Rethinking Incarceration and Empowering Recovery: RlvER Clinic
Objectives

1. To describe a post-incarceration care model;
2. To outline the CIH RlvER Clinic;
3. To demonstrate the impact of this model.
Post-Incarceration Care Model

- Acknowledge the gap that exists between carceral settings and civilian life;
- Create infrastructure to ensure the continuity of care between complex settings;
- Provide support to address the social determinants of incarceration
Post-Incarceration Care Model

- Patients are referred directly from the carceral settings to a post-incarceration clinic.
- Prior medical records are shared between the carceral setting and the clinic in a HIPAA compliant method to ensure continuity of care.
- Post-incarceration care focuses on acute and chronic medical problems, connectivity within society and collaboration with local organizations to improve health and wellness outcomes.
Post-Incarceration Care Model

- Release from incarceration
  - Direct referral to clinic
  - Contact made with clinic
    - Immediate access to:
      - Behavior Health Clinician
      - Social Worker
      - Healthcare Provider
      - Community Health Worker
      - Nurse Navigator
Post Incarceration Care Model

The Transitions Clinic Program works to solve this problem by:

**Building Capacity** for team-based, patient-centered care for chronically ill returning prisoners.

**Hiring + Integrating** community health workers (CHWs) with a history of incarceration into the medical team, helping patients navigate healthcare and social services.

**Leveraging** the services within an existing community health center, located in neighborhoods with the highest rates of incarceration.

**Partnering** with both community organizations, and correctional and government agencies that work closely with the incarcerated community.
Post-Incarceration Clinic Model Success

- Participants in the Transitions Clinic in San Francisco were less likely to visit the emergency department and had 50% fewer emergency department visits.
- This resulted in $912 less per year spending in health care cost utilization.
- More than half of the participants had at least two primary care visits after release and engagement within the program.
- This model reduces illicit drug use/overdose risk, criminal behavior, recidivism and even mortality.

CIH RlvER Clinic: Keys to Success

- Allegheny County Jail
- Health Network
- Community

CIH RlvER Clinic
CIH RlvER Clinic Goals

• To increase access to health insurance and social services;
• To provide comprehensive care to recently incarcerated individuals who face multiple social determinants of health;
• To address a variety of healthcare conditions including diabetes, substance use disorders, Hepatitis C, and behavioral health.
• To alleviate the social determinants of health by engaging with an in-clinic social worker and Community Health Worker;
• To transition patients to long-term primary care providers after engagement within our clinic.
CIH RlVER Clinic Model

Discharge and Release team at ACJ notifies CIH RlVER team about patient release by sending a referral

Social worker and community health workers contact patient within 24 hours of release.

Immediate connection made to health care provider to address healthcare needs including medication for opioid use disorder

Multiple touchpoints by team prior to appointment

Patient arrives to appointment.

Healthcare provider completes initial appointment with assessment of chronic conditions and medication needs.

Social worker and CHWs continue initial assessment of SDoH needs.

Continued engagement in healthcare and social work with regular meetings with CHW.
CIH RlvER Clinic Structure

Two physicians, nurse practitioner, and pharmacist
- Treat primary care issues in addition to medication for opioid use disorder, Hepatitis C and low-barrier model of care

Nurse Navigator
- Focuses on medical management within clinic

Community Health Worker
- Visits people in ACJ to establish close rapport
- Works closely with community based organizations to ensure optimal community engagement on release

Social Worker
- Works with drug and alcohol programs to improve patient outcomes with substance use disorders
- Works collaboratively with housing teams to improve access to safety

Patient Care Navigator
- Ensures quick access to health insurance and benefits on release
- Establishes continuity of care plans for patients after completion with CIH RlvER Clinic

Psychiatrist
- Funded by grant
- Focused on effective access to care by regular screenings with PHQ-9 and PTSD
More than a Clinic

• Holistic care model focused on outreach and community building

Rare medical clinic aims to keep repeat offenders out of jail

RiVER Clinic tries to close in-patient gap in Allegheny County Jail
CIH RlvER Clinic Outcomes

- To reduce hospitalizations and emergency department utilization
- To treat and eradicate Hepatitis C in referred patients
- To reduce opioid overdoses
- To increase use and retention in MAT
- To reduce recidivism
- To show a reduction in social determinants of health needs
CIH RlvER Clinic Outcomes to Date

- Started in June 2021
- >400 referrals from ACJ
- Engaged 60% of those referrals
- 50 active patients
- >100 have completed care with us and transitioned into their community
- Reduced rates of return to use and reduced rates of recidivism by engaging patients in rehabilitative programs
- Twelve patients have completed treatment for Hepatitis C and achieved SVR
- Of patients engaged, only one overdosed within 2 weeks of release from jail
Thank You

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