture of public health and public safety because we're trapped in old statutory and regulatory language, and that we figure out how to change that world. Erica Goode did an article on this in the *New York Times* three weeks ago, in order to really facilitate the opportunities we have last.

And I guess, my last recommendation would be to make sure that we pay attention to how we build bridges—that we have these two separate silos. We have a criminal justice silo over here, we have a community health silo over there—these silos have not been very good at talking with one another and informing one another. And I guess, the third would be that here, in D.C., on a policy level, that we do everything that we can to bridge those gaps and to make sure that folks understand that public health and public safety are incredibly intertwined. And with that, Ed, I'll go to the folks to your right.

ED HOWARD: Terrific. Thanks very much, Steve. Can I just ask you one question? You were talking about new terms. I'll tell you one new term that I would appreciate your defining, and that is criminogenic.

STEVE ROSENBERG: Sure. So, what we now know is, is that we now have identified the causes of behavior that result in people behaving in a criminal justice manner—that people becoming justice-involved. And those come under the general heading of 'criminogenic,' so that means the characteristics that have way more to do with mental health, they do with housing, they have to do with lifestyle, they have to do with anger management, they have to do with peer relationships—that there's this whole bevy that we know now how to treat. The challenge has been the regulatory framework in a post Affordable Care Act world that limits our treatment. And I want to make it clear that this is a bipartisan issue. That Governor Perry, Governor Deal of Georgia—they've been going out, and also promoting treatment of criminogenic behavior rather than incarceration. What changes is, for states that have enrolled in the Affordable Care Act, the ability to really scale this at a level that a state governor cannot necessarily do.

ED HOWARD: Excellent. Thanks very much. We turn next to Debra Rowe from Returning Citizens United.

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DEBRA ROWE: Thank you Ed. Good afternoon. During my incarceration at the Lawton Reformatory in the late 1980s I witnessed the disheartening maltreatment of women who were ill and resided in my dorm. For example, the women who were sick were kept at the very end of the dorm. This was during the time when HIV and AIDS became prevalent in communities and several of the women that I am referencing had HIV infection. During that period I met my colleague, here, Jacqueline. You see, we, along with a few other sisters were the voice for those women. We raised Cain to force the correctional officers to get off of their behinds and get them to the infirmary when needed and we bathed and fed them ourselves. Upon release, I was offered a job by the D.C. Department of Corrections Health Administration to educate my inmate and re-entry peers about HIV disease.

While studying for my job, I read a report from the Center for Disease Control that stated that 16 percent of those entering D.C. jails had HIV infections. And I wondered how did they know that, and I began my personal inquiry because I knew that HIV testing was not being offered at that time. I'm going to venture out and say that they were blind testing these inmates and, after advocating for testing in the jails, the correctional medical staff was frantic that they didn't have the resources for the testing which confirmed my suspicion about the blind tests.

I see the same parallel with Hepatitis C in that many, many women, some of whom have served 10 years or more or less, who have had blood draws, have contracted Hep C infections and were unaware of their status until they came home and visited a free community physician's office and learned of their results from a laboratory result there. One inmate, who has served 15 years in prison, went from Lewisburg to Cumberland, then to Petersburg and then to Petersburg, Penn and had blood draws upon entry to each of those institutions, yet he did not learn of his Hep C diagnosis until he was tested at a community clinic upon his release.

According to the Center for Disease Control, the prevalence of Hep C infection in prison inmates is substantially higher than that of the U.S. general population. Among prison inmates, 16 to 41 percent have ever been infected with Hep C and 12 to 35 percent are chronically infected compared to 1.5 percent in uninstitutionalized U.S. population. It's primarily associated with a history of injection drug use.

CDC recommends that correctional facilities ask inmates questions about their risk factors for HC infection during their entry medical evaluation. Inmates reporting risk factors should be tested and those who test positive should receive further medical evaluation to determine if they have chronic infection and/or liver disease.

Although it's not exclusively considered a sexually transmitted disease, the Hep C virus has the potential to be spread through sexual contact. It shouldn't matter that they are incarcerated, they have the right to know. All of this is happening in the private prisons.

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In closing, the inmates that reported that their health services are limited and they're being charged. They have to pay \$5.00 to sign up for sick call and medications and you can pay and sign up to see a dentist, for example, and may not see him till the following year. One inmate told me a few days ago that he had an abscess that swelled up to the size of a baseball after three weeks before he was treated.

I'm passionately concerned about those who are 55 and older in the system. This concludes my story and I'm happy to answer any questions and I do concur with all of Steve Rosenberg's recommendations. Thank you.

ED HOWARD: Thank you very much, Debra. And, of course, for those of you who haven't been reading health policy stories for the last year or so, Hep C, at \$1,000 a pill, has a cure and prison systems and other correctional facilities right now are having to figure out how to deal with the kinds of percentages and the numbers of inmates and residents that Debra was talking about. So, public health meets correctional policy. You bet.

Now, we'll turn to Jacqueline Craig-Bey. Jacqueline, thank you so much for being here.

JACQUELINE CRAIG-BEY: Thank you for having me. My name is Jacqueline Craig-Bey and I am a former inmate. I have several stories from when I was incarcerated as it relates to the medical in prison. While I was there I broke my leg and it took them approximately a week before they got me to the hospital. And I was taken to the infirmary there in the jail and they put a makeshift cast on. I mean, it was just put on with no padding, no anything. I don't even know if they maybe had a license to put this thing on me, but when I finally got to the hospital a week later the doctors over there laughed about it and called one another and come and see this funny thing that was on my foot. And the medical facility just isn't a place where inmates should be. Nobody there is actually looking to take care of inmate. It's just a job to them and they're just there for the paycheck.

When I was pregnant—I had a child while I was incarcerated. And after I had my child, you know, women here know that you have to have a six-weeks checkup after having a child. Well, I saw the doctor in the hallway and he just touched my stomach and said, oh, you're fine, and that was my six-weeks checkup. And these are the type of things that go on in the prison and are not talked about. Nobody talks about the people who have HIV and they're afraid for other people to know that they have HIV so they don't go to the medical facility and get their medications. They don't want people to know their status. So these are people who are sitting there with this disease and not being treated. They don't have the staff to talk to these women and men to let them know that it's okay to come to the infirmary. Or some kind of way to give them this medicine without everybody knowing what the medicine is because when you go to the line everybody knows what everybody's taking. So, some people don't want to take their medication and

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that's a problem. That's a big problem. There should be some kind of way where women or men can get their medication without the world knowing what you're taking.

Also, I've seen people pass by in prison for things that could've been prevented. Women were coming down with cancer in Connecticut and it was just crazy. There was so many women at one time coming up with these cancer diagnoses, and before they would take them to a facility to be treated they would sit in there and talk about all these different tests and had they taken them to a facility to be treated before doing all these different tests and sitting them there waiting around they could've been treated and would've been fine probably. But, instead, they sat there and waited and waited and waited, and these women died in prison. And when they got there nobody said that they were—they had cancer or anything so they were not tested for these things but yet they had these different illnesses and nobody in prison cared. Nobody cares what goes on with an inmate. They consider us the forgotten. The ones that nobody cares about.

