Rethinking Incarceration and Empowering Recovery:

RIvER Clinic

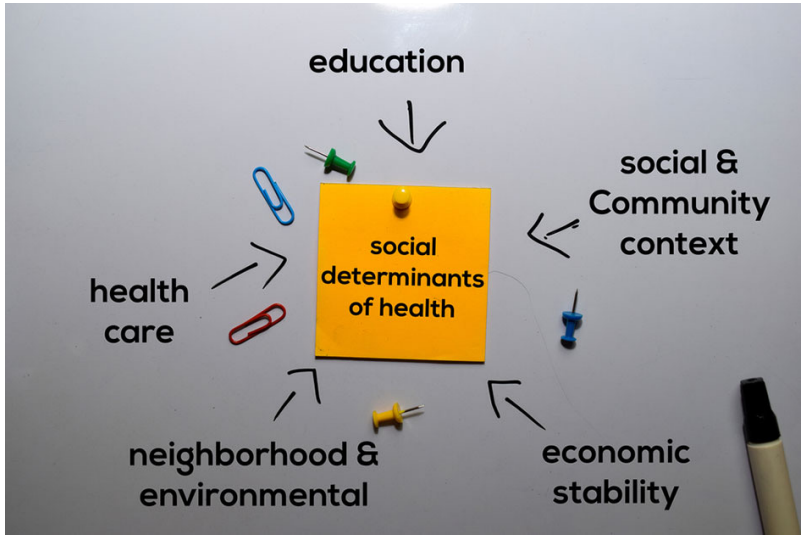
AHN

Objectives

1. To describe a post-incarceration care model;
2. To outline the CIH RIvER Clinic;
3. To demonstrate the impact of this model.

Post-Incarceration Care Model

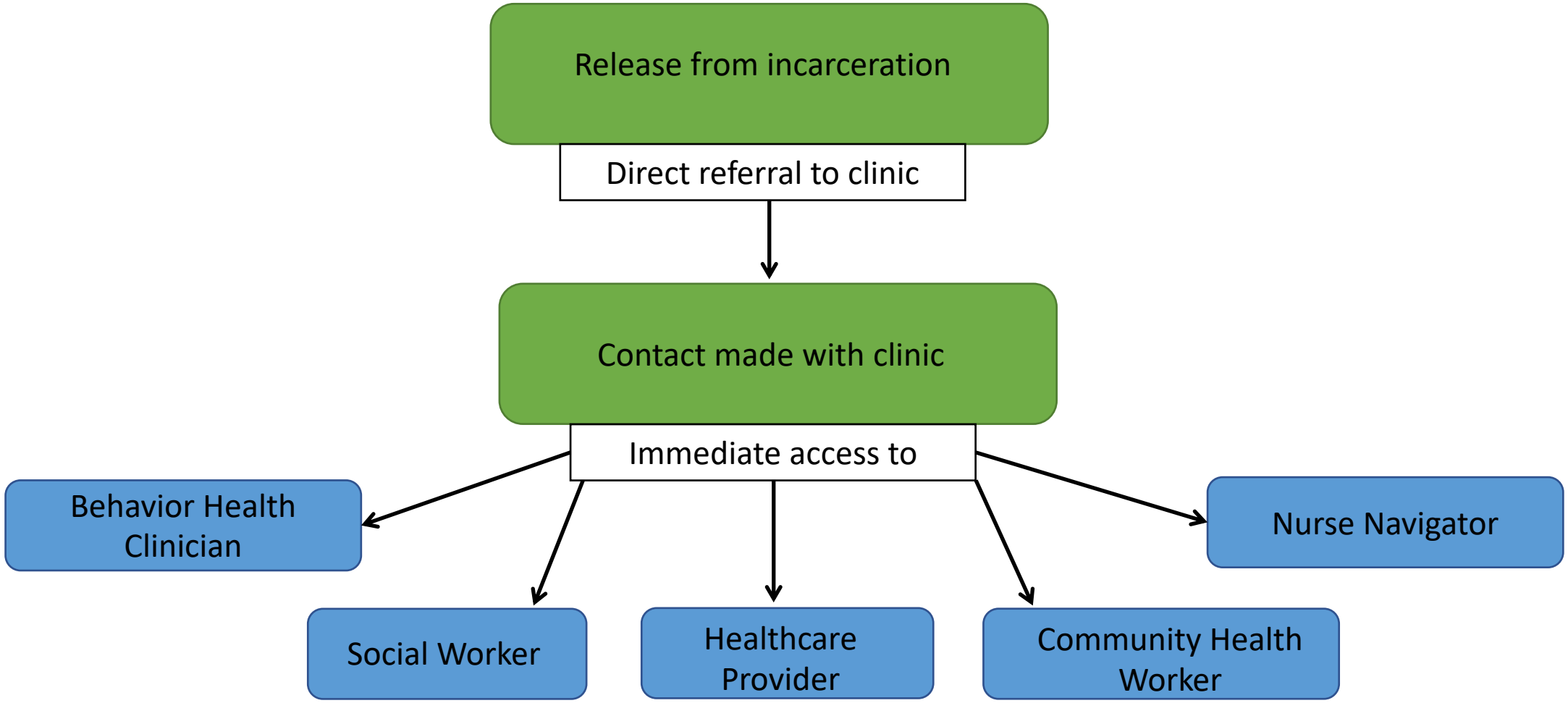
- Acknowledge the gap that exists between carceral settings and civilian life;
- Create infrastructure to ensure the continuity of care between complex settings;
- Provide support to address the social determinants of incarceration



