Justice-Involved Health Information: Policy and Practice Advances in Connecticut

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Abstract

Sharing health information across correctional boundaries presents many challenges. Three such projects in Connecticut may be of value in informing other jurisdictions of similar opportunities. This article describes the development and implementation of an interagency release of information (ROI) document and process, a voucher program to provide discharge medications at the time of release, and a statewide research-oriented health information network.

Keywords: voucher, medication, networking, release of information, probability matching

Introduction

The transition into jail or prison carries many potential health and healthcare risks. Many people who are incarcerated have chronic medical and psychiatric conditions under treatment.[1–3] Many others have acute psychological or substance-related issues upon incarceration.[4,5] Recognition of care provided by the range of primary and specialty care providers in the community and coordination of that care upon and during incarceration is an ongoing challenge that every jail and prison healthcare system faces.

Similarly, when an incarcerated person is released into the community, continuity of care is a manifest challenge.[6–8] In one study of former inmates released to the community, the adjusted risk of death was 3.5 times that of other state residents.[9] Indeed, during the first two weeks after release, the relative risk of death among former inmates was 12 times that of a community-matched population.[10] In another large study cohort (n = 2,115), prescriptions for HIV medication were filled by only 5.4 percent of eligible inmates within 10 days of release from prison.[11] Such treatment disruption is associated with substantial morbidity.[12] These mortality and morbidity issues occur for reasons of both communication and access to care, and contribute to significant health disparities.[13,14] Lack of continuity of care is particularly problematic for individuals with serious mental illness, who are otherwise at elevated risk of reincarceration.[15] In addition to the care for the individual, public administrators and legislators who work to improve public policy face ongoing challenges: having access to data that span diverse community, judicial, and correctional domains has traditionally been quite problematic.

While others have described efforts to create bridges to the community, this article describes three initiatives in Connecticut that target effective communication, continuity of pharmacological treatment, and policy development: a statewide interagency release of information (ROI) document, discharge medication vouchers, and the Connecticut Health Information Network, respectively.[16,17]

Interagency Release of Information

An ongoing challenge and frustration in providing care to patients is access to information about previous episodes of care that spans multiple boundaries, whether judicial[18,19] or nonjudicial.[20] The standard approach has been to develop a specific form to affirm the patient's desire for the healthcare organization to release information from a specified time period to the current care provider.[21] Often, the patient may have received care from multiple providers, and each provider organization may require a different form. This process often results in inefficient, delayed, or inappropriate care and exposes the patient to significant risk. This problem is acute and repeated many times each day in the correctional setting: people come into the jail setting directly from the courtroom after a varying time in police holding cells. Many are undergoing treatment in the

community for serious mental illness and/or for substance addiction. Historically, multiple discordant ROI documents would need to be completed and transmitted. The same process occurs when individuals are released back into the community. In Connecticut alone, there were more than 25,800 admissions to correctional facilities and more than 25,900 community releases in 2012.

To address these concerns, a group of affected state agencies in Connecticut convened to discuss a solution to this challenge. Several federal and state regulations and statutes informed this effort. From the federal perspective, Title 42, Part 2, of the Code of Federal Regulations governs the confidentiality and disclosure of alcohol and drug abuse patient records for individuals receiving substance abuse treatment.[22] Then, the Health Insurance Portability and Accountability Act (HIPAA), Title 45 of the Code of Federal Regulations, Parts 160 (General Administrative Requirements), 162 (Administrative Requirements), and 164 (Security and Privacy), establishes regulations governing the confidentiality and disclosure of protected health information including the release of psychotherapy notes; psychotherapy information must be requested on a separate form from any other health information.[23] Specific to Connecticut, the Connecticut General Statute §52-146 governs the confidentiality and disclosure of certain information and records for individuals, §17a-688 governs the confidentiality and disclosure of information and records for individuals receiving treatment or rehabilitation for alcohol dependence and drug dependence, §19a-583 governs the confidentiality and disclosure of HIV-related information and records, and §19a-581 governs the release of confidential HIV-related information.[24]

Two groups authorized by the Connecticut legislature, the Alcohol and Drug Policy Council and the Criminal Justice Policy Advisory Commission, identified the sharing of substance abuse, mental health, and primary care information as critical to care coordination and continuity for individuals treated in Connecticut's publicly funded healthcare system. Both advisory bodies determined that delays existed in the exchange of primary care and behavioral health information. Staff interviews demonstrated that a factor contributing to these delays was that line staff often questioned the validity of any given ROI form. The idea of developing a universal ROI form was discussed and rejected, given both historical and organization-specific issues. Following substantial discussion, the advisory groups recommended the development of an interagency memorandum of agreement (MOA) that listed the necessary elements that needed to be part of a legitimate ROI acceptable to all participating agencies.

