COCHS CONNECTION

COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

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A MESSAGE FROM THE EDITOR

Welcome to the first issue of *COCHS Connection*, a newsletter on the provision of health care services in local correctional facilities.

As you know, local correctional agencies must provide health care for their inmate populations. No matter where you are or how many inmates are in your facility, it's not easy. There are always too many inmates, too much illness, not enough staff, and not enough dollars to do the job.

On a positive note, though, new ideas and new approaches are in the works for making jail-based health care more effective and more efficient. *COCHS Connection* was created to help you stay on top of these developments. With 12 million people passing through our nation's jails each year, local correctional agencies are more than enforcers of law and public safety—they are in a unique position to improve public health and reduce recidivism.

At COCHS—Community Oriented Correctional Health Services — our mission is to help local correctional facilities improve health care delivery by fostering partnerships between jails and local community health care providers. *COCHS Connection* will focus on the challenges and opportunities within this unique field of community service, and on the differences between jail and prison health care. You can find additional information and resources on our website at www.cochs.org.

COCHS Connection is absolutely free. However, if you wish to continue receiving this newsletter, we need to hear from you. **To subscribe to *COCHS Connection*, please send an email to newsletter@cochs.org** and indicate if you would like to receive the newsletter by email or in hard copy through the mail. In addition, we welcome your comments, feedback and questions.

We hope that you'll find *COCHS Connection* interesting, informative, and useful as you look for ways to maintain, redesign, or improve jail-based health care in your community.

Paul Sheehan
Chief Operating Officer
Community Oriented Correctional Health Services

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A MESSAGE FROM THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Through COCHS—Community Oriented Correctional Health Services —we have invested $7.4 million to replicate what we saw as a promising model for improving community health.

To many people, the connection between jails and their communities may not be apparent, but that connection became clear to us when we saw what was happening in Hampden County, MA, where local corrections officials partnered with local doctors to screen and treat inmates.

Why do that? Because jail inmates are part of their communities not separate from them. Jail inmates are not like prison inmates, who serve long terms in faraway facilities. Instead, they cycle in and out of the local jail, bringing their health problems back with them to their community. These problems include HIV/AIDS, substance abuse, tuberculosis, severe mental disorders, and a host of communicable illnesses.

As a foundation, we invest heavily in the health of vulnerable populations, which include the chronically homeless, those with mental illness, people with addictions, children aging out of foster care, and people dealing with poverty and living in violent environments. After visiting Hampden County, we realized that we could not address the needs of these populations without taking into account the role that jails play.

Many jails are becoming *de facto* providers of health care. That's a tough job. Our experience with COCHS shows us that local corrections officials want—and need—help to address the multitude of health and human service issues present in their jail populations. COCHS offers an approach that works.

By linking jail inmates—often for the first time—with a local doctor or other health care provider they can continue to see when released, a connection is formed that ultimately will help improve the health of the community.

In COCHS, we see an innovative and effective approach to community health care that we hope will take hold across the nation. Jails provide a unique opportunity for improving the health of local populations. By investing in COCHS, we seek to leverage that opportunity.

Nancy Barrand
Special Adviser for Program Development
The Robert Wood Johnson Foundation

OCALA COMMUNITY CARE LAUNCHES IN FLORIDA

An Interview with Sheriff Ed Dean of Marion County, Florida

On January 2, the Marion County (FL) Sheriff's Office launched Ocala Community Care (OCC), a community-based, not-for-profit organization charged with providing health care to the county's 2,000 jail inmates, replacing the for-profit contractor that formerly managed the jail's medical unit. Sheriff Ed Dean has been the driving force behind this innovative initiative. Here, Sheriff Dean describes how OCC came about, its goals, challenges, and vision for the future.

Q: How did you come up with the concept for OCC?

A: Faced with rising health care costs and mandatory budget cuts, we were looking for a new and innovative way to provide health care to the inmates at the Marion County Jail. We came across the COCHS website and reached out to the Hampden County Sheriff's Office in Massachusetts. I spoke with Sheriff Ashe and admired what COCHS was trying to do through the creation of community collaborative networks —taking care not only of the health care needs of inmates, but also meeting other health care needs in the community.

Q: How did you adapt that approach to your community?

