Using Telehealth to Create a Virtual Safety Net and Ease Community Reentry

by Rita Torres, CCHP

When it comes to providing health care, county jails in rural Colorado and New Mexico, as in many parts of the United States, face distinct challenges including provider shortages, long distances, a revolving door of patients, and recidivism. Thanks to a Health Resources and Services Administration grant, at Health Care Partners Foundation, a nonprofit organization that provides medical and mental health services in county detention facilities, we are using advanced telehealth tools to create continuity of care – and a seamless transition to health care services after discharge – for incarcerated individuals in several local jails. And we're hoping to reduce recidivism in the process.

We began to explore the idea of delivering services via videoconference and phone consultations several years ago as a way to expand provider resources and increase access. But as the revolving door continued to turn, concerns grew about the lack of a safety net to ensure continuity of care for those individuals being released into the community. The HRSA grant, awarded in 2018, promised to bridge that gap.

The focus of the grant: development of advanced technology tools to expand the existing virtual network into the community, thus providing recently discharged individuals, especially high-risk patients with mental health and substance abuse issues, continuity of care as they reintegrate and develop relationships with their own community providers.

The ultimate goal of the jail-to-community program was to reduce recidivism by identifying root causes in the areas of health, mental health, and substance abuse as well as social, environmental, economic, and educational realities.

The first year of the grant was dedicated primarily to building a dual-state, multicounty network to identify common issues and develop workable solutions, while also recognizing individual state and county government systems. County detention centers in New Mexico, for instance, are run by county administrators recommended by the county managers and approved by the county commissioners, while in Colorado, they are run by elected sheriffs. Despite local differences, all four participating counties – Las Animas and Huerfano counties in Colorado and San Miguel and Colfax counties in New Mexico – were committed to working together to reate bridges to the community.

During a strategic planning process, the four-county consortium identified common and individual issues, created a vision statement and a statement of purpose to encompass the global essence of the program, developed a road map to solutions, and put together priorities and strategic action plans.

The next step was identifying an electronic telehealth system that could realize those priorities. To be successful, the system needed to be flexible and easily accessed by patients and providers, include tools for assessing patients and developing treatment plans, and interface with other electronic systems.

HRSA pointed us to a Jail-to-Community Transition initiative launched in 2007 through a partnership between the National Institute of Corrections and the Urban Institute, which included a detailed assessment form focused on the well-being needs of individuals within the jail systems. This tool held great promise, if we could find a partner to expand the NIC/UI form into a digital tool that would work together with telehealth and EHR systems.

Introducing the Dream Team

We reached out to Soraya Abad-Mota, PhD, in the computer science department at the University of New Mexico, who put together a "dream team" of graduate students with expertise in software development and reporting systems. Their mission: to develop virtual screening, assessment, and treatment tools and an electronic care coordination system for follow-up and tracking to establish a seamless continuity of care structure.

The first electronic tool developed was a prescreening instrument, which collects demographic data about the population coming into the facility, including age, gender, race, ethnicity, any substance abuse and/or mental health issues, and past incarceration history, as well as anticipated length of stay and severity of charges. This tool is installed on each booking officer's desktop computer and takes only two

Purpose and Vision Statements

Purpose: Our collaborative partnership serves individuals transitioning from detention centers to the community by using telehealth connectivity, local care coordinators/advocates, and local support systems to provide responsive and high-quality care to improve their responses to behavioral health crises, reduce health care costs and recidivism, and support them in their recovery.

Vision: All county residents released from detention centers have access to primary and behavioral health services and other community support services for successful integration back into their communities.

minutes to complete. The information collected helps to identify individuals who are appropriate for the program.

Monthly reports are generated for the four counties, including information such as the percentage of detainees with substance abuse and/or mental health issues; their ages, ethnicities, and genders. The counties appreciate being able to clearly identify the demographics and high-risk needs of their jail populations, which is helpful for budget negotiation and grant-seeking.

