Wednesday Lunchtime Speaker: Dr. Evan Ashkin

Dr. Evan Ashkin is a professor of Family Medicine at the University of North Carolina at Chapel Hill. His work is focused on addressing health disparities and gaps in care for marginalized populations.

Dr. Ashkin founded the North Carolina Formerly Incarcerated Transition (FIT) Program in 2017 to help address the absence of a linkage to care for people released from incarceration with chronic disease, mental illness and/or substance use disorder. The FIT Program now works in 6 counties across North Carolina.

Dr Ashkin also leads a technical assistance team assisting communities working on linkages to care for people impacted by incarceration with a focus on opioid use disorder and implementing Medication Assisted Treatment in carceral facilities.

Implementing the Transitions Clinic Network Model in North Carolina Before Medicaid Expansion

Evan Ashkin MD

Director NC FIT Program

Professor

UNC Department of Family Medicine

NC FIT
FORMERLY INCARCERATED TRANSITION PROGRAM

TRANSITIONS CLINIC

Presentation Overview

- Focus on Connections to Healthcare
- Transitions Clinic Network Model
- Implementation in North Carolina
- NC FIT Evaluation Data
- FIT and Opioid Epidemic
- Q+A

- No Disclosures

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Churn in Carceral System

- ~600,000 people released from Prisons annually
- ~ 10 Million cycle through Jails

Prison Policy Initiative

The NEW ENGLAND JOURNAL of MEDICINE

Release from Prison—A High Risk of Death

Over 12x increased risk of death in first 2 weeks after release

- The leading causes of death:
  1. Drug overdose
  2. Cardiovascular disease
  3. Homicide
  4. Suicide
  5. Cancer

I. Binswanger, et al NEJM 2007; 356:157-65

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Risk of Opioid Overdose Death

- NC Data:
  - Risk of Death from Opioid Overdose in the first 2 weeks post-release from prison is 50x > general population

- Am J Public Health. 2022;
- 112(2):300–303. https://doi.org/10.2105/AJPH.2021.306621

Challenges of Reentry

- Released with few Economic Resources
- Return to Low Resource Communities
- Lack of Government Identification
- Lapsed Driver's License
- Discrimination:
  - Housing
  - Employment
- Reunification with Family, Supports
- Lack of Primary Care Provider
- Low Health Literacy
- Treatment of Mental Illness/Substance Use Disorder

The Transitions Clinic Network Model

- Co-Founders: Shira Shavit MD, Emily Wang MD, MAS
- Model created by centering the experience of people impacted by incarceration

TCN Guiding Principles

- Those Closest to the Problem are Closet to the Solution
- Nothing about us Without Us

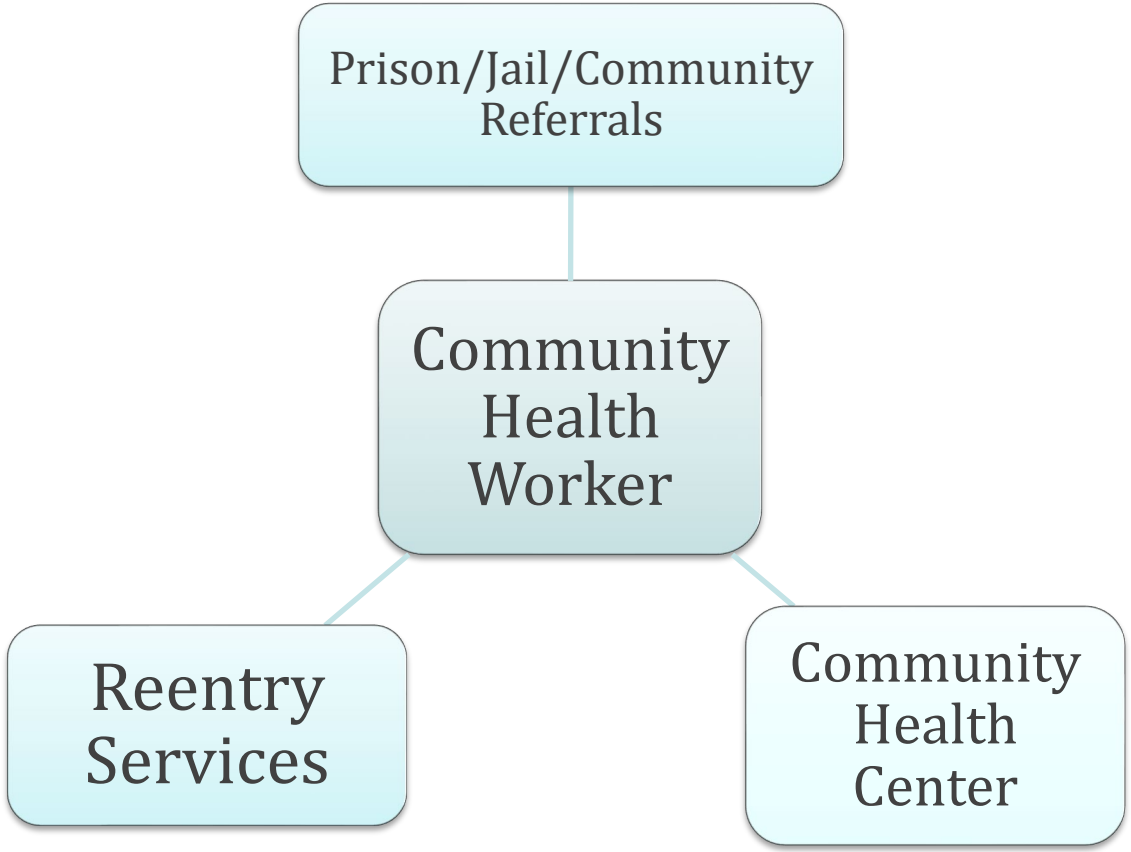
TCN Development

- Focus groups held at San Quentin Prison in California
- Consistent message was that people coming out needed navigators with a shared life experience.
  - » Facilitate Trust
  - » Build Rapport
  - » Peer Support
  - » Understand challenges of transition from life on the inside, back to the community

Community Health Worker

- Strategy developed to hire people with histories of incarceration and train as a Community Health Workers (CHW)
- Created CHW training specifically focused on Reentry
- Embed CHW into Primary Care Medical Home
- Work with clients to create comprehensive reentry plan
- Connection to Essential Healthcare Services