A: Our premise is the same as Hampden County's, but we have enlisted a different mix of providers in a community collaboration. The community formed a not-for-profit corporation, OCC, whose Board of Directors comprises leaders in the health community, including the CEO of the major hospital, Steve Purves; the former hospital CEO Dyer Michel; the head of the local health department, Dr. Nate Grossman; the head of our mental health consortium, Russell Rasco; the executive director of the Medical Society, Debbie Trammell; several local well-known physicians, including Dr. Segismundo Pares, Dr. Mike Jordan, and Dr. Mel Seek; Attorney Randy Klein; and Chief of Staff Tom Wilder of the Sheriff's Office, who has an ex officio position. So, we have all the major sectors collaborating to provide inmate health care.

Q. Why do you believe OCC will work better than your previous arrangement?

A: We're required to provide the community standard of medical care to inmates. Who better to provide that standard of care than the community itself? In addition, we need to better leverage our inmate health care dollars so that they provide more benefit to the community. As envisioned, OCC ultimately will form a linkage with the Federally Qualified Health Center (FQHC) that is also providing care in the community to the uninsured and the indigent.

Q. What is the connection between jail inmates and the community?

A: Inmates return to the community once their sentences are complete. Then they will probably join the estimated 45,000 citizens in Marion County who are uninsured. So that's one concern. We also have a concern for inmates with mental illness who receive psychotropic medication while they are in jail, but then stop taking medication once they leave. Under OCC, they will now have continuity of service after their release, which should help keep them on their medications. We hope that this continuity of care will also reduce our recidivism rates, as it has in Hampden County.

Q. What is the fundamental change you're trying to bring about through OCC?

A: I would like to see inmate health care dollars serve as a catalyst for delivery of health care to a wider range of persons in the community. Our model is flexible and we believe it will be more efficient. If it really takes hold, it should benefit the larger community of uninsured and indigent in Marion County through reduced overhead and cost savings from our jail health care program. The community will have more resources available with which to do more.

Q. How will OCC benefit families in Marion County?

A: Over time, we may see benefits across generations of families in our community. Families of inmates comprise a large portion of the uninsured and indigent in any community. By incorporating the delivery of health care services for inmates into the larger community health care system, the community hopes to reach more people and provide them with better access to health care, which could have a benefit across generations of families.

Q. What do you see as your greatest challenges, and how will you address them?

A: Gaining continued community support for the collaborative will be important. We will also have to be very attentive to rising medical costs within our sphere. As a community-based, not-for-profit organization, I believe that OCC is positioned to deliver the same quality of care as a for-profit provider, at a lower cost. But it will take work. Let me be clear that this is not a self-operation program. Many jails provide health care themselves to inmates. Here, in Marion County, is truly a community collaborative, managed by providers from the community. That's the distinction. The future of inmate health care may be influenced by how well this works. I'm of the opinion that this may be a model for slowing down rising costs and leveraging health care dollars to provide broader services in every community.

Q. What is your long-term vision for OCC?

A: I would like to see OCC partner with our community FQHC so that they can ensure continuity of care for inmates, especially those who are mentally ill and who return to the community, in order to reduce recidivism. I also hope that we can find creative ways to control rising costs of medical care.

Q. Is there anything else you'd like to say about the program?

A: I believe that quality of care under OCC will not suffer in any way, and it may well improve. We have hired someone with extensive experience in inmate medical quality control, and that person will develop quality control measures and report back to OCC monthly. This is an outside, ongoing quality control check in addition to OCC's internal quality control mechanisms.

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NATIONAL ASSOCIATION OF COUNTIES AND COCHS CONDUCT NATIONAL JAIL SURVEY

Results show variety of service delivery methods, expenditures and outcomes in local jurisdictions

Correctional facilities are mandated by law to provide health care, but across the country, the manner in which facilities provide that care can vary greatly. Limited revenues, limited access to resources, political pressures for other services and many other forces can impact the type of care counties can provide to inmates.

The majority of local correctional facilities (76%) report expending between 10-20 percent of their overall corrections budget on health care services, but frequently the amount expended is not reflected in the level of health care services received by the inmates, according to a recent survey of county officials conducted by the National Association of Counties and Community Oriented Correctional Health Services (COCHS). Several jurisdictions report expenditures that exceed 20 percent of their overall budgets on health care, but in many cases these same jurisdictions perform fewer comprehensive initial medical screenings and deliver fewer services than jurisdictions that are spending less. The differences in costs are based primarily on the structure that the county has in place to provide health care services to inmates. Fifty-eight percent of the counties report using private vendors by contract and 54 percent report using a local hospital. Only 37 percent report that they use their own-in house medical staff to provide inmate health care.