A key to the program's success are our telecounselors, licensed professional counselors who are trained to evaluate, assess, and treat the total person for all areas of well-being. For each individual, the telecounselor develops a short- and long-term plan, coordinates care, and makes appropriate referrals to community programs and systems to support that individual's specific needs. They also work closely with telehealth providers.

Once the booking officer completes the prescreening assessment, a report is sent to the telecounselor who begins the Transition Assessment Tool. The TAT includes drop-down boxes and comment sections along with referral and case management sections. "This is the easiest and most complete electronic assessment tool I have ever worked with," says Christina Wick, lead telecounselor for the project. "Working with the dream team allowed providers like me to test it, give input on use and simplicity, and make recommendations. It makes my job so much easier!"

We also worked with CORHIO, a health information exchange for securely sharing clinical information among multiple providers and patients. That information identifies any community services or resources the recently discharged individual may have utilized. Armed with that information, the telecounselor begins the referral and care coordination process for whatever is needed, such as telemed services, tele-addiction specialty care, community-based resources, medication-assisted treatment, transportation, housing, and continued counseling. Upon discharge, the patient receives a summary of the final TAT report. Telecounselors follow up within 36 hours for up to 90 days or until the individual has successfully transitioned into community resources and provider network systems.

Capt. Rick Mangino from Las Animas County reports that two individuals called the jail after being discharged to request copies of the summary transition plan. "They feel this program is really trying to help them get back on track and actually cares about them," he says.

What Happens Next? Back to the Future

The funding for this program will end in 2021. We have been working on several initiatives to ensure the program can continue after the end of the grant.

As a result of the COVID-19 pandemic, telehealth in all sectors of health care has become more widely used and accepted, and billing systems for telehealth have also expanded. With over 95% of detainees eligible for Medicaid and/or Veterans Administration benefits, processes for ensuring those benefits are in place upon discharge allows for billing systems to continue the needed medical, mental health, and substance abuse programs for continuity of care.

New Mexico passed legislation requiring that insurance payors contracted with Medicaid provide transitional services to individuals being discharged from jails, and county detention centers have established insurance representative contacts who are coming into the facilities to ensure compliance with the legislation.

In Colorado, an innovative state-funded jail-based behavioral health services program (called Criminal Justice Services for Community Behavioral Health) has improved access to behavioral health treatment in jail while also supporting continuity of care after release.

State Rep. Donald Valdez, who represents the Colorado counties in the program, says, "Legislative leaders need to support these programs to address the substance abuse and behavioral health issues within rural communities. Telehealth is proving to be a solution for expanding access to provider and community resources."

Our advanced technology jail-to-community program has begun to produce a key outcome measure that all county detention centers would like to achieve – a reduction in recidivism. Compared to a recidivism rate of 68% in the four counties prior to the program, among those individuals who have completed the program, the rate is only 20%. Now that is a program worth keeping!

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Success Stories

Success story #1: A 45-year-old man with a history of multiple incarcerations and a medical history of asthma, mental health issues, and alcohol abuse reported being non-compliant with medications and unmotivated to manage his health care, although he reported having a primary care physician. Prior to discharge, the TAT assessed his needs and identified provider and community resources. Seventeen days post-discharge, the patient was still using telehealth services, maintaining telehealth follow-up visits, complying with medication use, and using community-based health care providers.

Success story #2: A 54-year-old woman with a history of multiple incarcerations and a medical history of asthma, COPD, fibromyalgia/chronic pain, depression, and PTSD reported difficulty managing her health care needs and remembering medical appointments. After using the TAT, the telecounselor scheduled community referrals and a primary care appointment. Within one week of discharge, the patient had followed through with the scheduled appointments and was maintaining medication compliance. She completed requested postrelease drug tests and attended court-ordered recovery meetings. Initially she had difficulty making it to community counseling appointments, so she continued with telecounseling until transition to a community mental health provider was achieved.