Transitions Clinic Network Model



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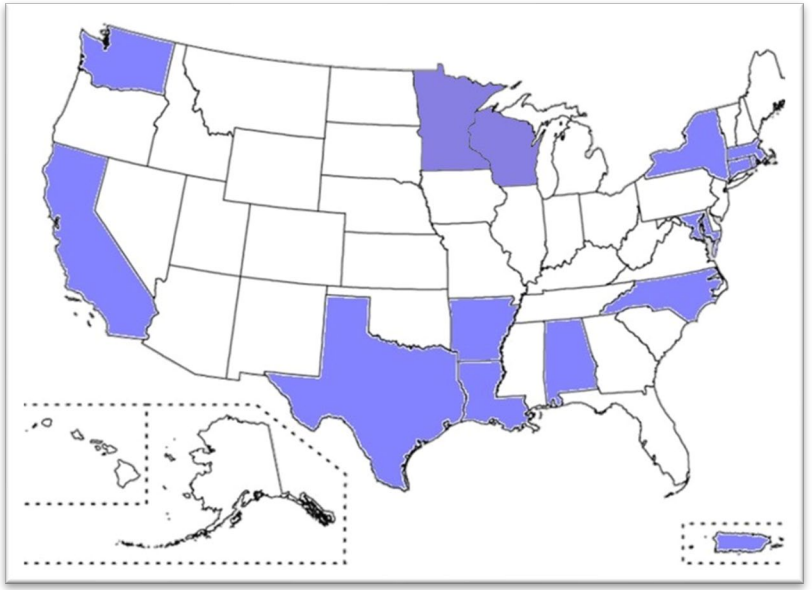
The Transitions Clinic Network

TCN has supported 48 primary care clinics in 14 states and Puerto Rico in implementing the TCN model of care.



TCN is a national network of community health centers which employ CHWs with histories of incarceration within primary care teams to address the health of people returning from incarceration.

TCN Evidence Base

- 50% Reduction in Emergency Room Utilization
- 50% Reduction in Preventable Hospitalizations
- 45% Reduction in days of Incarceration in 1st 12 months post-release
- Reduction in Parole and Probation Violation
- ROI of $2.55 for every 1$ invested

Implementation of TCN Model in NC

Formerly Incarcerated Transition (FIT) Program

NC FIT
FORMERLY INCARCERATED TRANSITION PROGRAM

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Core Mission/Goals of NC FIT

- Improve the well-being of people impacted by the criminal legal system
- Focus on people with chronic medical conditions, mental illness, and/or substance use disorder
- Create and implement comprehensive reentry plans with our clients
- Link our clients to essential health services that are patient-centered and culturally sensitive

Core Elements for FIT Program

- Community Health Worker (CHW) with personal history of incarceration.
  - Hired by Health Department, Medical Clinic or other community Reentry program
- Primary Care Clinic aligned with mission and values of FIT
  - Integration of CHW into clinic operations
  - Clinician Champion
  - Work with NC FIT to assure fidelity to TCN model
- Collaboration with local Reentry partners
  - Strong connections to reentry programs to address multiple barriers to successful reintegration
  - Join NC FIT Program network

CHW Leadership

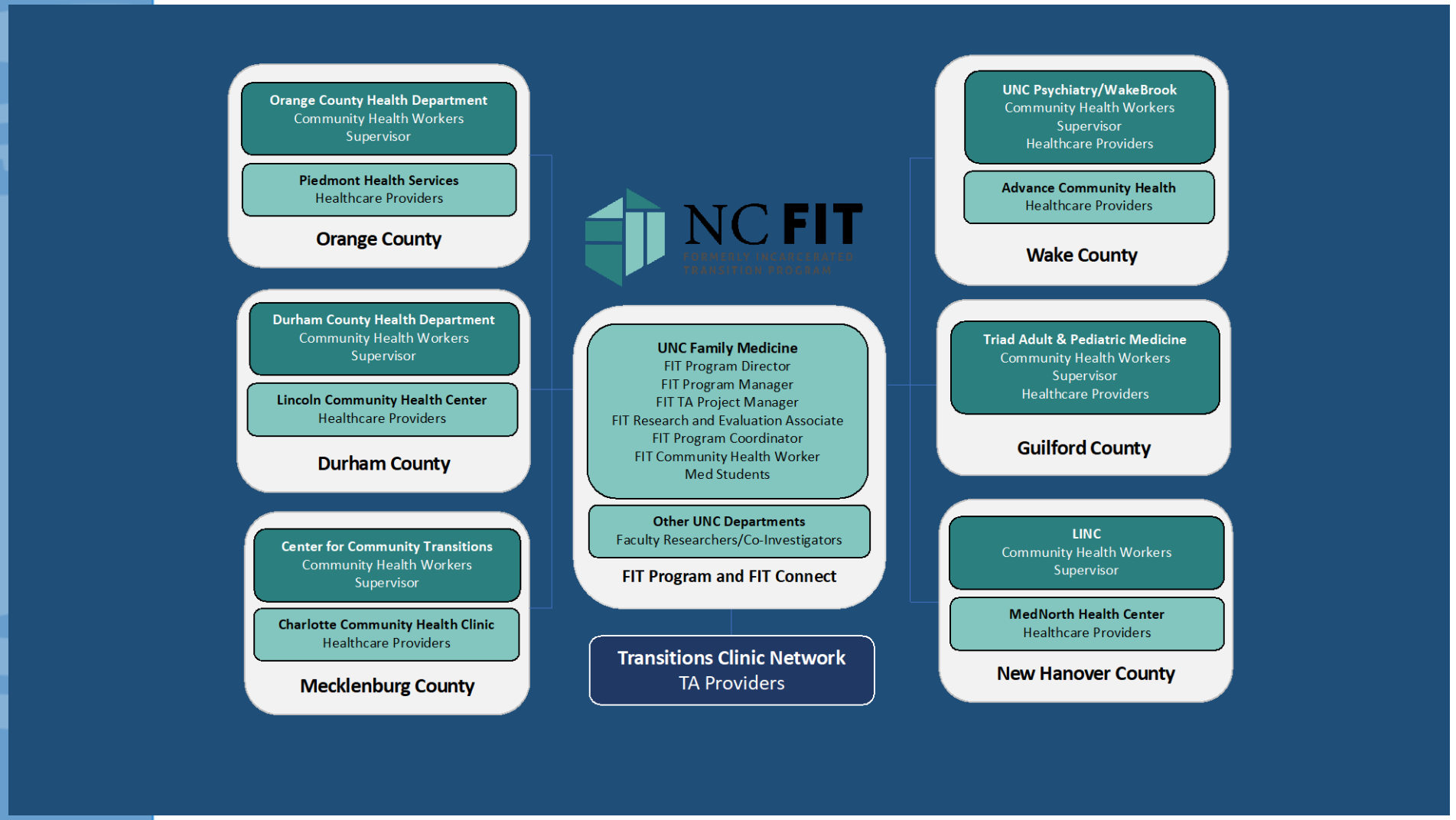
- CHWs having meaningful roles in:
  - NC FIT Program Leadership
  - All Committees
  - Research and Evaluation
  - Education in Health Sciences