The most common health care screenings conducted on intake are for mental health issues (75%), tuberculosis (72%), substance abuse (61%) and high blood pressure (58%). The most common health care services provided by county correctional facilities are emergency treatment (84%) and routine care (78%).

Only a few jurisdictions report that they regularly connect chronically ill inmates to local health providers after release and most acknowledge that the inmate likely goes to an emergency department for continued services.

Jurisdictions that do connect inmates to post-release medical services rely on a loose, rather informal connection because the inmate and his health history are usually well known in the community.

Nearly 180 jurisdictions responded to the online survey and another 30 participated in a more detailed phone survey. The survey gathered demographic information such as the average daily inmate census, what inmate health services are provided, and the percentage of the total correctional budget that local facilities spend on health care. The survey also looked at who provides care in the jail, such as in-house employees, private companies, local hospitals or community health clinics.

Even in this small sample of counties there was a wide variation in the types of health care services provided to inmates and the costs of providing these services. The researchers acknowledge that because of the small sample size, it's difficult to compare jurisdiction sizes, delivery methods, services and expenditures across the nation.

Although most counties report spending a large portion of their correctional dollars on health care, it is clear that on a national basis, little assistance has been available to help counties provide this service more economically.

Most respondents cite lack of funding as the barrier to providing more comprehensive services. Three-quarters of respondents said they exceeded their health budgets at least once in the last three years and almost one in three (30%) said they exceeded their budget every year. Only 29 percent of responding jurisdictions report that they have current plans to change their inmate health care delivery structure in the next one to five years.

FOUNDATION REPORT IDENTIFIES CORRECTIONAL HEALTH CARE FUNDING OPPORTUNITIES

A new Langeloth Foundation report, *Philanthropic Opportunities in Correctional Health Care*, reviews the history of correctional health care, discusses best practices, and offers recommendations for foundations interested in this issue. The report examines challenges and the lessons learned and best practices exhibited by state and local collaborations. The report recommends that foundations support access to Medicaid funds; data collection, research and evaluation; capacity building; policy advocacy and system reform; training and technical assistance; curricula development; support services to families of offenders; gender-specific health care; and convening stakeholders.

Additional information on this report is available at *www.langeloth.org*.

ORANGE COUNTY, FLORIDA'S INNOVATIVE JAIL MANAGEMENT-ELECTRONIC MEDICAL RECORD SYSTEM DRAWS PRAISE AND INTEREST

Among the many challenges corrections officials face is providing inmate health care, and managing the paperwork generated by this enormous task. This paperwork often gets lost, slows down communications, and creates administrative nightmares.

Two years ago, by electronically integrating its inmate management and medical records systems, the Orange County Corrections Department in Orlando, FL, went completely paperless.

"On November 6, 2005, we operated on paper. On November 7, we took away their pencils," says Jane Jenkins, assistant manager of the Department's Corrections Health Services Division. "Within a few weeks, even the most die-hard said they couldn't remember how they lived without this."

After getting the green light from the Orange County Government to pursue an electronic medical management system, the Corrections Health Services Division issued an RFP for a vendor and selected Altoona, PA-based Digital Solutions, Inc. (DSI). DSI chose a compatible electronic medical record (EMR) system designed by General Electric (GE).

Today the inmate management and medical systems are fully integrated and operate in "real time." When a booking clerk enters an inmate's demographic information into a computer, an EMR is automatically created. As intake information is entered, pertinent data are automatically transferred to the inmate's EMR.

Conversely, when a doctor or nurse enters information into the inmate's EMR, data essential to corrections are transmitted into the inmate management system. (Under federal privacy laws, only certain health-related information can be shared, such as whether an inmate requires a bottom bunk or a special diet or whether he or she is under psychiatric observation or may keep medications.) Medical records for more than 4,300 inmates can be accessed instantly in any of the eight medical facilities on the 75-acre campus by authorized medical professionals.

Nurses use hand-held personal digital assistants (PDAs) while administering medications to keep medical records up to date. A nurse downloads information for his or her housing area before getting medications for each inmate. During rounds, the nurse scans the inmate's identification card, administers the appropriate medication, and records the action (accepted medication, refused medication, inmate not present, etc.) into the PDA. At the end of each medication round, the nurse places the PDA into a computer station that uploads the information into each inmate's EMR. Similarly, lab results are automatically uploaded when a physician orders a test and receives results.