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



Post Incarceration Care Model

TRANSITIONS CLINIC

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.*

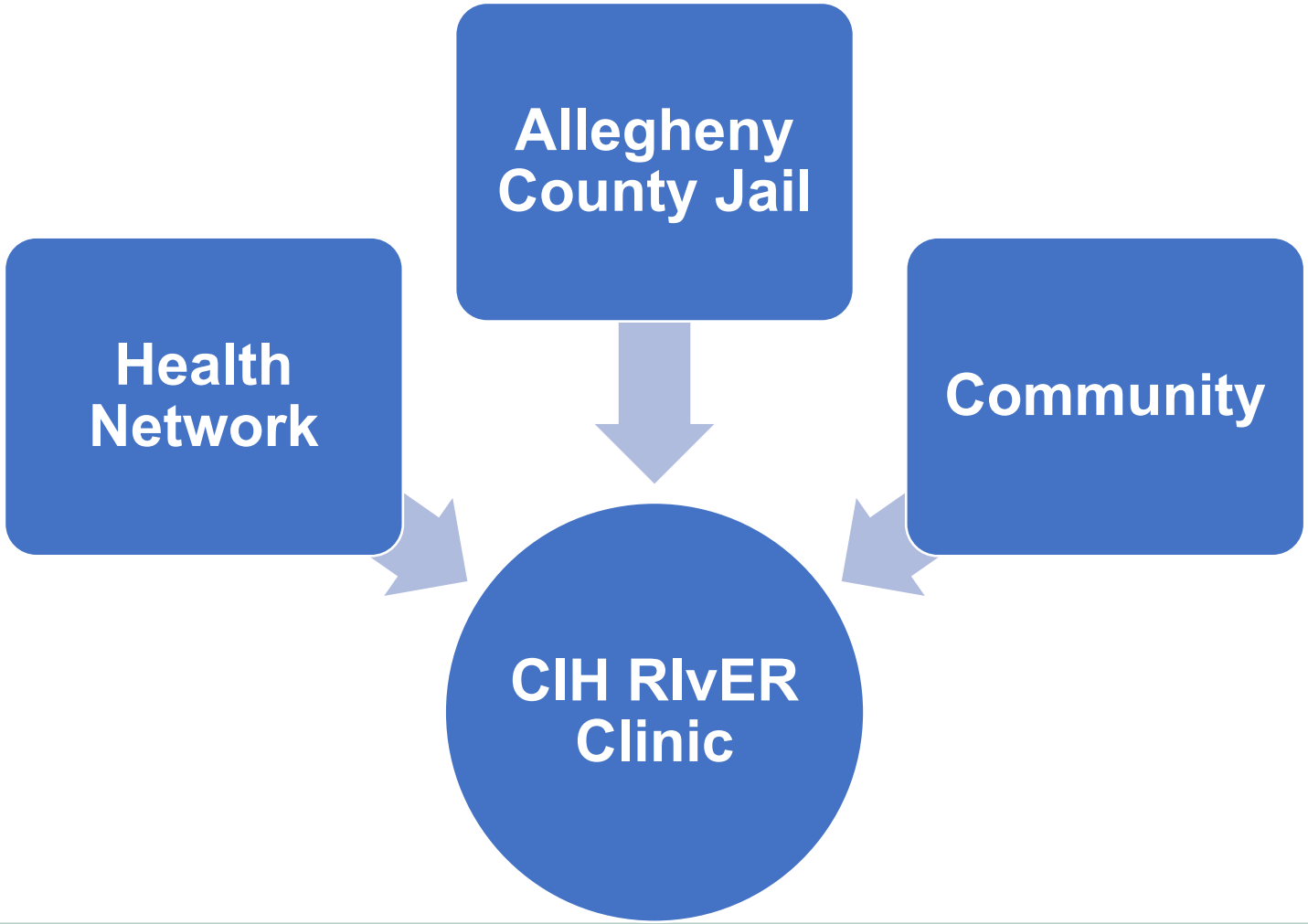
PARTNERING *with both community organizations, and correctional and government agencies that work closely with the incarcerated community.*

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.