Barriers Related to Medicaid non-expansion

- FQHCs struggle for Financial Viability
  - Lack of funding to hire and support CHWs
- High percent of people that are uninsured
  - Cannot afford sliding scale fees at FQHCs
  - Cannot afford medications
  - Access to Specialty Services, Imaging, Diagnostic Procedures
  - Access to Preventive Services
  - Limited Access to Behavioral Health Services
  - Limited Access to Substance Use Disorder Treatment

Implementation of NC FIT

- 2017: Started with grant from NC DHHS to hire first FIT CHW through Durham County Health Department
- 2018: Duke Endowment grant to continue funding in Durham and add Orange County
- 2019: Contract with state prison system for 5 CHW positions.
  - » Expanded to Wake (Raleigh), Guilford (Greensboro, High Point) Mecklenburg (Charlotte) Counties
- 2022: Developed partnership in New Hanover County with LINC Inc. to establish program in Wilmington
- 2023: Plans to expand to Winston-Salem and Asheville



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FIT Program Evaluation/Outcomes
Led by David Rosen MD, PhD

- Preliminary data from 2018-2021
  - All Clients: 544
  - Study Participants: 161

FIT clients and study participants

Compared to all FIT clients,
study participants have:

- similar Age, Gender, Race
- similar # of co-morbidities
- slightly more social needs

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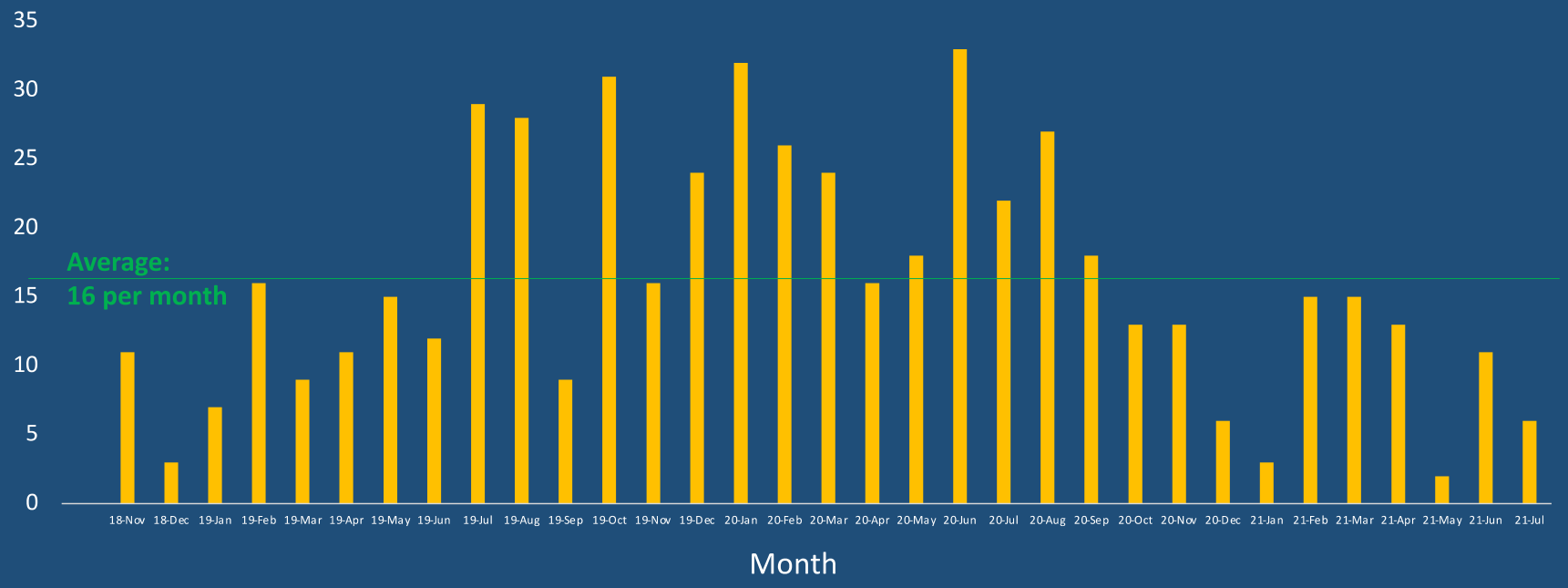
FIT Program Enrollment, Nov 2018- Jul 2021 (n=544)



