



# A local health department-administered correctional health care program: Strengths and challenges to implementation



Nancy L. Winterbauer, PhD, MS<sup>1,2</sup>; Ryan Marie Diduk, MPH, CHES<sup>1</sup>; Max Solano, MD<sup>3,4</sup>

(1) Institute for Health, Policy, and Evaluation Research, Duval County Health Department (2) College of Public Health and Health Professions, University of Florida (3) Division of Institutional Medicine, Duval County Health Department (4) Shands Jacksonville, Department of Internal Medicine

## DIVISION OF INSTITUTIONAL MEDICINE (DIM)

Since October 2006, the Duval County (FL) Health Department's (DCHD), newly created Division of Institutional Medicine (DIM) has contracted with local authorities to provide healthcare to inmates housed in the county's jails. The DCHD, DIM provides health care to over the 50,000 newly admitted inmates each year.



## DUVAL COUNTY DEPARTMENT OF CORRECTIONS (DOC)

Each year, the Duval County Department of Corrections (DOC) admits 50,000 offenders into their 3 facility system. Daily, the facilities provides housing to approximately 3,600 inmates. While some of the offenders are released within 24 hours, many of them are housed for up to two years. Those that are being held in the facilities have a need to access health care services.



The provision of correctional healthcare by a local public health agency is unique and offers great potential to improve community health, because: 1) the health of incarcerated individuals is generally poorer than the non-incarcerated population; 2) jails are local institutions, meaning that the opportunity to establish a continuum of care from jail to community exists; and 3) the "revolving door" from jail to the community through which inmates frequently cycle heightens the potential impact of this population on community health and life.



## BACKGROUND

The use of the county health department, in place of a private agency to provide correctional health services developed from a HRSA-funded, Corrections Demonstration Project (CDP), which brought the DCHD, the DOC and other community agencies together. The goal of the CDP was to provide continuity of care for HIV+ inmates as they cycled from jail to community. Through the implementation of this program, the DOC and DCHD developed a strong working relationship; each agency recognized that the correctional population was deriving from the larger community which both agencies served. In 2006, this relationship became a formal contract between the City of Jacksonville and the DCHD, which was contracted to provide medical services within county correctional facilities.

## METHODS

Qualitative interviews were conducted with DIM staff (n=13), DCHD staff (n=5), and corrections staff (n=7) to gain insight into the facilitators and difficulties of program implementation.

The interviews were audio-recorded, transcribed, verified, and analyzed. To control for validity and reliability of results, an inter-rater reliability method was utilized. Analysis included identifying key themes within and across each participant group.

## TRADITIONAL VS. PUBLIC HEALTH MODEL OF CORRECTIONAL HEALTH CARE

<u>Traditional Correctional Medicine</u>	<u>Institutional Medicine</u>
<b>Adversarial:</b> Constant struggle between provider and inmate. Inmates are manipulators always trying to con the provider.	<b>Patient Centered:</b> "Patient" not inmate. Patient completes evaluation to determine appropriate intervention based on patient beliefs and cultural sensitivity.
<b>Commissary - Access of Care:</b> Unclear scope of services and referral of inmate to use of commissary for conditions that may require treatment and in clear violation of accreditation standards.	<b>Comprehensive care with clear scope of services:</b> After careful evaluation of the patient, the treatment plan includes pharmacologic and non-pharmacologic approaches with education of the patient, based on his/her beliefs. Upon agreement commissary may be used, otherwise patient is provided with necessary treatment. Scope of services is based on patient condition and co-morbidities.
<b>Biological</b> The inmate has to show something wrong and obvious on physical exam to be treated.	<b>Biopsychosocial</b> Disease is understood as biological variation around normal. The biological component is largely minimal and the psychosocial component is the area most often needing treatment.
<b>Defensive</b> All the inmates want something for comfort, manipulation, to get status.	<b>Factual</b> Assessment and plan is delineated after careful H&P, and if the objective bio-psycho-social findings are inconsistent with the subjective findings, and particularly if significant morbidity has been excluded, the patient is educated about his/her condition, and a clear treatment plan including pharmacological and non-pharmacological approaches as appropriate are initiated.
<b>Reactive</b> Professionals wait until significant morbidity is present to start aggressive treatment protocols.	<b>Proactive</b> Professional focus on identification of risk factors, and preventative measures to decrease risk of significant morbidity.

Adapted from: <http://www.jhsph.edu/faculty/gh-102/InstitutionalMedicine/InstitutionalMedicine%20Briefing%20BHS%20Ppt%20Shands%20VascularCenter%206-10-06%20Meds%20Dr%20JRM.pdf>

## STRENGTHS OF IMPLEMENTATION

1) Perceived benefit of a non-profit versus for-profit agency	"DIM is not making a profit. The money that would normally go towards profit, goes into labs and testing... into education.
2) JSO/DOC and DIM share a community focus	"The people that we deal with in the jail are a subset of the community that is accessing the public health care system in the community...[they are] involved in public health through clinics on the outside, or should be, even if they're not."
3) JSO/DOC and DIM share a common identity as governmental agencies	"...you know the people in general, the citizens, they look at government agencies as just - we're all here to get our paycheck, that we don't care, and we actually do and so does the Department of Health and it really makes a difference here.

## CHALLENGES TO IMPLEMENTATION

1) Administrative structure	"Bureaucracy, bureaucracy, bureaucracy."  "...a lot of the challenges just have to do with the state hiring system. ...[we're] not able to hire a part time person and say okay come on to work. They have to go through orientation, they have to get their fingerprints done...but that could take two to three weeks just to get somebody hired in the state process and you know when you need people you need people now you don't need people in three weeks
2) Staffing: 24/7	"[administration] tells us we're not different, we're a DCHD clinic. No we're not... we don't open at eight, we don't close at five, we don't just treat women, we don't just treat children, we work all day and all night ... we are completely different, other than our paychecks come from the State of Florida."
3) Public health workforce	"...still trying to change the mentality of health care providers"  "...the philosophy that we're here to practice medicine, we're not correctional officers, we're not judges, we're not lawyers, we're not here to judge what they have to say, that what they did was right or wrong, we're not here to do any of that."  "...it's a true education process at the end that we're getting but still that's an obstacle

## CONCLUSIONS

- The provision of correctional health services through a local public health department offers significant advantages to communities including: health education, prevention and transition services.
- Facilitators of program implementation include a DOC-DCHD/DIM shared focus on community and identity as state agencies and the perception that a non-profit agency will make fuller use of resources.
- Nonetheless, implementing correctional health services from within a local public health department framework is best seen as a *process* that requires system flexibility in order to meet the demands of a fast-paced, 24/7, clinic operation and staff development to work in the correctional setting