Shavit, S et al. “Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison.” *Health Affairs.* June 2017. https://doi.org/10.1377/hlthaff.2017.0089
Mattick RP, et al. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (review). Cochrane Database of Systematic Reviews. 2009
Degenhardt L, et al. Mortality among regular or dependent users of heroin and other opioids: a systematic review and meta-analysis of cohort studies. Addiction. 2011 Jan;106(1):32-51
Kerr T, et al. Predictors of non-fatal overdose among a cohort of polysubstance-using injection drug users. Drug Alcohol Depend. 2007 Feb 23;87(1):39-45

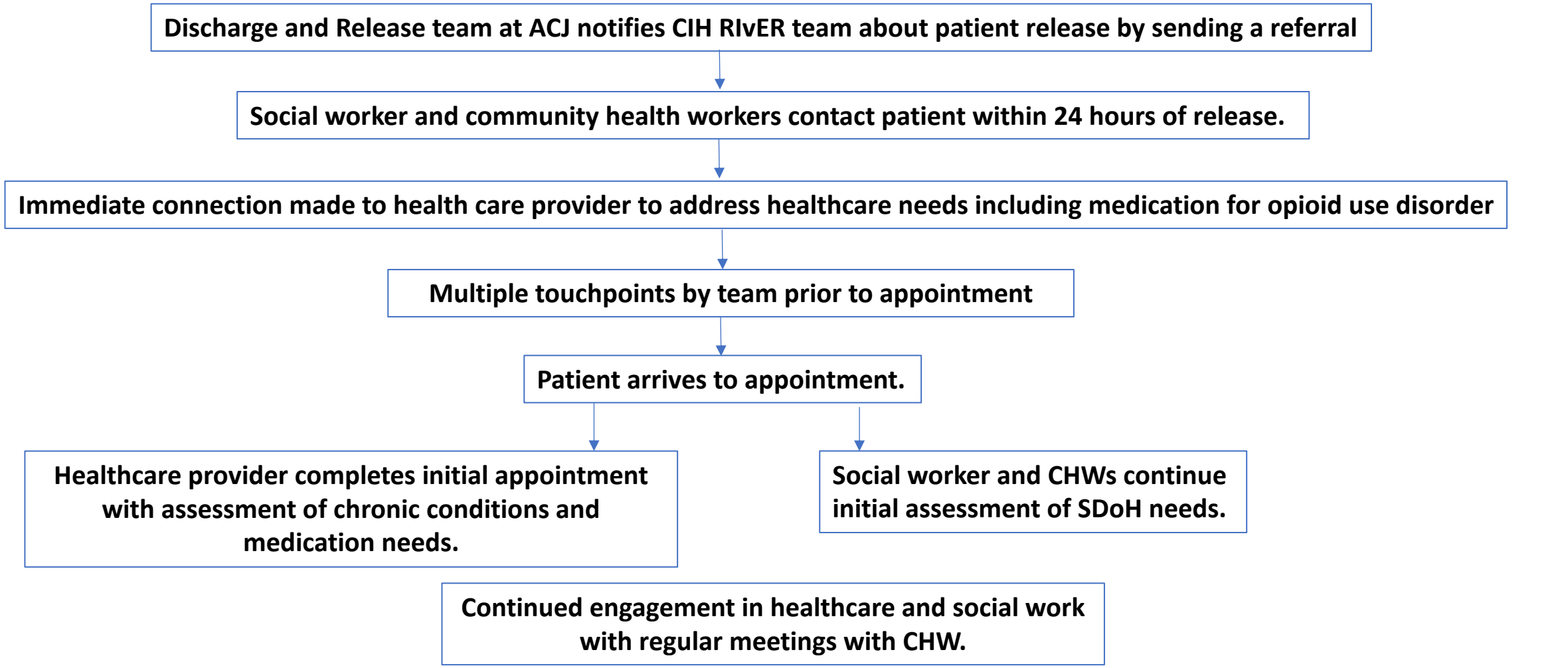
CIH RIvER Clinic: Keys to Success



CIH RIvER 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 RIvER Clinic Model



CIH RIvER 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 RIvER 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 cl ny County Jail

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CIH RIvER 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 RIvER 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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