The Department of Correction, the Department of Developmental Services, the Department of Children and Families, the Department of Mental Health and Addiction Services (DMHAS), the Board of Pardons and Paroles, the University of Connecticut Health Center's Correctional Managed Health Care (CMHC) division, and the Judicial Branch subsequently entered into an agreement to accept each other's ROI form for the purpose of sharing substance abuse, mental health, and primary healthcare clinical information. This process became effective on May 1, 2011; the Department of Children and Families became a signatory on March 1, 2012.

Under the agreement, a receiving agency or facility must accept a completed ROI form from the originating agency or facility. Further, a receiving agency or facility may not require that the ROI be filed on the receiving agency's form. For instance, a request for release of mental healthcare information on a newly admitted Department of Correction inmate originating from CMHC sent to a DMHAS facility would be filed on an authorized CMHC ROI form and sent to DMHAS, which must accept the request as long as the form is complete.

The executed MOA spelled out the requirements for each party's ROI form. At a minimum, each form contains the following elements:

- Name or general designation of the person or agency permitted to make the disclosure;
- Name or title of the person or agency to whom or to which the disclosure is to be made;
- Name of the individual receiving services for whom records are being requested;
- Purpose of the requested information;
- How much and what type of information is to be disclosed (e.g., substance abuse, mental health, and primary healthcare clinical information);
- Signature of the individual and/or his or her legal guardian, conservator of person, or other personal representative;
- Date on which consent statement is signed;
- Statement that the consent is subject to revocation at any time except to the extent that the program has already made use of the information;
- Description of how the individual may revoke consent;

- When consent will expire if not previously revoked;
- A statement that refusal to grant consent will not jeopardize the individual's right to obtain present or future treatment except where disclosure of the communications and records is necessary for the treatment; and
- A statement that the individual completing the consent has been advised that any information disclosed may be subject to redisclosure and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.

Given the above standards, all participating agency ROI forms were reviewed, revisions were made where needed, and the final ROI forms were accepted. The MOA requires the following:

- Each party's ROI is to be posted on its website with a control number (e.g., http://www.ct.gov/doc/LIB/doc/PDF/AD/cn4401.pdf);
- All staff will accept complete ROIs from other MOA agencies;
- No changes can be made to ROI forms without notice to all parties of the MOA, with adequate time for review; and
- The parties shall meet at least twice yearly to discuss any issues that arise.

Implementation required a process of education for each member agency's relevant staff. Miscommunications were inevitable at first. However, within a few weeks of enactment, this statewide interagency MOA on ROI forms led to a significant improvement in healthcare information sharing across multiple agencies involved with the judicial system along with an expected ongoing improvement in effective and efficient care delivery.

The Medicaid Prescription Voucher Program

In Connecticut, CMHC traditionally provides a two-week supply of medications upon the prisoner's release from jail or prison, whether the individual was sentenced or released on bail prior to conviction or sentencing. Individuals who are released at the anticipated end of sentence are fairly reliably provided with this supply of medications upon their release. However, prisoners may be released unexpectedly at the time of any court appearance. There was no practical method of providing these prisoners with their medications at the time of release in court.

In 2007, an interagency committee that included representatives of the Office of Policy and Management (the state budget agency), the Department of Correction (DOC), DMHAS, and the Department of Social Services (DSS; the agency responsible for managing Medicaid), the Bureau of Pardons and Paroles, and the Court Support Services Division of the Judicial Branch (CSSD; the agency responsible for court management and judicial marshals) was formed. At that time, CMHC began to train a group of clinicians as discharge planners to be deployed throughout the correctional facilities. The role of the discharge planners is to support the community transition for individuals with significant medical and mental health needs.