*Date not recorded: n=19

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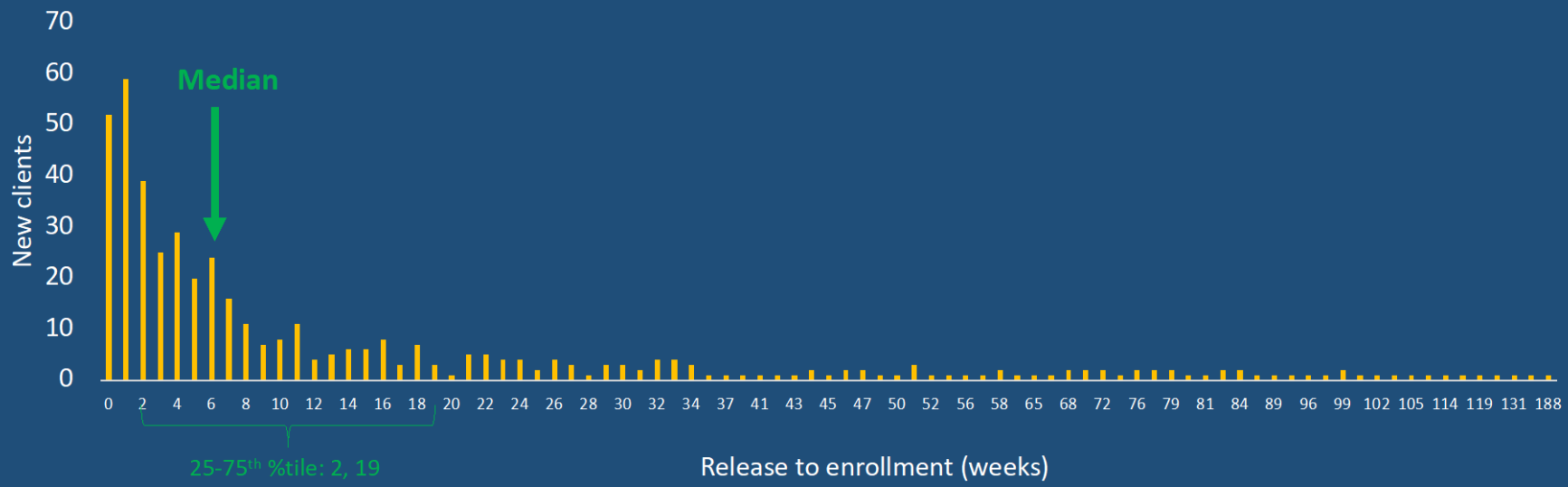
Time from release to program entry

Nov 2018- Jul 2021

NC FIT



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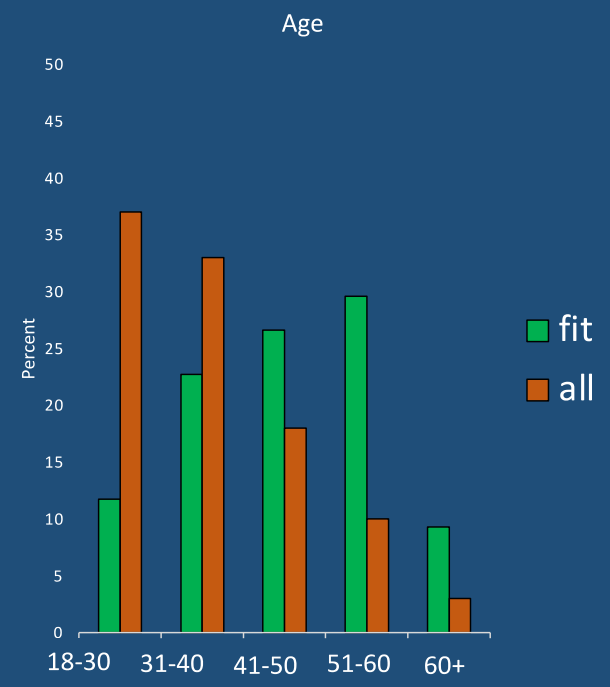
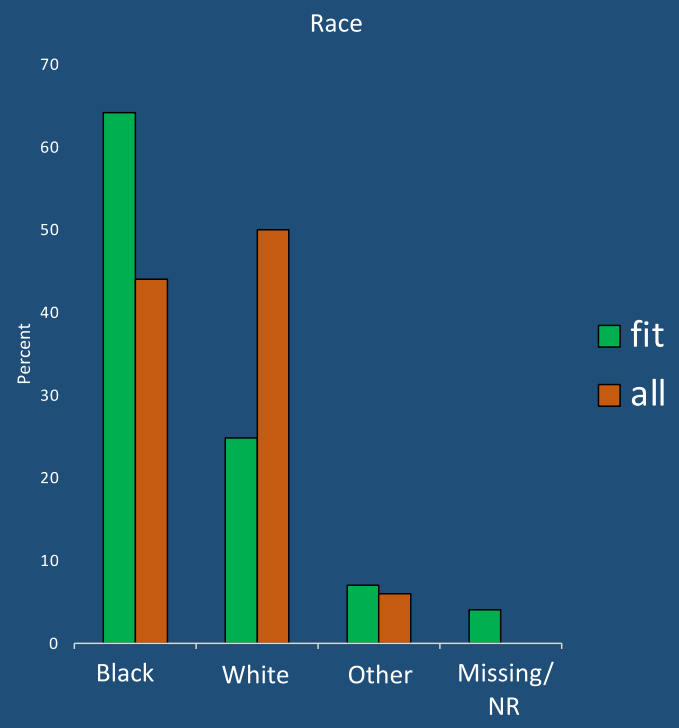
Demographics of FIT vs. all released persons





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Socio-demographics (n=161)

Characteristic	Level	n	%
Education	Not HS Grad	28	17
	HS/GED	86	53
	Some/College Grad	47	29
Marital status	Single & never married	103	64
	Sep/Divorced/Widow	48	30
	Married/partnered	10	6
Children (dependents)	Any	14	9
	None	147	91

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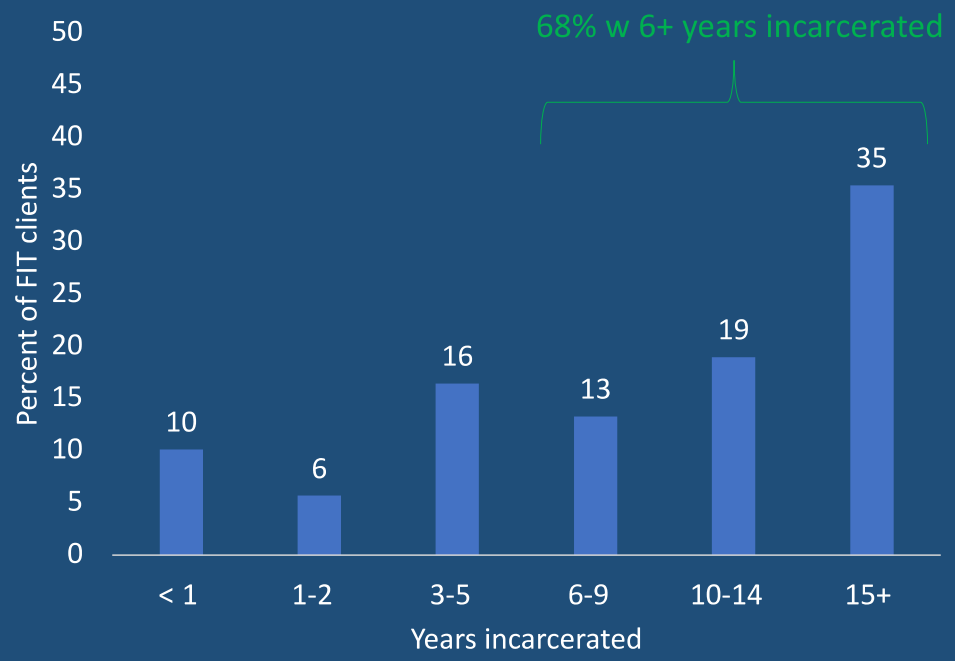
Lifetime years incarcerated (n=161)