The new system also saves the Department time. A "sick call system" uses a phone tree triage that allows inmates to dial a number, enter their inmate identification number, and request medical, dental, or mental health services. Requests from these calls appear on a medical facility triage screen and nurses respond within 24 hours. All information from the call becomes part of the inmate's EMR. According to Jenkins, some inmates requested medical attention two or three times a day under the old system. Because the paperless system creates a quicker response, the number of repeat requests for medical care has fallen dramatically.

"We used to spend hundreds of hours on paper records, tracking reports and audits," Jenkins says. Records and reports are now created automatically and corrections officers and health care providers are happier.

In addition, Jenkins notes: "We have seen large benefits on the security side of the house. Inmates know that corrections officers can find out whether requests for special diets or housing are legitimate."

Jenkins reports that since the EMR system's implementation, acute illness goes untreated less frequently and health providers are managing chronic illness better. This translates to fewer emergency room visits by inmates, which in turn reduces the number of hours spent by corrections officers guarding inmates in unsecured settings. As a result, community safety is enhanced.

Discharge planning has also improved. Case managers can see from inmates' files whether they need medical attention prior to release. They can also ensure that inmates leave with needed prescriptions, and notify the local health department if an inmate has been diagnosed with tuberculosis or AIDS.

In addition, the system simplifies health care if an inmate is re-incarcerated, because the EMR is still in the system. Health providers know right away when they have to deal with a severe illness.

Jenkins offers the following advice to other jurisdictions exploring similar systems: Train, train, and do more training. Prior to implementation, Orange County corrections and medical staff received basic computer training on how to use a mouse, Microsoft Outlook, and other fundamental personal computer applications. Afterward, they learned how to use the inmate management and EMR systems. Training is ongoing and occurs every time a new form or application is added.

Now that the system has been up and running for two years, Jenkins says the possibilities for expansion are endless. Recently, the jail's pharmacy interfaced with the EMR system. Also, a local community health clinic has implemented the same GE medical record system. Jenkins envisions a day when all the information systems of the jail, community health center, state labs, local health providers, and the county health department will be integrated. "We will continue to tweak and grow," she says.

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FIRST COCHS' SITE: HOW D.C. HEALS OFFENDERS

With technical assistance from COCHS, the District of Columbia was one of the first major cities in the U.S. to implement a program bringing community-based health care to jail inmates. The following opinion article, written by D.C. Council Member David Catania, appeared in the September 16, 2007, issue of *The Washington Post* in response to a news report on prisoner reentry.

Robert E. Pierre's Sept. 2 front-page article, "Back From Behind Bars," made an important point about the need to better support the reentry of former prison inmates into the District and surrounding communities.

We should also spotlight the 3,500 people detained daily at the District's two jails. Many of our inmates have serious mental health, substance abuse and communicable health problems that they bring back to our community after their release. The District is one of only a few jurisdictions in the country that has implemented an approach that links inmates with doctors from neighborhood health centers. With the support of groups such as the Robert Wood Johnson Foundation, the District, which is the first major city to adopt this approach, could serve as a national model for inmate health care.

Last year, the D.C. Department of Corrections partnered with Unity Health Care, the city's largest federally qualified health center, to provide jail inmates with medical care that follows them after release. Doctors from Unity screen inmates while they are in jail, identify their health problems and develop a treatment plan designed to continue after they are released. Unity operates nearly three dozen clinics and homeless shelters across the District, all of which participate in this program.

Our strategy is to integrate correctional and local health services and thereby invest in the health and safety of the community. How? Because jail inmates are not isolated from our community — in fact, nine out of 10 inmates are released within 30 days. They tend to be at high risk for illnesses such as hepatitis C, tuberculosis and HIV. Typically, they do not seek health care themselves and can be hard to reach. Thus, jails provide an excellent opportunity to identify and address inmates' health problems. Once they are released, every effort is made to connect them to the local health care system, usually for the first time.

This connection benefits everyone. Healthier inmates are less likely to spread disease when they are out of jail, which means that the community is healthier. And a healthier community is a safer community.

This model is not without challenges — indeed, it is difficult — and it requires a great deal of support from all sectors of our community. But we know that the approach is sound, and with the appropriate leadership, we can make it work. As chair of the D.C. Council Committee on Health, I am firmly committed to community-based health care for jail inmates as a way to improve their health outcomes and to protect the health and safety of all our residents.

David A. Catania, *Washington*
The writer is an at-large member of the D.C. Council.