Shortly thereafter, the DSS Prison Release Entitlement Unit was reorganized to support an expedited Medicaid application process. The DSS Regulation Review Committee formally approved extending the active Medicaid status through 180 days of incarceration and reinstatement of Medicaid status for those incarcerated for a longer time without having to submit a new application. The actual process that took shape after four years of planning and coordination is complex and multistage. The following describes key aspects of the program.

The Medicaid Prescription Voucher program was originally piloted in December 2010 for use at the York Correctional Institution in Niantic and the Willard-Cybulski Correctional Institution in Enfield along with the New Haven, Waterbury, and Middletown courts.[25] The program expanded in November 2012 to include the Osborn Correctional Institution in Somers and the Corrigan- Radgowski Correctional Center in Uncasville as well as the Bridgeport, Stamford, Norwalk, Milford, Derby, Meriden, Bantam, and Danbury courts.

In this program, a voucher is issued to individuals who are being released and need prescription medications ordered by correctional health staff.[26] The voucher guarantees payment by the DSS for up to a 30-day supply of prescription medications. Simple instructions are included on the form for staff, for the patient, and for the community pharmacy. Instructions are printed in English and in Spanish.

By design, the voucher is valid for only five days after the authorization date. The intent is to encourage compliance and to be sure that medication adherence is maintained. Significant disruptions in care will often require a prescriber to clinically reevaluate the patient prior to restarting medication. The quantity dispensed is limited to no more than a 30-day supply. The prescription is written by a licensed prescriber at CMHC; the duration of the prescribed medication might be less than 30 days based on the professional judgment of the prescriber. The former inmate goes to any community pharmacy that routinely accepts Medicaid. Once the voucher is presented to the pharmacist, the discharge prescription is requested by the community pharmacy by faxing the front of the voucher to the CMHC pharmacy along with the community pharmacy cover sheet.

Commonly, the CMHC prescriber has already written the discharge medication prescription. In that case, the CMHC pharmacy faxes back the prescription promptly. If not, the CMHC pharmacy notifies the community pharmacy by return fax that the discharge medication prescription has not yet been written. The CMHC pharmacist then contacts the physician on call. That physician either calls the community pharmacy directly with the orders or writes discharge orders and sends them to the CMHC pharmacy, which then in turn faxes them to the community pharmacy. The process of obtaining discharge medication prescriptions takes from under an hour to, at longest, until the next business day. Therefore, if the community pharmacy receives a faxed notice that discharge orders are not already written, pharmacy staff advise the individual that the order may not be ready for some time. The individual may choose to return later for the medications.

For most releases directly from a correctional facility, staff at the facility have already notified DSS and arranged for medical benefits to be activated. For releases from court, which are generally unscheduled, the court staff faxes an application for benefits to DSS, and DSS is prepared to activate these benefits very quickly. The community pharmacy then bills through the normal process. DSS guarantees payment for the prescription medication even if the individual is subsequently determined to be ineligible for Medicaid. If Medicaid eligibility is not confirmable through the DSS Automated Eligibility Verification System within five days, a backup paper method is also in place.

As one might anticipate, implementation of this process encountered many challenges. Training of involved staff at each court was required. Pharmacy staff questioned the validity of the vouchers. Multiple meetings and phone calls were needed to assure them of the validity until the voucher process became an accepted practice over the first year. When the project began, fewer than 25 percent of former prisoners returned to a correctional facility to retrieve their medications. At this time, depending upon the facility and court involved, 40 to 60 percent of all discharge prescriptions in the voucher program are filled. The percentage filled by each facility has increased over time as the voucher program has matured. To date, CMHC does not have an electronic health record, computerized physician order entry, or electronic prescribing (e-prescribing) system. In the future, integrating e-prescribing into this protocol would likely expedite the process and enhance accuracy of the medication dispensing of the voucher program. Even with the current limitations, this program has achieved real success in the process of improving continuity of care for a disadvantaged population.