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Type of assistance needed

	n	%
Medicaid or other insurance	345	63
Employment	335	62
Housing	318	58
Foodstamps	262	48
Disability	198	36
Debt	77	14

Number different types of assistance needed

Median	25th %tile	75th %tile
3	2	4

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Most common self reported conditions at intake

Condition	n	%
Hypertension	241	44
Chronic Pain	180	33
High Cholesterol	139	26
DM, high "blood sugar"	136	25
Circulator Disorders of Legs/Feet	100	18
Asthma	91	17
HCV	88	16
Behavioral:		
Anxiety/Depression	271	50
Drug Use Disorder	207	38
Alcohol Disorder	133	24
PTSD	149	27
Bipolar/Manic Depression	140	26
Schizophrenia/Schizo-affective	73	13

Number of conditions

Median	25th %tile	75th %tile
4	2	6

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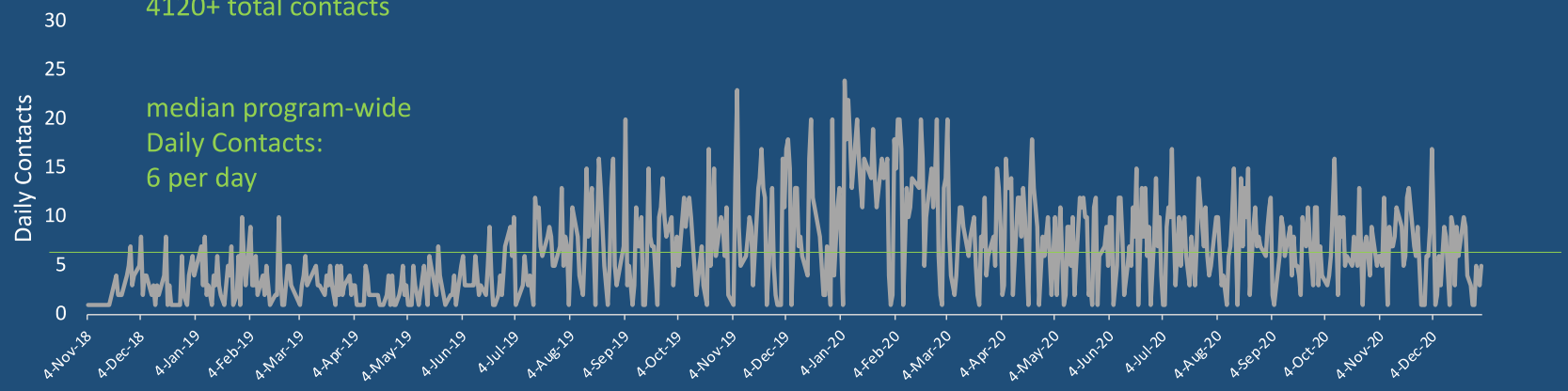
Community Health Worker (CHW) contacts with clients, Nov 2018-Dec 2020

4120+ total contacts

median program-wide Daily Contacts: 6 per day



median Monthly Contact Rate: 2.4 per client-month

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CHW contacts - Reason

	n	%
Care coordination	1642	42
Medication adherence	1027	26
Retention	899	23
Physical health	884	23
Social issue	879	23
Mental health	328	8
Substance use	178	5
Other	661	17

Assessed 2019 - 2020
Reflects multiple reasons per contact

FIT clients and study participants

Compared to all FIT clients, study participants have:

- similar Age, Gender, Race
- similar # of co-morbidities
- slightly more social needs

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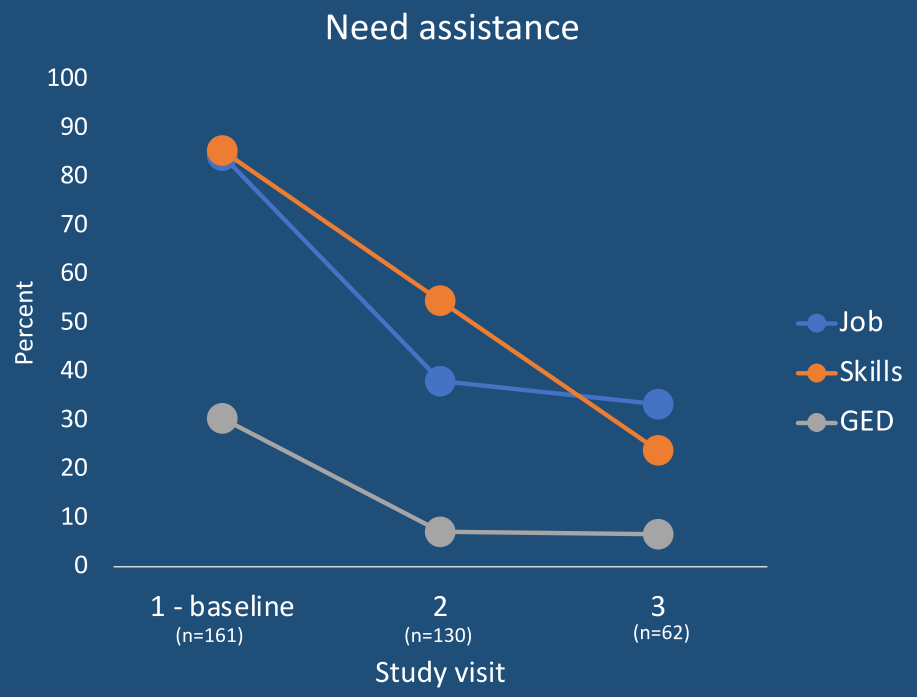
Employment /training needs decline over time