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NEW BOOK ON INMATE HEALTH CARE CALLS FOR COMMUNITY-BASED APPROACH

A new book, *Public Health Behind Bars: From Prisons to Communities*, examines the burden of illness on the growing U.S. prison population and analyzes the considerable impact on public health as inmates are released. Edited by Robert Greifinger, the book identifies the most significant health problems behind bars (including communicable disease, mental illness, addiction, and suicide) and concludes that the public health of communities is best served by correctional health programs that provide primary care and prevention services.

Greifinger, a former chief medical officer for the New York State Department of Correctional Services, solicits contributions from more than forty practitioners, researchers, and scholars in correctional health, mental health, law, and public policy. These experts help outline strategies linking community health resources to correctional facilities so released prisoners can transition back into the community without unnecessarily taxing public resources or falling through the cracks.

HISTORY OF THE RELATIONSHIP BETWEEN CORRECTIONAL HEALTH AND COMMUNITY HEALTH:

John R. Miles has an extensive history in correctional health programs. In 1996, Miles developed the Corrections and Substance Abuse Unit at the U.S. Centers for Disease Control and Prevention (CDC) and fostered the concept for the first Corrections Demonstration Project supported by both CDC and the Health Resources and Services Administration. He has established strategic national and regional partnerships to support continuity of care among corrections, substance abuse, public health, and community programs.

Currently, Miles serves as Senior State Liaison with the Portfolio Management Project for the CDC's Office of the Director. He is also Senior Associate at McKing Consulting Corp. in Atlanta. Miles assisted in the development of the yet-to-be-released Surgeon General's report on correctional health and the community, and is the editor of the Journal of Correctional Health Care. He is also a board member of COCHS.

Q: What can you tell us about the CDC's history with jail-based health care?

A: That history goes back a number of years, to the episodic screening programs for STDs in local jails that focused on syphillis control in the 1960s and then shifted toward gonorrhea and chlamydia in the early '70s and '80s.

Back then, the CDC lacked a good understanding of correctional health programs and how corrections systems functioned. Not until the AIDS epidemic gained momentum in the '80s was there recognition that many of the behaviors that put people at risk for HIV also placed them at risk for incarceration. During the early '90s, prevention efforts for HIV were focused on injection drug use, because that was a major risk factor for HIV transmission. CDC worked closely with the Substance Abuse and Mental Health Services Administration to gain a better understanding of addictive behaviors to identify and reach at-risk populations. Prevention staff quickly realized that if they could not find these individuals in the community or drug treatment centers, the best place to look for them was in corrections. That's when we started to move toward a more comprehensive partnership in working with correctional systems at all levels: local, state, and federal.

We began to recognize that jails were critical sentinel sites for the early identification of community public health problems. In the mid-1990s, Surgeon General David Satcher asked that I set up an office focused on corrections within the CDC. We started to reach out and work with our colleagues at the Department of Justice. Those first years were really a process of learning the issues and figuring out how to develop medical screening and prevention programs that could be operated and supported in a correctional environment.

Q: What innovative and effective programs for jail-based health care have you seen?

A: Around 1993 or '94, a project officer from the STD program introduced me to Tom Conklin, a physician who was doing some very innovative work in his jail in Hampden County. Dr. Conklin laid out a plan for a seamless system of jail-based health care, using providers from the community. That conversation led to a demonstration project funded by both the CDC and the National Institute of Justice to enhance and evaluate the Hampden County Public Health Model for Corrections and the Community.

We learned a lot from that demonstration. With our colleagues at the Health Resources and Services Administration, we translated those lessons into the first national corrections demonstration project, with seven states. This five-year demonstration showed that if you deal with health care problems up front, especially in the jails, you can reduce the burden of disease in communities and begin to deal with some of the underlying social and public health problems that exist in economic and socially disenfranchised communities and populations.

We demonstrated that bringing community care providers in to provide care for jail inmates established a community care connection for the newly released individual. The model itself was good, and not just for physical health care, but for dental care, mental health, nutrition—all those issues that impact people's health, particularly people who don't normally seek health care. We also saw the importance of case management and continuity of care, especially for people with HIV. Linking people back to ongoing care and support systems in the community provided the essential link for individuals to reduce high risk behaviors and maintain a healthier, productive lifestyle.

Now, taking that model and implementing it in every jail across the country probably was not feasible, but we recognized that parts of it would be. Since then, we've seen other programs in Florida, Los Angeles, San Francisco, and Houston that have implemented this concept. They're not all the same, but the concept is there and they recognize that it's a valuable model.

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AN INTERVIEW WITH JOHN MILES

Q: What is the greatest challenge to making this concept work?