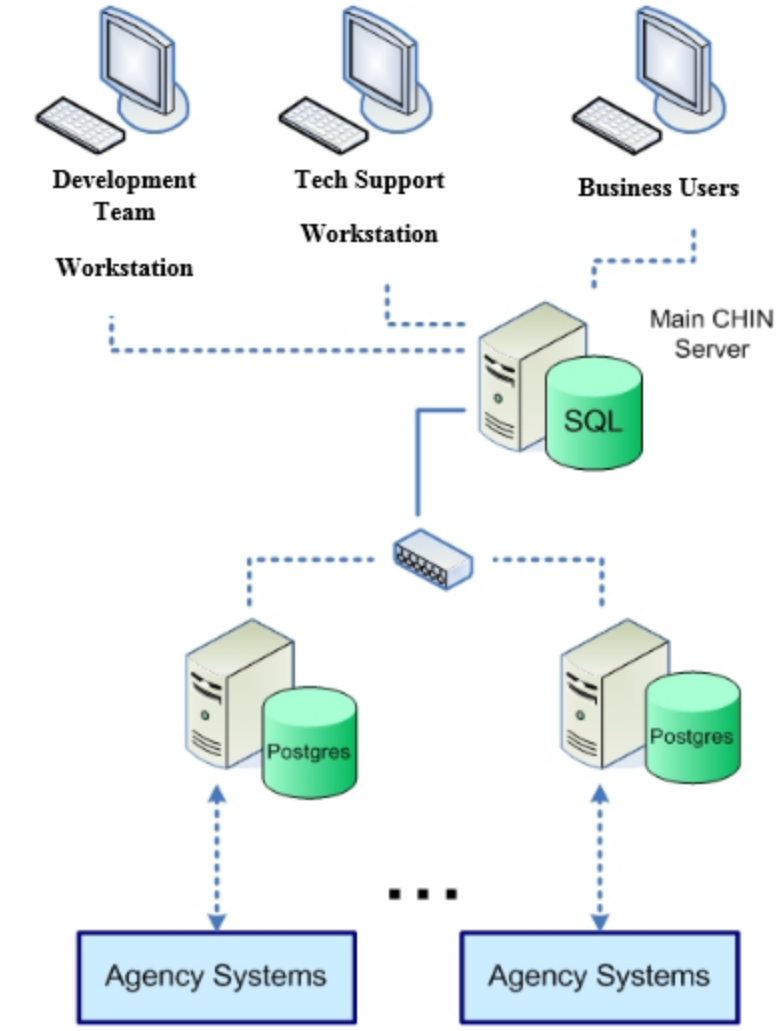
Connecticut Health Information Network

The Connecticut Health Information Network (CHIN), maintained by Connecticut's state agencies, is a federated network that enables the integration and sharing of diverse data for state-level policy purposes. Initially authorized under An Act Implementing the Provisions of the Budget Concerning Human Services and Public Health (Connecticut Public Act 07-2),[27] CHIN has been developed through a partnership involving the Center for Public Health and Health Policy at the University of Connecticut Health Center; the Connecticut Departments of Public Health, Children and Families, and Developmental Services; and OpenClinica LLC. CHIN provides access to de-identified health, human service, and educational information across state agency databases for agency personnel, policy makers, researchers, and government officials.[28] CHIN provides this access through a distributed network architecture that

- Allows shared access to data from disparate databases
- Allows agencies to retain complete control over access to their data
- Enables creation of data sets and reports that integrate data across databases at the level of the individual record by using cutting-edge approaches to record linkage
- Complies with all relevant security and privacy statutes and de-identifies data before releasing data to the end user
- Has minimal impact on business practices

To achieve the above objectives, CHIN was developed as a distributed system, with two types of modules. The CHIN Main application module (hosted at UCHC) serves as a broker for performing record linkage, aggregating and de-identifying data, and building and executing queries. The CHIN Remote application modules provide an interface with the source data to be included in CHIN, conducting data retrieval, mapping, and transformation. Each data source incorporated into CHIN has one CHIN module (see Figure 1).

Figure 1: Connecticut Health Information Network (CHIN) Architecture



CHIN is accessible to both data consumers and data owners through a web-based interface that supports query, data management, and system monitoring capabilities.