So we have to care for one another. So I would call attorneys and people that I knew in the district and have them to fly to Connecticut to help one of the sisters or brothers that needed some help because otherwise we'll sit there and languish in prison with no help at all and it's just a really sad thing for us to languish away like that.

And that's all I have to say to that.

ED HOWARD: That's quite a lot to have to say. Thank you Jacqueline. Let me just ask both of you, you've described some conditions that would result in the issuance of some arrest warrants if they occurred in some other situations and I wonder what your perception is of the progress that is being made in the facilities you know about toward addressing some of these shortcomings.

DEBRA ROWE: There is no progress being made. People are still—Jackie was in—how many years ago, in Connecticut—

JACQUELINE CRAIG-BEY: 2001.

DEBRA ROWE: Okay, 2001. Women and men are still dying and family members—I receive calls from family members that they were just notified that their family member died and they buried them, or they died and they can't give you any answers: are you going to be able to make accommodations for your loved one, or not? You know, it's just point blank like that. They're still dying. All of what I just talked about, this young man with the abscess, or the people coming home with Hepatitis C and not knowing, or the people that are in there very ill, our women—D.C. gave up the rights to our inmates. We were blessed to be Lawton Reformatory during that time, but they closed our local prison. So all our women are in a medical facility way down in Florida. D.C. residents—that's another thing. They're far away from home and they're sick, and they're far away from home. At least if they were in the vicinity, and they're supposed to be in a 500-mile

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radius but they're not. They're all over the country. Our inmates are spread all over the country. But not just speaking for our D.C. inmates, any inmates, because I collaborate with a lot of different states on advocacy for reentry, but anywhere, the family contact is very important. It's very important that you're able to have contact with your family especially if they're ill. And just like I said, if you're blind testing people and they don't know, just like cancer, if it's undiagnosed then, I mean, look at the people that go to the doctor and they tell you you have six months to live. But that cancer was in your body longer than that. So, but they're just—it's like they're just forgotten because they're locked up. And, you know, but when they come home, they have what they call the New Federal Second Chance Act because they deserve a second chance. So these long imposed sentences, and then you're not going to take care of them, and, like I said, you have, in Oklahoma, you have a lot of elderly geriatric people—I mean, a man came home, 70-something years old. And he called my colleague and he said, he's still on parole. They said I gotta get a job. They said I gotta get a job. What is he going to do? That used to be your night watchman or something like that. What is he going to do? All we could do was get him some glasses. He didn't get proper treatment for his vision. So my colleague helped him to get glasses but we couldn't help him find work. But still, why hold somebody till 77 and 85 and they're sick, and it's very expensive to take care of them, so I know that these reforms and they're talking about Medicaid and all of that now, but they're going to have to go back and cover a lot of inmates because a lot of our people are suffering in prison. And, if you make too much noise about it or your family calls and advocates you can get put in a hole, you know, and imagine having a toothache and you're in a cell, because you know you need to pace back and forth. Any pain, you gotta – you need some type of relief. But you're in a cell and agony in a cell, not in an infirmary. At least in an infirmary you can lay down and you're getting seen or anything. A year to see a dentist? A year? And you're paying for it now. You're paying for it. You work and if your family's not sending you money then you work in a detail so you have money for commissary, but now you pay \$5.00 for this, \$5.00 is taken of your money. You're paying for your service but you can't be seen. It's—no. There's no program. There is no progress.

STEVE ROSENBERG: Ed?

ED HOWARD: Steve, please.

STEVE ROSENBERG: And I don't disagree with anything Debra is saying but I want to frame it. Traditionally, we sent folks out to islands when they needed to be incarcerated. Devil's Island, Alcatraz, Rikers Island, Australia, parts of the United States early on in our history. We've always had this approach that folks who were in the justice system should be isolated and kept separate from folks. In that process of keeping folks separate, the kind of experiences that I'm hearing, Debra, you and Jackie describe are not uncommon. The blessing is we're all in this room, in this very lovely Senate chambers today, and we're in this room for this very lovely Senate Chambers today because we have this bipartisan opportunity to change that and we have this bipartisan opportunity to

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change that because we recognize that keeping folks isolated on an island does not make sense in the 21st century, and that we have to figure out how we build bridges, and those bridges are partially electronic medical record, bridges which we'll be talking about in the second panel, those bridges are partly thinking differently about how we do sentencing for non-violent, non-sexual offenders, but that the important thing, I think, is the pony in this, is, is that we're sitting here in this beautiful room in the Senate today because there are several hundred of you who are recognizing that public health and public safety are intertwined and managing public safety by keeping folks on an island is not the way that we want to go forward.

ED HOWARD: Pretty good frame. We are going to stop at this point and ask if you have questions for any of the panelists who are up here. Let me remind you that you can either fill out a card or go to a microphone so that everybody else can hear your question and if you are part of the Twitter verse you can use that as a medium to get the question to us as well. There's another microphone right over here, sir. And I would ask everybody who comes to a microphone to identify themselves and try to keep the question as brief as we can so that we can get to the most questions that we can. Thank you.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I have a quick comment about disability. I worked for Social Security Disability for a while in Baltimore and very often we could not get prison health records. I mean, we had people who weren't in prison who had no records at all. The people who were in prison we knew they had records but very often the prisons wouldn't send them and the states wouldn't work terribly hard. That should be something easy, especially with electronic records.

ED HOWARD: Debra?

DEBRA ROWE: I want to say now we have, in the district, made progress in that area. I used to facilitate a federal partner's meeting. It was U.S.-Parole, with our medical system here which is Unity Healthcare. That's where all of our community health clinics are. And we sat down and we worked it out where all medical records—because even when an inmate leaves the prison they had trouble getting their records. So now all of the records follow them, and they all go to Unity, and they're centrally located in Unity. And that's one progress we have made in the district.

DR. CAROLINE POPLIN: And a one-sentence question: does the work that they do in prison, does that count towards Medicare—Social Security Medicare?

STEVE ROSENBERG: No, it does not. There is a statutory prohibition for Medicare paying for any services that are provided—Medicare first, but Medicare paying for any services provided behind bars. There's also a statutory provision that if you're on parole or probation you cannot receive a Medicare benefit. On the Medicaid side, there's

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something known as the Inmate Exception, which goes back again to the original finding of Medicaid, which states that if you're an inmate of a public institution, is the exact statutory language, then you cannot receive Medicaid benefits at all. So, again, one of the challenges, going back to my comment about islands, and what I'm hearing you say is, is we need to figure out creatively how we build bridges to those islands. Obviously medical records is a part of it. Thinking about bringing standards of care that Medicaid brings is another part of it. But at this point we were all very much in the process of understanding it is not in our benefit to maintain those islands and then the query becomes how do we build a bridge?

DR. CAROLINE POPLIN: Thank you.

ED HOWARD: If I can just—I don't know whether this is something that you've had to grapple with, but one of the parts of your question was whether the work that was being done in prison could be counted as a quarter that would give you credit toward Medicare coverage eventually.