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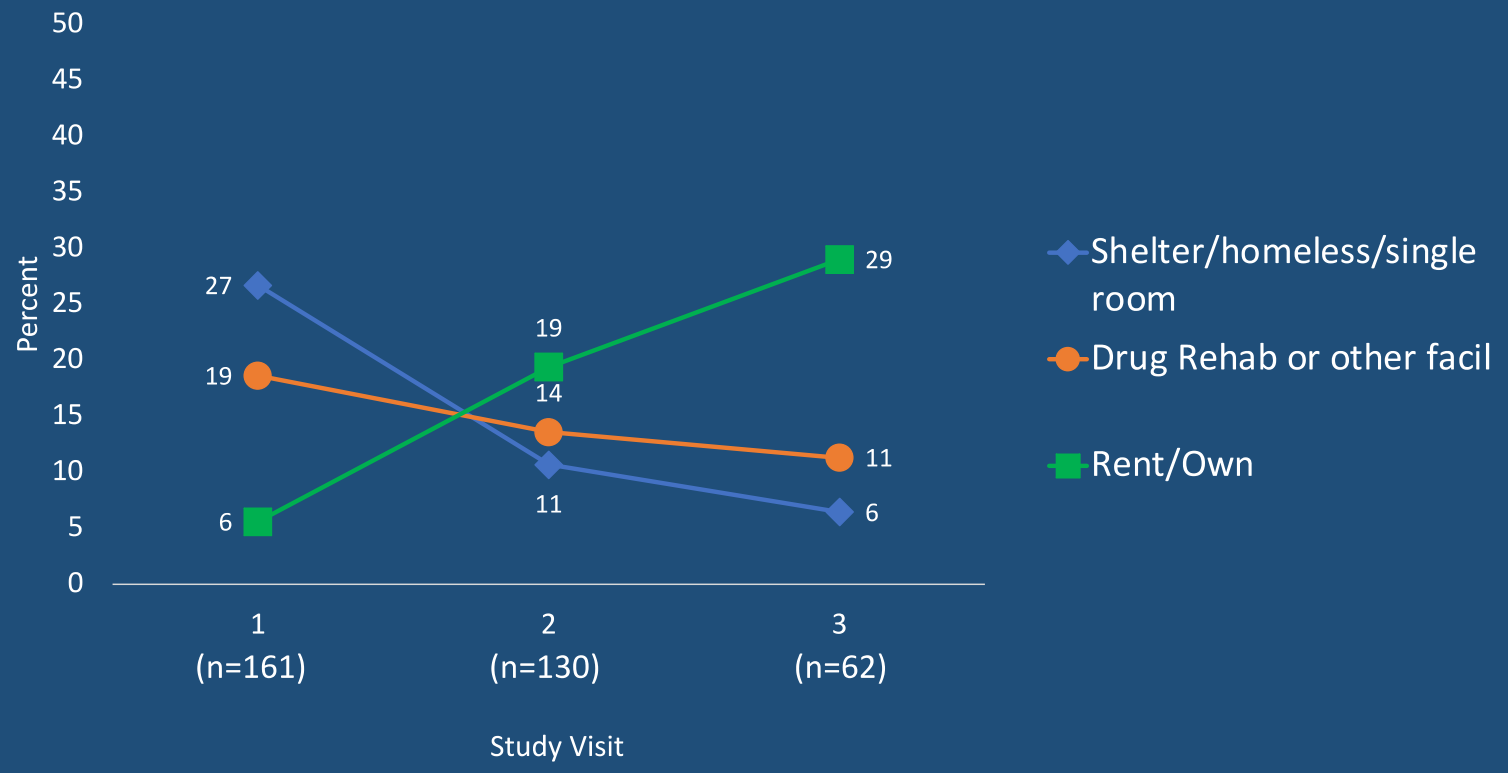
Living situation



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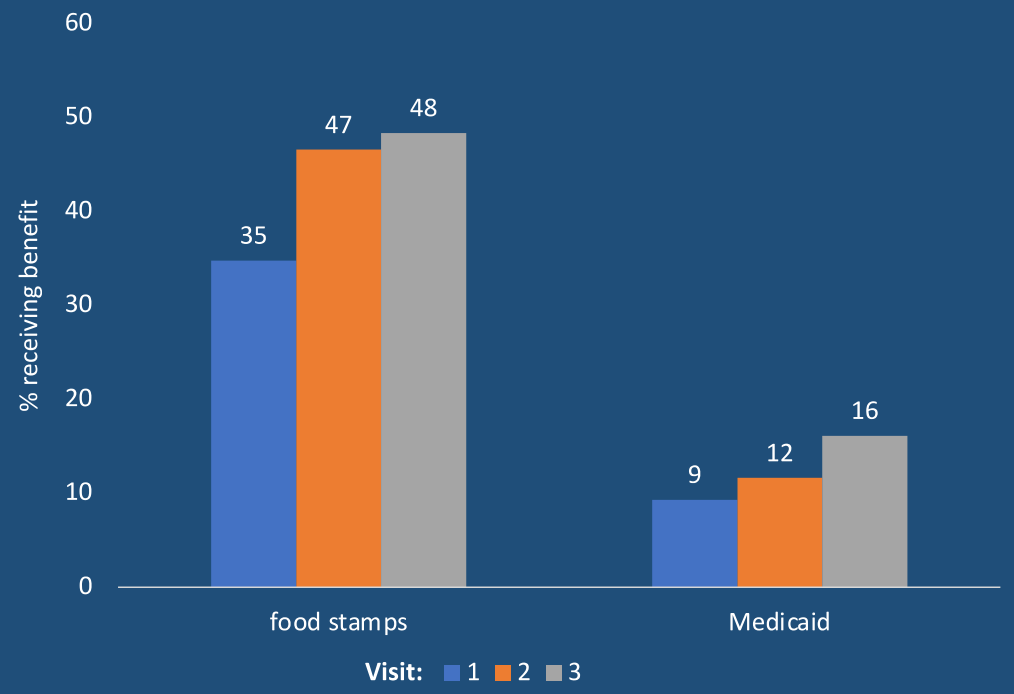
Benefits received