In 2010 the University of Connecticut received an RC-4 Award from the National Institute of Mental Health (1RC4-MH091939; NIMH; Connecticut Correctional Health Services Research Partnership PI: D. Shelton; UCHC Site PI: R. Trestman) to create an infrastructure to support correctional research in the State of Connecticut. The availability of the CHIN technology, as well as the desire to have the corrections infrastructure interoperate with other research networks that could provide data on inmates before and after incarceration, led to the decision to incorporate the Connecticut Department of Correction information management system and inmate health information into CHIN. Two data systems were targeted for inclusion:

- The Offender Based Information System (OBIS), the Connecticut Department of Correction's inmate electronic data system, which contains demographic information, sentencing information, and health-related information from treatment received within a correctional facility. This system contains 330,361 individual prisoner records collected over 40 years.
- Patient medical records provided by Correctional Managed Health Care (CMHC). Available information on the inmate population includes medical classification information (for custody purposes), infectious diseases, medication history, clinical scheduling, and laboratory and radiology test results.

Security

CHIN is a HIPAA-compliant platform that implements field-level security and metadata management components to ensure data security and privacy, using role-based access control to limit who can create and submit data access requests for review and approval. CHIN is designed as an administrative, statewide database that is fully HIPAA compliant. Given that it draws from databases that contain information on the entire population of Connecticut, and the goal is to inform policy, individual access permission is not generally feasible. Each research proposal is Institutional Review Board (IRB)–approved and must meet IRB standards for de-identified data use with a waiver of consent. Of note, none of the agencies participating in CHIN has a privacy board that is separate from its IRB (or equivalent). The production data sources providing data to CHIN contain sensitive information. Thus, the system has been designed to provide administrators and data managers with control of the release of data even after the data have been provided to the CHIN application. Access to fields within a data set is controlled by agency personnel, not by the CHIN administrator. Fields containing personally identifiable information

- Are only used for record linkage when matching data sources and are expunged from the CHIN Main application once the matching process is completed
- Are *never* selectable for inclusion in queries
- Are *never* available for download
- *May* show up in the metadata registry (Browse and Create Query pages) if the agency chooses to make its metadata public

Record Linkage

One of the unique features of CHIN is its probabilistic record linkage engine developed by the University of Connecticut's Booth Engineering Center for Advanced Technology. Many of the data sets that could be accessed to obtain comprehensive, longitudinal data on inmates prior to and following incarceration do not contain a deterministic numeric identifier (e.g., social security number), necessitating the use of probabilistic linking approaches. The CHIN record linkage engine improves on other available open-source products by simultaneously integrating three or more discrete data sets in a computationally efficient manner. The latest version of this application supports scalability for handling larger data sets, multithreaded/parallelized execution capabilities, and deterministic identifier support (e.g., social security number) for subgroups of CHIN data sources. The probabilistic record linkage has been successfully tested with 1,000,000 individual records across multiple sources.

Governance

The RC-4 leadership group and an information technology subcommittee have met over the past two years to establish policies for access to Connecticut Department of Correction data through this system. These groups have developed a consensus regarding access to data through CHIN that includes the following provisions:

- Agencies participating in CHIN will manage access to their data (using the Management Console).
- Each agency's existing IRB or the equivalent will continue to review all requests to access data through CHIN.
- No data will be released through CHIN without approval from each involved agency's IRB or equivalent.
- All users will be required to sign a data use agreement.
- The metadata registries for data sources will be publicly available as permissible by law.

Formal agreements regarding each agency's participation and the terms and conditions of data access and data release must be established between UCHC and the agency prior to production deployment. This process and evolving protocols are poised to allow meaningful, efficient, and effective analyses that will soon be used to guide data-driven public policy.

Conclusion

The interagency ROI document and process, the medication voucher initiative, and CHIN reflect initiatives to improve data sharing and access for justice-involved individuals. Each of these projects took multiple years to develop and involved multiple agencies. Building a collaborative environment in which the jurisdictional and bureaucratic barriers are addressed and overcome is an ongoing process. As such initiatives evolve, a logical goal of cross-boundary healthcare collaboration would be consistent with a patient-centered approach and would include a broad-based ROI process to share healthcare information and

assure care continuity, electronic prescribing to reduce or eliminate disruptions in medication management of chronic and acute illness, and cross-agency population-based data sharing to advance policy decisions in a timely and sound fashion. These three initiatives demonstrate the feasibility of such collaborations as well as the potential for improving the health of individual patients and the health of involved populations.

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