STEVE ROSENBERG: And the answer is no.

ED HOWARD: No? Okay.

GLENN FIELD: Glenn Field, Washington Lawyers Committee for Civil Rights and Urban Affairs advocate, and a few other civil rights law firms. Debra, I heard you mention a 500-mile law and we constantly let this government get away with it. We have a law that established that any D.C. offender or D.C. inmate could be moved no more than 500 miles just to keep up with your family member, your loved one. Notice that while people in the District of Columbia do get locked up, most of the time they've probably been traumatized, and I'm sure Ms. Rowe can identify with that. We have racial disparity going on here in the District of Columbia, any inmate, like 3,500 returned back into this city, and 85 percent goes back within 3 years. So you celebrate. Am I right, Ms. Rowe? You celebrate that you made it past three years because it's a revolving door and it has been set up for that, for the revolving door end of it. I'm just asking Steve and the panel, if you can agree with me, in a prison industrial industry do they make a profit off of this revolving door, so when you don't get proper healthcare, as far as mental healthcare, and when you've been traumatized—post traumatic stress disorder—you're coming back to prison and the private industry makes a lot of money. They don't spend that money on healthcare, mental or physical. If you came mentally, prison system in the private industry and your pill cost \$1,000, or 30 pills cost \$600 you're not going to get that medication. You're not going to get the treatment that you had another facility or when you were at home because 60 percent of any profits in the prison system as far as private is concerned, is medical, and a lot of people have been suffering and they're going to suffer more and then they're allowed to come back out on the street. What this is pointing out to Steve, you know, mostly that we do need—wouldn't you think we need some advocacy and some monitoring mainly at these private prisons in making sure that

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their discharge plan starts earlier than 8 months, between the discharge plan that you physically and mentally start getting these people back into health instead of sending them back out on the street passing on diseases and thinking about new crimes and things of that nature because people take drugs because they've been traumatized in these prisons, so it creates a criminal because they've been traumatized they don't know how to deal with these mental health illnesses. They have to supply their habit and they're coming to get the citizens when they come home because they haven't been treated correctly. So you got worse off than what you were before you went in any system. So I'd like the panel to comment on any and all of that. Thank you.

STEVE ROSENBERG: I'd like to answer that question by framing it slightly differently. We have proprietary companies that provide Medicaid services all through the United States but those companies are regulated. Those companies have performance measures that they need to meet contractually. The challenge with the correctional health system is by and large it's an unregulated industry, okay, and if you have an unregulated industry then you have the opportunity for both the kind of human suffering that we heard Debra and Jackie describe, and the opportunities, sir, that I just heard you describe. And I think, again, that's partly where being in this room in this building points to something we don't allow, in any other sector, spending 8 billion dollars on healthcare. Do we allow it to be unregulated? Do we allow it to operate without standards, without quality assurance, without any of the things that are statutorily required? So we now leave that under our federal system, we leave that up to states and counties to go ahead and regulate or not regulate as they may see fit. And so, what I'm hearing you describe is an underlying challenge that our federal system has allowed state and localities to make their own determinations as to what regulatory quality assurance framework they're going to put down on correctional health. And in many jurisdictions that's very nominal.

ED HOWARD: Okay. We have two folks at a microphone and we really need to get to our second panel as well, so I would ask you to ask your question and we'll try to get it answered as expeditiously as possible.

MARY TIERNEY: I just want—my name is Mary Tierney. I'm a pediatrician and I worked in correctional health before. I had the privilege of getting a CHPA 1 grant. We did outreach to youngsters who were coming out of the juvenile justice system. We got them on Medicaid before they were—or at least at the time they were discharged. We coached parents and coached the youth and the two people that really should be given credit is Jane Adams in Kansas who ran the program, and the Medicaid director who was full force behind this in Dr. Andy Allison at the time who was the Kansas Medicaid Director. He was magnificent in getting this. The recidivism rate was dropped by 50 percent even in the highest risk youth. I'm sorry. I don't have a question, but I think it's a good model to think about.

ED HOWARD: Thanks, Mary.

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LINDA FLOWERS: Linda Flowers, AARP Public Policy Institute. So, in my mind—and thank you for this panel, it's just been tremendous and very insightful and I'm learning a lot. So, it sounds like there's this cost shifting going on between federal government while they're in there not paying for the things that people need and then they get out and then they're a state—they're in a federal prison, then they're a state responsibility whether or not there's a Medicaid expansion or they become disabled, their aged and can get onto Medicaid that way. So, I'm wondering if you could—first there needs to be more data about the amount of money that is not being spent on one end and how that translates into increased spending at the state level once most of these people get out of prison, which one of your—I think that could be a powerful tool for states to use to try to leverage some better improvements while people are incarcerated in federal penitentiaries. And the other thing is, I wondered if you can also try to figure out a way to cut the data by state to sort of show, to state the value of doing the Medicaid expansion, that you're going to save a lot more money on other unanticipated costs because you've made a way for people to have a pathway to healthcare. But, and also, I wonder if you can talk about any best practices in states working with the federal government and states working together to have a better outcome while people are incarcerated, and then when they transition out into a state—into states, so. I think you can beat this issue up a whole lot more than what I'm hearing.

STEVE ROSENBERG: So, Linda, those efforts are actually already underway. The Federal Bureau of Prisons has just instigated a requirement for a standardized release in terms of doing substance use disorder evaluation. I think we're starting to see that kind of process come down. On the Medicaid expansion side, I think the data that I gave you from Washington State speaks very loudly to how there is a direct relationship between healthcare spending, recidivism, and criminal justice spending. So I don't think it's because of a lack of data that we haven't been able to make that push. I think, again, we have to realize that public health and public safety are intertwined and interconnected and it does not serve anyone's interest, let alone the taxpayer, to keep folks isolated on an island without the appropriate regulatory framework that we come to expect as part of our federal, state, and local partnership. And so what I would say is, is the data's there and we're in the process with the ODP trying to implement exactly the kind of thing you're talking about. What we haven't done yet is we haven't made this conceptual leap and that's what we're all here today to talk about. We haven't made this conceptual leap that says we need to figure out how to build as many and as sturdy bridges between community and corrections as we can.

ED HOWARD: Okay. Bob, last question.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. I remember when Senator Wofford ran for senator from Pennsylvania and made a big case about prisoners being one of the only populations in the United States that had a right to healthcare. In fact, that was based on a Supreme Court decision. How does that precedent not create the political power to implement the kinds of solutions that you're hinting at,

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and haven't we learned anything from the Tuskegee experiment? It seems like collecting data and not using it is a violation of our civil rights. So where is that—how does that fit into this problem?

ED HOWARD: Where are the lawyers?