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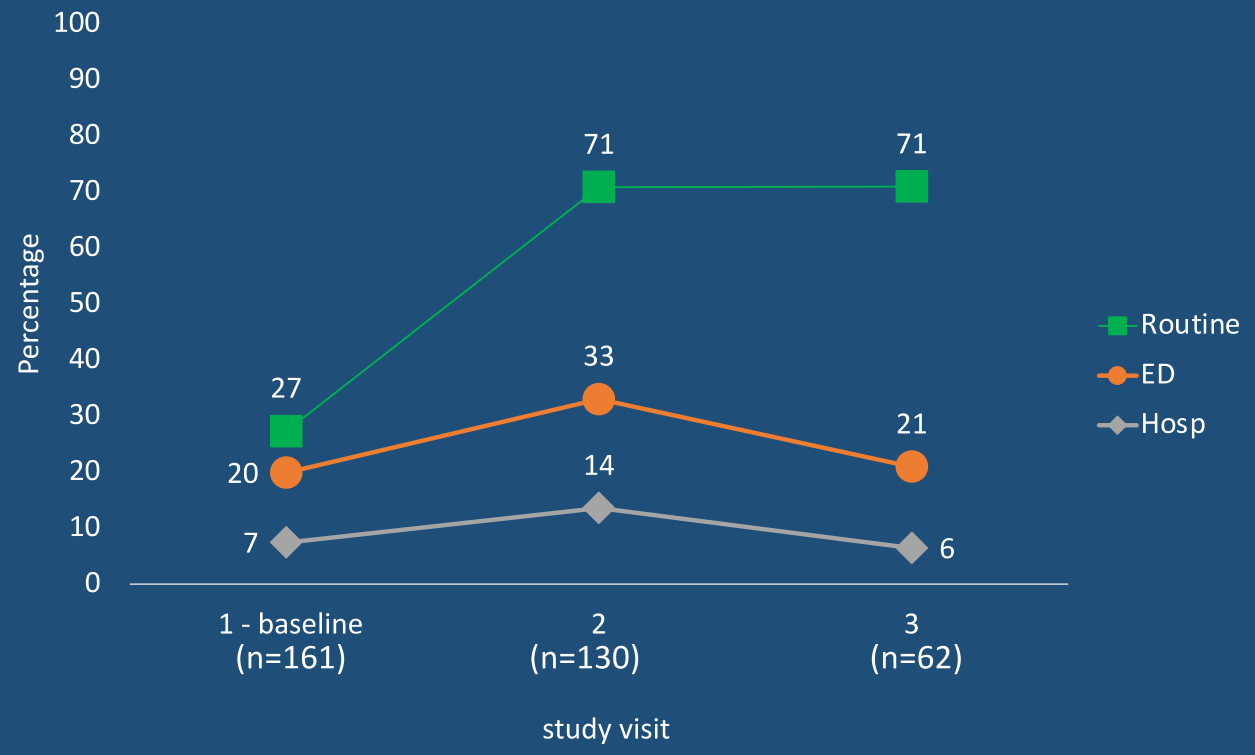
Healthcare utilization in past 4 months (n=161)



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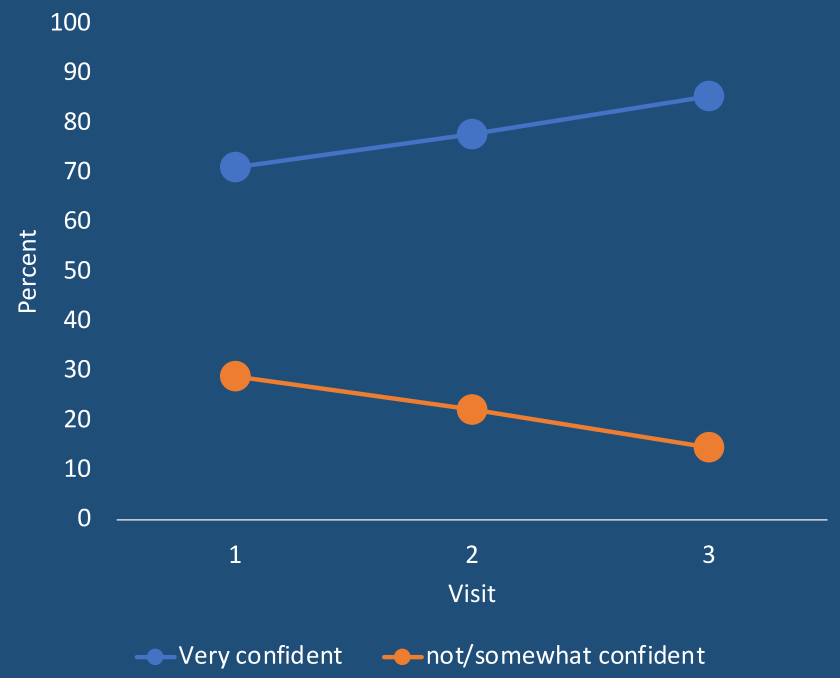
Taking all medications as prescribed