A: Most frequently, it comes down to the resources that are available in the community and their willingness to work in correctional settings. Sheriffs have limited budgets and they need community support to make this model work. That's why corrections officials at the local level are often skeptical about taking something like this on, because they don't want to be left holding the bag. This is especially difficult for small jails, those with 100 beds or less, which account for more than 2,000 of the 3,300 jails in this country. Since small jails contract most if not all of their medical care for inmates —a doctor or nurse who comes in —their resources to provide the level of education, case management, and support needed are limited. It's not impossible, but it's hard. The kinds of things that, say, the Harris County jail can do in Houston can't be done in a small-town jail near Amarillo. They can screen and they can treat, but there may not be a community care provider who can provide the link to community services and follow-up if needed after the individual is released. Frequently, the community care providers are already the jail health providers, which is ideal, but they often lack the resources to provide the level of case management that is required to deal with individuals who also have histories of drug addiction and mental illness.

Q: What are your thoughts on health care in jails versus prisons?

A: While there are similarities, they are really different. Prisons house a more stable population. They aren't dealing with the myriad diseases that you see in jail but with chronic diseases and conditions, such as HIV, asthma, hypertension, and even illnesses related to aging because of the increasing proportion of elderly inmates.

Jails, on the other hand, are directly linked to the communities they serve, and reflect the social medical problems within those communities. Over 12 million people pass through jails every year. Most don't stay more than a few days, and over 50 percent are gone within 48 hours. Local jails provide a public health opportunity for us to access a population that's at high-risk for a limited period of time. Although limited, jails can provide medical care and treatment and begin to educate inmates so that they can take better care of themselves when they are released. But you can't do that for everybody due to the limited time they are in jail. Most programs don't start screening people unless they've been there three or four days.

"IF YOU DEAL WITH HEALTH CARE PROBLEMS UP FRONT, YOU CAN REDUCE THE BURDEN OF DISEASE IN COMMUNITIES AND BEGIN TO DEAL WITH UNDERLYING SOCIAL AND PUBLIC HEALTH PROBLEMS."

Jails today are being asked to deal with complex community issues like mental health, substance abuse and social disparities that they weren't designed or funded to do. The Los Angeles County jail, for example, is the country's largest mental health institution, and Riker's Island (New York) and Cook County in Chicago are right behind. As many as 20 to 30 percent of inmates are now reported to have a co-occurring mental disorder. That's what jails are dealing with: not just security and custody, they're dealing with folks who have severe psychological and physical problems that are taxing their capacity. Jails were not designed to be long-term health and social service providers. That's why communities really need to be involved; they have the social service organization and resources that can make a difference.

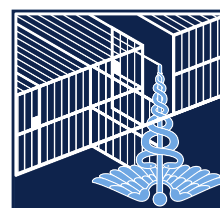
Q: How can local corrections officials convince communities to invest in jail-based health care?

A: They need to show that dealing with underlying health problems and behaviors in jail and linking these individuals (populations) to outside support services actually reduces the burden of disease as well as long-term costs for the community. And a healthier community is a safer community. We need to convince communities that they have a stake in this, and that's a struggle.

Q: What can you tell us about the yet-to-be-released Surgeon General's report on corrections and health care, which you helped write?

A: We wanted to look at the entire public health system, with corrections as one part of it, and how together we could reach this disproportionately impacted population and improve health outcomes. The report outlined some of the gaps and issues in community health, as well as similar issues that we face in corrections. It identified the benefits and challenges of providing good continuity of care as inmates re-enter their communities. This is a very balanced report, with input from large numbers of people. It's hard to understand why it hasn't been released, because there's nothing controversial that other reports haven't said in some way. The report that the National Institute of Justice and the National Commission on Correctional Health Care did in the early 2000's on the health status of soon-to-be-released inmates really provided a baseline. The Surgeon General's report basically took the next step to look at how we can do a better job in the community, how we can do a better job in corrections, and how we can do a better job with re-entry.

COCHS
COMMUNITY
ORIENTED
CORRECTIONAL
HEALTH
SERVICES
675 61st Street
Oakland, CA 94609



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CONTACT:

For information on COCHS, please contact:

Community Oriented Correctional Health Services
675 61st Street
Oakland, CA 94609
Tel: 510 595 7360
editor@cochs.org

Community Oriented Correctional Health Services (COCHS) is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community. Ultimately, COCHS hopes to help local communities around the country reduce the incidence of chronic disease and the cost of health care.

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