STEVE ROSENBERG: Well, there are really several questions. First I have to be a nerd here and slightly correct then Senator Wofford's thing—it's actually Native Americans Under Treaty and Incarcerated Individuals, and two the individuals in America prove healthcare is a right and not a privilege. In terms of the Estelle v. Gamble and the Supreme Court case, what the Supreme Court ruled was is that the responsibility of a jurisdiction is to not be deliberately indifferent to the healthcare needs of an individual. So, for example, if you had a lawyer, going back to your example, Debra, waiting a year to get a dental appointment, well, that dental appointment was made. I wasn't deliberately indifferent to that person's needs. And I go back to regulatory frameworks, okay, that if you, again, think about how we do manage care within a community setting we require a certain number of days after which an appointment has to be made. We require a certain level of credentialing in order to provide care within the context. We don't do that in correctional health at this point. We're still on an island. And I think that's the point that you're going to hear me say over and over again this afternoon.

ED HOWARD: Alright. I don't want to cut people off but I do want to give us the benefit of our last two panelists. Jacqueline, Debra—thank you so much and if you're going to be sticking around anyway maybe we'll find some stray questions at the end of the Q&A for the second panel. Thank you so much. [Applause.]

ED HOWARD: And I'll ask our second panelists to come up if I could.

Alright. We are reconstituted, panel wise. You've heard from Steve Rosenberg. And the other panelists, on my right Dr. Sharon Lewis, who's the medical director for the Georgia Department of Corrections. She's a board certified pediatrician and a nationally respected expert on quality assurance with more than 20 years of experience in healthcare and managed care and right now she's responsible for delivering adequate and cost-efficient care to the inmates in the Georgia correctional system. Next to her, is Dr. Asher Turney, who is the medical director for Centurion of Tennessee, which is a joint venture of Centene and MHM Services with which Tennessee contracts to provide healthcare services for its correctional system. Dr. Turney is board certified in both urgent care and occupational medicine and he's got a special interest in health inequalities and the health of vulnerable workers. Welcome to both of you, and I would ask, I guess we need to pass the clicker to the lady who is next, Dr. Lewis.

DR. SHARON LEWIS: Good afternoon. As you all heard, I am a board certified pediatrician so I tell folks that I have 55,000 bad kids under my care. What I'd like to do

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is to give you an overview of the Georgia Department of Corrections, which I think is a reflection of a lot of other correctional departments throughout the United States. Fortunately we have had lots of success in improving the healthcare that is being delivered to the inmates in our custody and fully respect the Estelle versus Gamble ruling with mandated healthcare.

To start out, Georgia has a little bit of difference here. We're the 9th largest state in overall population but we're the 5th largest prison population. We have roughly 55,000 offenders in prison and about 145,000 probationers. Ninety-four percent of our population is male and 6 percent is female, and I think that this is, again, a reflection of other states. The male population, unfortunately, has a predominance of African Americans. Sixty-two percent of our population is aged 25 to 45 chronologically, and I'll speak a little bit more in just a second about that. Fifty percent is over 35, so you think about your general population in the free world and how we mirror what is in the free world. We operate 120 facilities, 31 of those are prisons. We also operate county and private prisons, transitional daycare and day reporting centers, probation detention centers, and boot camps. And again, we're responsible for producing constitutional mandated healthcare. Does everyone understand what that is? It means there are basically three minimal standards. One is that all inmates have the right to access care. Secondly, they have the right to care that is ordered. And thirdly, they have a right to professional opinion of those providers to order that care such that the example that I give is is that we can't have a dentist that tries to do an appendectomy. So that's the third piece of it.

Our demographics are such that 37 percent of the inmate population has significant chronic illness. That number and percent is up after about 4 years. Four years ago it was about 33 percent, and I think that every state is challenged with this where they have an increase to acute and chronic disease and the diseases that are most prevalent are HIV, cardiac, Hepatitis C, chronic obstructive pulmonary disease, mental illness, and cancer. Seventeen percent of the Georgia population receives mental health services and there's some difference with that. In the female population, 50 percent of our female population is receiving mental health services compared to about 12 percent in the male population, and we think that's attributed to cultural differences and then mostly in the female it is behavioral disorders, it is the mood disorders.

Most of our inmates, when we say chronologic age, their physiologic age exceeds their chronologic age because of their lifestyle prior to incarceration. They experience drug use, they had lifestyle factors of smoking, alcohol, nutrition deficiencies, and lack of activity or meaningful activity. They had minimal to no healthcare, either medical, dental, or mental health, and have an accelerated listing of chronic diseases.

We have an increased population of aged, blind, and disabled, and our admission age is older. The average now is about 33 years of age and then it therefore translates into our older age of the population which is about 36 years. So we're not getting more young people in, that I call, but rather the older folks are starting to come in.

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In fiscal year 2013, these are some pretty startling statistics for us. Those that are over 35 years of age represent 54 percent of our population and account for 75 percent of the claims. Those that are over 50 years of age are 18 percent of the population and account for 47 percent of the claims. But most importantly here is that those that are over 65 represent 2 percent of our population but account for 8 percent of the claims. So if you're looking at \$180 million budget that's a lot of money. Those that are over 65 years of age, their average claim cost is around \$3500 versus those that are less than 65 years of age representing only \$591. So that's a dramatic difference just based on the age.

Here, I'd like to look at the per diem budget. Over the last, at least 5 years, each year the Department of Corrections has been given a reduced budget. So we have this budget that is continuing to be reduced. We have the mandated constitutional healthcare that we have to provide. We are continuously having an intake of chronic illness which includes those women that come into our population pregnant and we're responsible for all their prenatal care and delivery, and again, they would be high risk. So all of the services that we are required to provide we're having to get very creative in the strategies that we use in order to provide that necessary mandated healthcare.

The covered population that you see listed below represents the population that's covered in our general population. We have probably about 6,000 inmates who are housed in what we call private prisons. There are several prisons within our state that take it so the cost for that does not come out of our per diem there.

So, again, here's our creativity. As you heard, I had a long history with managed care organizations and whether you like them or don't or whatever, it's the world we live in. And they are successful. So some of the principles that those managed care organizations have used we have applied in the Department of Corrections. The first one being, and I'm very proud of this, is what we call the Summary of Healthcare Benefits, and it is the same document, or a similar document, that you receive when you sign up for your own insurance. It basically tells you what is and is not covered, is and is not eligible, and basically what the insurance company will and will not pay for. But for us it lists out what services are eligible to the inmates and which ones aren't and it kind of puts everybody on the same playing field because the inmates then understand what services are going to be covered, which ones will not, and also the providers of those services understand which services are eligible. And to give you examples, we don't pay for umbilical hernias—for outies. We don't pay for cosmetic surgery. We don't pay to treat your acne or your male pattern baldness. We don't pay for your sex change operation or your sexual activity. So those are the kinds of services that are not considered eligible. All other medically necessary services—and those are the key words: medically necessary services—are provided to the inmates within our custody. This document has been reviewed by the office of our attorney general and, again, it provides the framework for constitutional healthcare.

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The second foundation is preventive care. I know you've heard, you know, an ounce of prevention is worth a pound of cure, and we truly believe in that. So it gives us no benefit to deny preventive services. We follow U.S. Task Force for Preventive Services guidelines doing routine health assessments, providing chronic illness clinics with all of the necessary medications that go with that, and on a frequency—and fortunately we have a locked up population so the fact that they miss an appointment that doesn't happen very much. They get to come when they're supposed to come.