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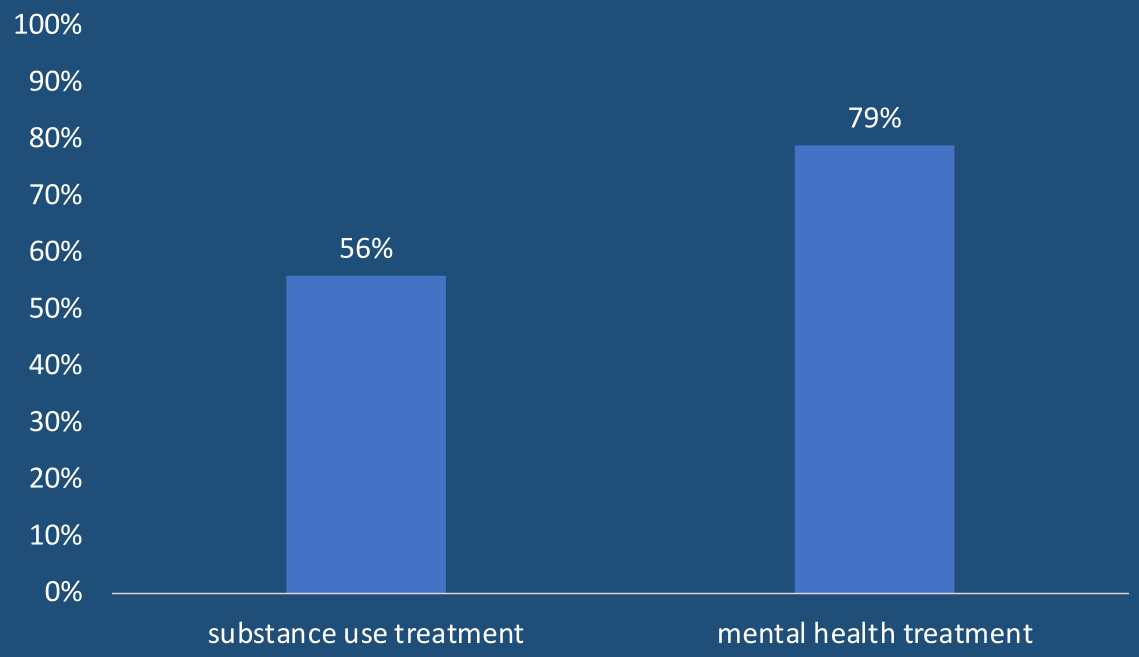
Accessed substance use or mental health treatment by 2nd follow-up visit



*Among study participants wanting substance use treatment or having a mental health referral

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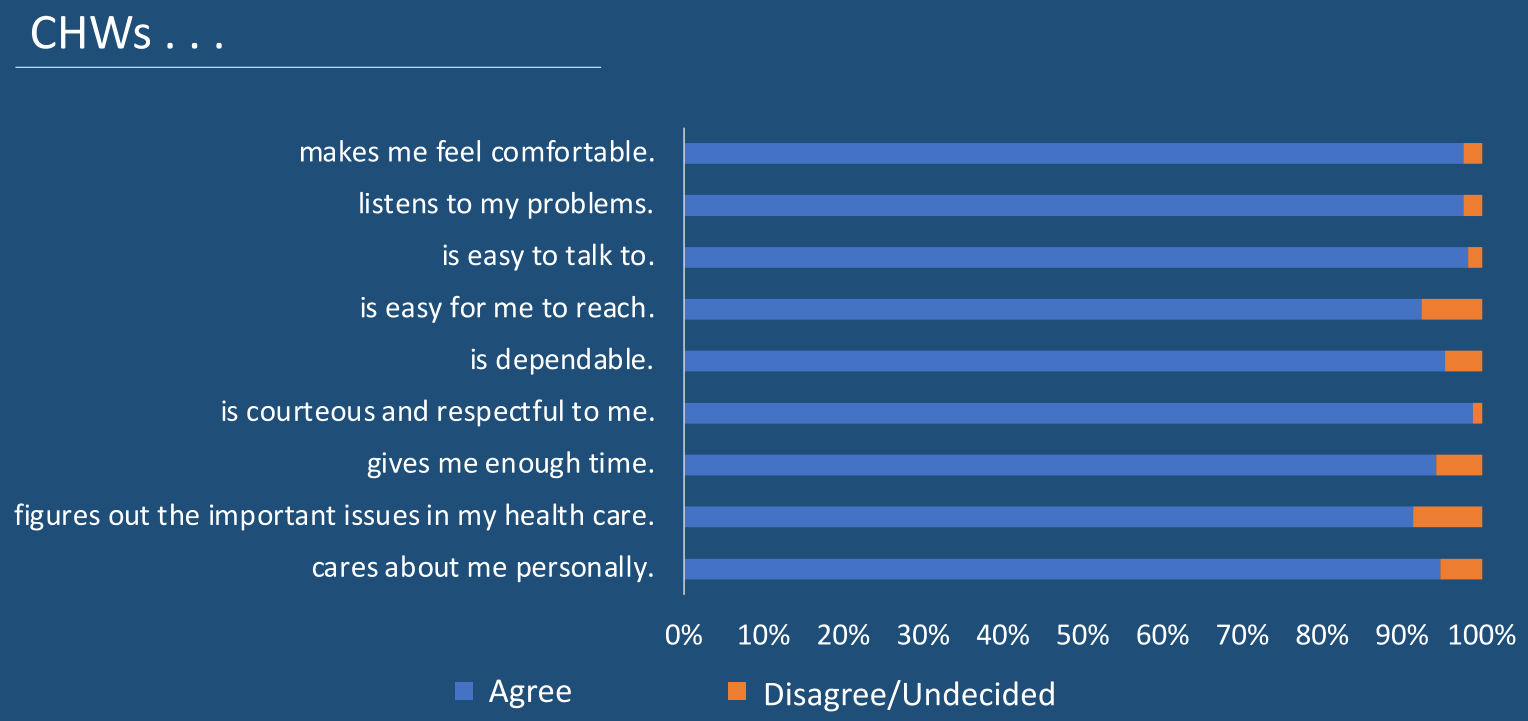
Clients' Assessments of Community Health Workers (CHWs)



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NC FIT and Opioid Epidemic

- Developed Jail-Based MOUD programs in 2 FIT Counties
- Developed state prison system MAT Pilot, inducing with Suboxone prior to release
  - Mountain Area Health Education Center (MAHEC)
- Technical Assistance in 22 communities across NC improving access to MOUD for people in jails, Diversion/Deflection, Harm Reduction
  - NC Harm Reduction Coalition
  - Duke Opioid Collaboratory

References:

Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison Shavit et al. Health Affairs 36, NO. 6 (2017): 1006–1015 doi: 10.1377/hlthaff.2017.0089

Cost savings of a primary care program for individuals recently released from prison: a propensity-matched study. Harvey et al. BMC Health Services Research (2022) 22:585 https://doi.org/10.1186/s12913-022-07985-5

Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven. Wang et al. BMJ Open 2019;9:e028097

Engaging Individuals Recently Released From Prison Into Primary Care: A Randomized Trial. Wang et al. American Journal of Public Health **102**, e22_e29, https://doi.org/10.2105/AJPH.2012.300894

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Contact Information

- NC FIT Program
  - » www.ncfitprogram.org
- Transitions Clinic Network
  - » www.transitionsclinic.org

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