We have a very active utilization management department that does preauthorization and concurrent review and discharge planning. Our pharmacy benefits management—we have an active pharmacy and therapeutics committee. We have a formulary. We have a co-pay which is legislatively mandated, and it's \$5 for those prescriptions that are considered to be non-chronic care. So, it's prescriptions that the inmates come in and say "I want." I want this, I want that. Well, it's a \$5 co-pay. And then thirdly, under pharmacy, is we have been fortunate because of our relationship with the Medical College of Georgia, now known as Georgia Regents, to be able to have access to 340B pricing for some of our purchases, primarily now for HIV drugs.

We actively manage our network, both of hospitals, physicians, ancillary services, durable medical equipment, prostheses, physical therapy, occupational therapy, and rehab. We have an active medical reprieve or compassionate release process so that any inmate who has a guestimate life expectancy of less than 12 months from a terminal or chronic disease can be considered by our Board of Pardons and Paroles, which is the clemency entity within Georgia, to be considered for early release.

We have telemedicine and telepsych, which has allowed us to extent provision of medical services not necessarily on site but through the telecommunications. We have a modular surgical unit in one of the prisons where, for ambulatory surgeries, we're able to take the inmates to that prison to be able to have the surgeries done. And last, we have a forensic unit in one of the tertiary care hospitals that has 22 beds. And the whole purpose of most of those is so that we have found the more services that we can provide behind the wire rather than sending the inmates out into the community, it is both cost effective, cost efficient, and that first goal is to provide public safety. That is the primary purpose with that. So we do a good job, I think, in providing and getting very creative in providing more and more services behind the wire.

Our challenges are, again, what I'd say is the grain of the population. All states are experiencing inmates aging because they have longer sentences, longer confinements, and all of the illnesses that you experience in the free world experiences with getting old our population experiences. So all the mobility issues, the cancer and all, we experience that. They have physical incapacity and immobility, progressive degenerative diseases. We have an increased concentration of chronic illness and this is in the face of diminishing budgets for healthcare. And with that diminishing budget we have to get very creative because there's increased liability associated with that funding decrease. We find

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that we have to establish protocols of who will get treated for certain diseases because of the treatments being so incredibly expensive.

We have an increased mental health burden with dementia, depression, psychosis, disruptive behavior, and the cost of the psychotropic medications, and then we experience barriers to re-entry which includes transition of medical care to appropriate providers. You can imagine that a lot of providers out in the community are not necessarily opening their doors and welcoming someone who is just being released from prison to come in and provide care. Oftentimes they come with no benefits and no resources to help pay for their services.

Vocational certification and employment opportunities is also a barrier. In Georgia, we have a law that basically says that those who become “certified,” like a certified nurse and nurse assistant—CNA—that can provide services in a nursing home, that certification doesn’t hold up once they are released. They are not able to use that. And thirdly, the residents’ restrictions, including those for sexual abuse and those that are confined from a sexual sentencing, they have the Thousand Yard Rule with churches, schools, parks, etcetera.

So the recommendations that I would have based on all of these is that 340B pricing would be made available and much more easily available to the Departments of Correction throughout the United States. We would establish guidelines for the potential impact on the Departments of Correction regarding the Affordable Care Act so that we’re not just kind of figuring it out as we go. Thirdly, that we would promote electronic health record exchange, meaning that electronic health records would be able to be exchanged through all venues from the prison system through the jails on out into the community providers. And lastly, to expand federal funding participation for inmate eligibility to help offset some of the costs within our prison system. Thank you.

ED HOWARD: Okay. Thanks Dr. Lewis. Let’s turn to Dr. Turney.

DR. ASHER TURNEY: Good afternoon everybody. My name is Asher Turney. I’m a medical doctor from rural Alabama and Tennessee, and I’ve been a doctor for about 10 years and after hearing some of the discussion earlier from Ms. Bey and Ms. Rowe, I just wanted to say we all can have a family member that could be incarcerated and I want them to get the best care they can deserve. In my experience I have not had that same issue. As a medical director for Tennessee, I work with the Department of Corrections and we try to avoid some of those circumstances that they describe. So I don’t think it’s an overwhelming across the board pervasive issue but there are certain situations that I work every day to prevent. So I just want to say my discussion today will be a little bit wider in scope. It’ll be mainly on some of the issues that we deal with in Corrections, but as I said, I completely empathize with anyone that has had a circumstance like that because that’s what I went into medicine to prevent.

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Like I said, I'm a preventive medicine urgent care specialist. I went to Meharry Medical College. Our goal was to help the underserved. This group is the underserved. It's the same vulnerable population that oftentimes were serviced at federally qualified healthcare Centers. This is the same population that needs access and so it's the same job for me whether I'm behind the walls or not.

So, I just wanted to kind of describe our situation in Tennessee. I am a vendor partner to the Department of Corrections. I work with Centurion, which is a company that has about 60 years experience in managed care, also in correctional healthcare. Our parent company, Centene, and MHM Services, provide us a lot of opportunities and tools that we can fulfill the individual states' needs.

We provide cradle to the grave service on Centene's side and, as well as behind the bars with Centurion. We provide local solutions to some of the most difficult situations our partners face. But we also use evidence-based medicine, which is probably something that is a newer term, but we use evidence-based solutions leveraging technology, predictive modeling, innovative preventive health models to limit the incidence and the severity of diseases just as some issues to note.

So, Tennessee, welcome to Tennessee everyone. We are, our Department of Corrections, we have 21,000 inmates across the state, roughly 11 facilities. They have small subunits, but roughly 11 facilities, and we do have some challenges. Each state has its own unique challenges and obstacles as it relates to correctional healthcare and we have worked really hard to improve some of those issues and make them more manageable. The population, as a whole—just in general, the general population—has diseases that affect it, right, and those same issues mirror in the correctional population. Oftentimes, sometimes it's magnified, like we talked about Hepatitis C as an infectious disease, or mental health illness. You have a significantly higher rate of mental health illness within corrections than you do outside the walls. And we've tried to deliver solutions to the TDFC that improve those concerns.

Centurion has managed the Tennessee contract since September of 2013. We have efficiently decreased the number of admissions to the hospital and ER by treating on site. By getting in early with our preventive health model to decrease the need for hospitalizations and trying to set up programs where we get the patients before they have an exacerbation that requires an ER run. We've also tried to install—well, what we've done actually, across the state we've installed electronic—sorry, telehealth, excuse me. And telehealth, I mean, just to kind of really quickly refresh, is a mechanism by which you can use an Internet connection and video or telephone to essentially discuss with a professional on one side and an inmate patient on the other with a nurse, have a facilitative medical visit. And it allows you to get to the patient much sooner because in the past you'd have to transfer outside the walls. So, we brought that on board, and it also reduces the risk to the public safety of transferring and it saves money from the standpoint of transportation and security.

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We've also developed some new onsite services which are continuing to improve the overall health and well being, and I will talk a little bit more about that on the next slide. I do want to say this, just to kind of tag along Dr. Lewis's comment, managed care philosophies are improving health outcomes, at least in Tennessee.

So, I wanted to just kind of briefly discuss a few considerations to some of the illnesses, and by far, this is not an exhaustive list of conditions, but as we talked about earlier mental health disease or illness, excuse me, is a lot more pervasive in the correctional population, and so we have to bring in innovative, multidisciplinary approaches so mental health, medical, legal, corrections—everyone at the table—to ensure that these patients get the care that they need. And our patients oftentimes, especially in the female population—and we'll talk about that in a second—they have a history of being a victim to violence and substance abuse and those do make more complicated treatment pathways.

As far as unique populations within corrections, I think we all have elderly populations. We take care of them whether they're inside the walls or not, but the difference in corrections is that the elderly population in corrections is physiologically older than their chronological age, so you have a person that's, you know, the life expectancy of a patient that's been incarcerated—that's how I see them, I see them as patients—late 50s, whereas the general population is much more near 70 or 75. So it's a huge difference. And so these patients are showing up to our door much sicker than they would've been and much further along in the process of diabetic retinopathy, diabetes, neuropathy—whatever the worst case scenario, they come in. And so it's a lot more difficult issue than it probably has been previously really discussed. But as far as older populations, we try to look at aggressive chronic disease programs. We're developing onsite long term facilities—long term care facilities—to provide assistance to let's say a demented patient or a patient that needs continual nursing care. And we're also providing hospice care. Of course, we understand, you know, cancer increases in incidence as we age, and so we're having a lot more patients with cancer, and so we're trying to treat those humanely, respectfully onsite.

As far as our female population, females have a higher—as a group—they have a higher incidence of mental health disease versus their male counterpart. We have less than 1 percent of the inmates in Tennessee are female, but they do have a significant number of medical problems and it is a different, completely different environment to treat patients. We do try to bring innovation also to their care by providing let's say, with pregnant patients, we provide centering. Centering is a new concept. It's been evidence-based. It shows, essentially, you work with a group of patients instead of one patient, and their experiences can then be exchanged and they learn from the grouping. So instead of the one-to-one doctor to patient ratio you have a 1 to 5 or a little bit larger group where you can have a nice exchange. And it actually facilitates better customer service, so we do care about our inmates and their considerations about our healthcare, but it also improves

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a better outcome. So we have less preterm babies and larger birth weights, so it's a good thing.

Lastly, Hepatitis C, and, you know, that's the elephant in the room. Hepatitis C is a very concerning illness, okay. It has surpassed HIV as the largest cause of death or highest cause of death, for a viral illness as of 2007. Our populations, you know, nationally, 17 percent or so, 17 point something percent, of the inmates that we have incarcerated have Hepatitis C. Almost 1 in 5. In Tennessee it's about 10 times the general population's rate, so we have about 10 percent roughly. There's no vaccine available. Not like Hepatitis B, and unlike HIV, Hepatitis is potentially curable. The new medications that are available may lead to that but they're very, very, very costly and difficult to get. So we are working towards aggressive management of our Hepatitis C cases, as this is a public health issue, okay. We don't talk about it often but a large percentage of inmates are going to be released and we want to make sure that they have the least issues so that they can have a most successful life and contribute back to society. My goal is not to be their judge and jury. My goal is to provide healthcare for them.

So, you know, talking a little bit more about innovative programs in corrections, as we talked about earlier, you know, telehealth, we can use it broadly for various specialties. It decreases the need for transfer including costs of staffing for officers. It reduces the time of diagnosis and it reduces the public safety risk. We also go further to go beyond just the treatment model. We look for prevention, so we, as an organization, are moving to a more customer driven model. I think empowering, you know, if you look at like 20 years ago, when managed care first kind of came around, 20 plus years now actually, but when it first came around we were more focused on providers, networks, facilities. Now we're actually focused on patients, consumers, and we do that through wellness programs, we do that through education. This is occurring in corrections as we speak. We have a program called Nurture. It's a telephonic—it can be group or it can be individualized, but it's a telephonic disease management program that provides wellness to the inmates. So, for example, a patient can actually, with a nurse as a facilitator, speak with an expert. So this goes above and beyond just having a doctor on site or a nurse practitioner on site, but have an expert in whatever their illness. Let's say it's diabetes. You'll have a diabetic expert talk to you and counsel you on mechanisms to improve your health. And it's been shown outside the walls to be very successful and we're in our terminal negotiations to implement it across our state. So these are goals that we're trying to implement to improve the ultimate health and well being of the patients.

As far as the future, the future is re-entry in some cases, and those cases we want to make sure we provide a bridge. An electronic health record, as one of the guests asked earlier, would be a great bridge because it provides the information in an efficient means to get to a safety net hospital, or to a community healthcare center, or to some other group that can provide healthcare after the patient has been discharged, or the sentence is expired. At this current moment, corrections, as a whole, does not have that opportunity. There are a number of difficulties in getting in the HR system and I think that that will be a potential

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opportunity for policymakers to look at finding a way to improve it, because this is ultimately, like we talked about, public health. And if it can connect to the U.S. public health system in some way where that information, before they come in, and then connect to while they're in to when they get out, and it would be a complete pathway, a complete life cycle that will ultimately help the patients in the long term, and that's one of our goals.

Like I said, Centurion is a company I am completely in support of taking care of people when they need care and we try to find individual solutions to our state's concerns. I want to just focus everyone on the recommendations. So my recommendations for policymakers, at this point, will be to look at integrative methods to provide behavioral and medical care on sites before and after entry and re-entry. Consider electronic health records as a mechanism to maybe, you know, through high tech or through some of the other funds that are still available, find a mechanism to assist the Department of Corrections in developing an electronic health record so that we have an ease of communication. It helps decrease unnecessary re-occurring medical visits because you have the information from the previous medical visit. Oftentimes doctors will reorder what the previous doctor has because they don't recognize it's already been done or they don't have that information immediately available and they have to make a decision then because the liability's on their shoulders. So I think it's very supportive.

And then, lastly, to continue to develop the discipline of correctional healthcare by empowering Department of Corrections and other medical institutions to partner and have medical residency programs, medical students, and other allied health professionals, and provide some type of funding to assist the Department of Corrections in hiring qualified professionals, similar to the National Health Service Corps where you have difficulty with accessing healthcare, well, they allow monies available to pay back loans and that's how they can recruit more and more physicians, nurse practitioners, etcetera. Thank you.

ED HOWARD: Thanks very much, Dr. Turney. We have about 20 minutes now where we can get some interchange among our panelists and give you a chance to ask some questions as we go forward. Remember you can hold up a green card, you can go to a microphone or you can Tweet and I'd like to get us started if the folks at the microphones would forebear just a moment. If I could get actually all of our panelists to really talk about something that was raised earlier in the program and Asher, you were talking directly about delivering the kind of quality evidence-based care that is the standard, as we go forward, and Dr. Lewis, as well, what kind of standards—we've talked about the need for regulation, for oversight of the proprietary providers of healthcare in prisons, or the proprietary prisons providing healthcare, what kind of a mechanism for oversight and what kind of standards are in place that you either have to impose or live up to, in the case of Dr. Turney, and Steve, maybe you can talk about the broader picture that goes beyond the specific states that were represented here.

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STEVE ROSENBERG: Well, and I think part of it just shows the alliance's gift in choosing what states to represent, that Dr. Lewis, because of her personal background in managed care, and Dr. Turney, because of Centene and Centurion's commitment to using managed care principles within the correctional institution have demonstrated to us what happens, and the effectiveness of bringing managed care principles. I think the question is, in both instances, it's a question of self regulations that's occurred both in Georgia and Tennessee that shows the kind of progress that both Dr. Lewis and Dr. Turney have created. I think the larger question I'm hearing you ask is should there be some sort of other regulatory type framework that would regulation correctional health within a different context and I'm not prepared to answer that question one way or the other, other than to say I think what we both heard Dr. Lewis and Dr. Turney say, is because of their personal organizational commitments to managed care principles that they've been crossing that bridge over to the island of corrections by using managed care, electronic record, telehealth, as mechanisms to cross that bridge. As to whether there should be other mechanisms, I'm going to leave that up to those of you who get to stay here in Congress to figure out.

ED HOWARD: How about the specifics. Dr. Lewis, what do you do with those private prisons? What standards do you hold them to?

DR. SHARON LEWIS: They're held to the same standards as SOPs, as all my facilities within the state. We perform annual audits to make sure that they are delivering the healthcare by the standards that we have outlined within our standard operating procedures within the Department.

DR. ASHER TURNEY: Yes, we too. I mean, the standard of care is no different inside or outside the walls. So we're held to that same level of care. We have to defend it in court otherwise. What I will say is that, you know, we, internally, also do audits in addition to our agency partner, they do audits on a regular basis, but we also do audits internally to insure quality measures and we are American Correctional Association certified and some of our other contracts are National Commission on Correctional Healthcare certified, and those also have rigorous standards similar to some of the Quality Commission's.

ED HOWARD: Is it part of your contract negotiations as well? Actually, I was thinking in terms of your negotiations with Tennessee in the case of Dr. Turney.

DR. ASHER TURNEY: You know, I'm not as familiar with that portion. I can get that answer but I'm not familiar with that portion.

ED HOWARD: Steve, in addition to what we might do further, do you have observations about what the other 49 jurisdictions might look like? We got the picture that maybe D.C. wasn't right up there at the top.

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STEVE ROSENBERG: Not at the time that they were incarcerated for sure. So, again, I think this is a part of our state, federal, and local partnership that up until now we've allowed each jurisdiction to govern the island of correction and correctional health as they see fit, and at times we're blessed with having someone like Dr. Lewis who has a personal commitment that she brings forth, then you have organizational commitments, again, from Centurion and MHM that they bring forth. I think there is no national framework, if that's your question, Ed, where we have made a societal decision that we're going to make sure that correctional health follows managed care principles. We have not because of the inmate exception. The typical Medicaid protections that are available to consumers have not been available within a correctional health setting because they have not been subject to any of the CMS standards of quality review or anything else that's required. So frankly, in our experience, when you've seen one jurisdiction you've seen one jurisdiction.

ED HOWARD: Okay.

DR. ASHER TURNEY: Ed, I do want to quickly—we do have—I was thinking more about contractual and we do have measures in place that our vendor partner would look at regularly and would charge something called a liquidated damage. And so there are incentives to make sure things are running very smoothly, just as far as contractual.

ED HOWARD: Very good. Thank you. Yes, go right ahead.

SPEAKER: Thank you for having us today. Specifically, Dr. Lewis, lots of strategies I'm curious about. Once you're outside of the wire I totally agree trying to do the best you can inside, it makes a lot of sense in that structure, never missing an appointment, that's real. Once you're outside, unless you have a really strong community intervention and were able to really coordinate that care from inside to outside that wire, how do we encourage those strategies? What do we do other than create a better link with electronic medical record and things like that to ensure that those folks that are then suddenly thrown out in this community once again—freedom, and all this time where they were more successful in a structured environment—they made those appointments, how do we encourage and make sure that once they're out they're a part of something? Thank you.

DR. SHARON LEWIS: I think a couple of things. One is, is that we can do a better job at trying to educate the inmates about their illnesses during our chronic care visits so that they have an appreciation for the severity of the illness. Secondly, is identify public health providers that are going to be willing to accept those discharged inmates under their care. We're having some difficulty with that but it's hard to say, but the more catastrophic an illness is for an inmate, we have discharge planners who try to coordinate the care upon discharge. For someone who simply has hypertension or diabetes that's well managed, unfortunately we're probably not doing as good a job at trying to hook the links up on the outside. But those patients that have cancer and chronic diseases, major

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chronic diseases, we try really, really hard to coordinate the care with appointments, at least in the beginning. We give them 30 days of medication to get them started. We try probably starting 6 months ahead of time to identify and research what benefits that are available for them with Medicare and Medicaid, Veterans, etcetera, and try to get that paperwork started so that those resources are in place by the time they actually get discharged.

STEVE ROSENBERG: And, frankly, I would say we're seeing a major difference between expansion and non-expansion states on this. An expansion state it's much easier to be able to create that linkage out into the community because these folks are being able to come out with insurance. In the non-expansion states I think both Dr. Lewis and Dr. Turney can speak to some of the challenges that they're having in having community providers that are willing to see basically what's going to be a no-pay patient.

ED HOWARD: Go right ahead. Do you want to identify yourself?

SPEAKER: I'm a long time, life time public health official in an expansion state, and it seems to me that a real lever is certainly consumer education but also with the state contracting. Because in an expansion state the state is paying for corrections and the state is paying for Medicaid. And so in order to coordinate those benefits, on the hospital side, we're looking at accountable care organizations, so that hospitals are coming out and working with community providers to make that transition after discharge meaningful and so as to avert unnecessary re-admissions. We're not doing that that I'm aware of, and maybe someone on the panel is aware of those kinds of innovations with following the individual outside of the facility into the community in a contractual arrangement so that there's risk sharing or there's saving sharing by the corrections officer as well as by the public health office. So I'm asking, really, the panel if there's any examples of that sort of innovation.

STEVE ROSENBERG: Yes, there is actually an example of that in Oregon, in part of their CCOs, they actually have set up a separate post incarceration CCO contractually, which has a risk sharing arrangement with that. That's the only one that I can think of off the top of my head that the state has done that. I think that's a great model and I think that's a great example we want to do. Again, I think the question is, that given our federal system, a federal, state, and local autonomy, the question is, has been how do you stimulate and how to you encourage those kinds of programs? Is that a federal grant program? Is that an initiative program? How do we do that? But yes, I think that's an excellent point.

SPEAKER: Thanks. It's a great panel. Thank you.

STEVE ROSENBERG: You have a question right there.

ED HOWARD: Oh, yes. Here we go. Thank you.

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RIKA: Hi. My name is Rika and I am with the National Association of Community Health Centers, or NACHC, and my question is mainly to Mr. Rosenberg, but anyone who has input. So, as a staff member at NACHC we have thousands of member health centers nationwide including those in COCHS partnerships. In addition to your island metaphor, I want to point out that the correctional system is also hidden behind concrete walls, layers of varying policies at the local, state, and federal level that are gray at best, the inmates are disappeared behind these walls and the label “criminal” and there are financial and systemic incentives for keeping it that way. So, from your experience of success building these partnerships at the community level, I’m wondering if you have any words of wisdom and lessons learned that you can share for us at NACHC while we’re at this national level, but then have these local member health centers that could potentially want to reach out and create these partnerships but might not even know where to start and who to contact.

STEVE ROSENBERG: Sure. So the first thing I want to do is I want to identify a huge obstacle which I think you know about, which HRSA has, up until now, been unwilling to allow health centers to have the change in their scope of service to define care behind bars. So while you have these health centers that may be actually the number one appropriate provider to be going out and providing care behind bars, HRSA, up until now, has not been willing to allow that change for scope of service. So for those of you who are here on the Hill, I want to point out that that’s not an insignificant issue.

In terms of lessons learned going forward, I think the number one thing is about understanding having a community board, you have to remember, community health centers are 51 percent user boards. And having that community board understand and identify that the folks behind bars are members of their community who are temporarily displaced. And I think that is a huge educational process within the community health center movement. I think that if you look at the work of Sheriff Ashe, one of our board members in Hampden County, Massachusetts, who started this model, he started it by him identifying that the folks in his county jail were community members temporarily displaced. He reached out to his local community health centers and invited them into his facility to provide care. That came from the correctional side. I think the challenge is, from the health center side, having an absolutely educational understanding that these are the fathers, brothers, uncles, of the women and children we primarily serve and that they are part of our community and, as such, we want to reach out into, behind those barbed wires and steel walls and guard towers to figure out how we create integrative care, the SAMHSA HRSA initiative on integrative care is another good model for that to be disseminating out to health centers.

ED HOWARD: Yes, ma’am.

AMY THOMAS: Hi. So, my name is Amy Thomas and I work for the Association of Community Affiliated Plans, and we represent 58 nonprofit managed care organizations

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throughout the country and we have one, in particular, in Rhode Island who's working with their department, their health services department, as well with the presence to help with that hand off between the prisons and them coming outside. And I particularly was curious if you have any research about the return on investment. You know, we're looking at this in Rhode Island but any research that's been done about how the handoff actually saves Medicaid—state Medicaid programs money.

STEVE ROSENBERG: And the answer is no because of data sources. So the Washington State data I was able to describe to you is unique because they merged their jail booking data, their Medicaid data, and their mental health utilization data and they have a master patient index that allows them to tie that data. No other state has that data at this point in order to be able to do that research. I think in Rhode Island you've been very blessed. You have Neighborhood Health Plan as a leader. You have A. T. Wall as a correctional leader who have understood and been working with trying to figure that out. I think we have something similar happening in the state of Vermont right now where there's also an effort to try to figure out how to link those systems. But, unfortunately, without what we simply, in nerd terms, call the master patient index, or some way of tying that data together we don't have a way to do that and then there's a lot of HIPAA concerns and other concerns of being able to do that. So they were able to do that in Washington, again, because of their unique dataset that allowed them to easily identify folks.

ED HOWARD: Okay. We have just a few minutes left. I'm going to ask you, as we go through these last couple of questions, to pull out the blue evaluation form if you haven't done it already and fill it out as you listen so that we can get some feedback on what we ought to do to serve your needs better. Linda, do you have a second question?

LINDA: It's a very quick question, yes. I think both of you talked about hospice care and long term care inside the prisons, and I was just wondering why can't these people be released at that point? Why are they still incarcerated when they probably are not a threat to society anymore? Just wondered.

DR. SHARON LEWIS: For Georgia, I can speak is that our clemency entity, which is what we call the Board of Pardons and Paroles, has the authority to decide whether someone is eligible to be released and we have a very active medical reprieve process. Right now we probably have about 65 percent of those inmates that we submit for consideration that are being granted a reprieve. So those inmates who have, as I said, a guestimate life expectancy of less than 12 months, or a chronic debilitating terminal, or otherwise, disease that's going to be particularly costly to the state we can submit those for consideration.

DR. ASHER TURNEY: And we have a similar process in Tennessee, but that is actually, our providers would be responsible for providing those cases to the Department of Correction and they would go through the normal process. The process has been

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recently revised to include some long term issues that are not per se terminal but are debilitating to be humane.

ED HOWARD: Okay, maybe this is the last question. It's maybe the toughest. We've sort of talked around it for a good part of the conversation. What impact do you anticipate Solvaldi, the new Hep C drug, having on correctional healthcare expenditures?

DR. SHARON LEWIS: Easy answer. The bankruptcy.

ED HOWARD: And therefore, what? Dr. Turney was talking also about trying to deal with a very large incidence of Hep C population. Are you going to prioritize? Are you going to test everybody? Are you going to allow the use of Solvaldi for some subset of those folks, and how are you making that decision?

DR. SHARON LEWIS: We're going to, and have started to, prioritize those inmates and basically leave the decision to the GI specialist who is rendering the care as to who is most appropriate, given the financial constraints. Sovaldi is a very effective drug, but to treat an inmate with fewer side effects, which is the big plus for that, we were talking about it—roughly \$120,000. So with that type of price tag you can imagine we can't treat everybody for \$120,000 otherwise we wouldn't be able to treat the heart disease and the diabetes and everything else. So yes, we do have to prioritize. We do have to follow protocol. And we are currently looking at the Federal Bureau of Prisons' guidelines for treatment of Hepatitis C.

ED HOWARD: Do you want to weigh in on that one?

DR. ASHER TURNEY: It's not an easy answer. I think that we still have a long way to go with the discussion. There's not been any definite, defined prioritization schedules that have been released on a national scope. The AASLV and the FBOP have released some preliminary guidelines which we also use. We have an advisory committee that has an infectious disease doctor or hepatologist to assist us in prioritizing patients based upon their medical needs. Case in point, Hepatitis C and HIV, they don't work well together. So when you have both illnesses your disease goes much faster. And so they're put at the top of the list. We look for worsening clinical courses and we put them to the top of the list or prioritizing. So I'll say that I think there needs to be still a lot of discussion between local, federal, FARMA, corrections, and public health on this discussion and we really need to find a solution, but it's got to be a collaborative deal.

ED HOWARD: Okay. Well. If you could put that composite slide back up Dexter, I'd appreciate it. Just for your use, our prac staff, led by Marilyn Serafini on this briefing, had put together a summary of the evaluations that several of our speakers today had put into their presentations. So when you're looking for things that you can work on, we've put it all on one page for you. So take that as grist for your legislative mill, or your policy mill.

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I want to thank you for your attention to a really underappreciated set of issues that we were able to address for that, by the way, I want to thank our friends at Centene for allowing us to put this program together and helping us to recruit some of the folks you have heard. I want to thank our panel and I particularly want to recall the eloquent testimony that we heard from Debra Rowe and Jacqueline Craig-Bey as well as the panelists you see up here and ask you to join me in thanking all of them for a very useful discussion on a very difficult topic. [Applause.]

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