P2PH
FROM PUNISHMENT TO PUBLIC HEALTH

PUBLIC HEALTH'S ROLE IN THE CRIMINAL LEGAL SYSTEM

Improving Healthcare Access and Outcomes for Justice-Involved Populations

DATA COLLABORATIVE FOR JUSTICE
AT JOHN JAY COLLEGE

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PANEL 1: HEALTHCARE AND THE COURTS

Moderator: Krystal Rodriguez, Policy Director, Data Collaborative for Justice

Kendall Sullivan, Director of Arraignment Court Operations, Center for Alternative Sentencing and Employment Services

Zakiya Rose, Project Manager for the Criminal Justice Division at the New York State Office of Addiction Services and Supports (OASAS)

Toni Mardirossian, Chief of Pathways to Public Safety, New York County District Attorney's Office

Aisha Greene, Bureau Chief, Rehabilitation Programs and Restorative Services, Queens County District Attorney's Office

If you have any questions for the panelists, please scan the QR Code below:

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COFFEE BREAK

The conference will reconvene at 12:00pm.

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PANEL 2: HEALTHCARE ACCESS IN THE JAILS

Moderator: Tiffany Sloan, Project Manager, From Punishment to Public Health
Sumeet Sharma, Director, Correctional Association of New York
Michael Matteo, KEEP Reentry Coordinator, Correctional Health Services, NYC Health + Hospitals
Mervin Otero, Program Manager, Osborne Association
Trevor Cummings, Senior Program Manager of the NYC Health Justice Network

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Discharge Planning for Patients with OUD in the NYC Jail System

Mike Matteo MS, CASAC
Tricia Bautista MD
William L. Vail MD/MPH&TM

DCJ + P2PH Conference – December 12th 2024

Correctional Health Services

NYC HEALTH+ HOSPITALS

Introduction to KEEP

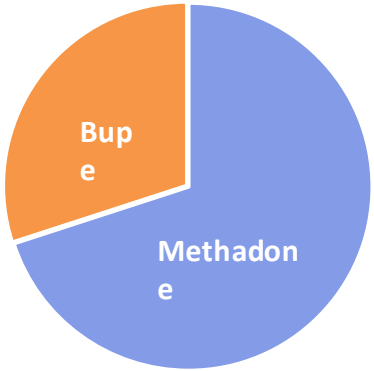
What KEEP is:	The Key Extended Entry Program (KEEP) includes a SAMHSA certified opioid treatment program within New York City Health and Hospital's Correctional Health Services (CHS).
What KEEP does:	Since the 1980s, KEEP has provided medication for opioid use disorder (MOUD) to incarcerated persons within the NYC jail system.
Medications offered:	Methadone, buprenorphine (sublingual and long-acting injection), and naltrexone (sublingual and long-acting injection).

Medications for alcohol use disorder (naltrexone, gabapentin, acamprosate, disulfiram, topiramate) are also offered through KEEP.

Breakdown of MOUD Services

As of November 2024, KEEP provides MOUD services to over 800 patients (approx. 13% of the total NYC jail population).

- 30% of current MOUD patients choose buprenorphine as their preferred medication.
- 70% choose methadone.



The medication a patient selects can significantly impact their discharge plan. KEEP is committed to educating patients on their medication options to support informed decisions about treatment and aftercare planning.

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Jail Discharge Planning Barriers

Discharge planning in the jail system is challenging due to the unpredictability of releases. Unlike other correctional systems, most individuals in NYC jails are detained without a set release date (approx. 8% are sentenced with known discharge as of early December 2024).

Unexpected Discharges:	**Posting bail, case dismissals, warrant lifts, and court rulings can lead to sudden releases.**
Timing:	**Releases can happen late in the evening, overnight, or directly from court – times and places where KEEP and other CHS staff are not available.**

Due to the nature of jail releases, CHS is one of very few healthcare systems which has no direct input or control over when patients are discharged from care.

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KEEP Discharge Planning

Because of the unpredictable nature of jail releases, KEEP discharge planning is done at point of program admission rather than close to date of release.

- **Referrals:** Patients are referred to a community OTP, FQHC, or the H+H PORT service and provided an aftercare letter. A pharmacy where a 30-day bridging prescription will be sent is selected, if applicable.
- **Coordination:** KEEP staff share patient info (demographics, medication, court and potential release dates) with community OTPs to assist with continuity of care.
- **Known Jail Releases:** Discharge planning can be tailored to patient needs.
- **Unknown Jail Releases (Majority of Cases):** Patients bring aftercare letter to OTP the day after release. Courtesy-dosing provided until admissions process is completed.
- **PORT Outreach:** PORT workers contact patients receiving buprenorphine treatment post-release to offer connections to care at Bellevue or Kings County Hospital centers.

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KEEP Discharge Planning Barriers

Several factors complicate smooth transitions post-release:

- KEEP is not aware of or able to track many discharges until the following day.
- Patients may lose their aftercare letter and other discharge planning paperwork provided to them by KEEP staff.
- Patients may have conflicting appointments (HRA, Parole, other treatment programming) that interfere with connecting with an OTP in the immediate post-release period.
- Patients are typically released without photo identification, which can make identity verification a challenge, impede OTP admission, and delay receiving medication.
- Patients can be discharged late at night, early in the morning, or right before the weekend – times when OTPs and other community resources are unavailable.

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Jail-Based Interventions

To address these barriers, several interventions have been implemented or explored by KEEP:

- **Pre-release follow up:** special visits for patients anticipating release within 30 days.
- **MOUD Education:** tailored counseling for patients new to MOUD and the substance use treatment landscape.
- **Peer support:** incorporation of peer advocates for additional guidance.
- **Improved pre-release systems:** including multiple "touch points" between KEEP team and patients to discuss discharge planning during every clinical encounter.
- **Collaboration:** continuously strengthening partnerships between CHS, community healthcare partners, the Department of Correction, courts, attorneys, social workers, and other stakeholders to improve of discharge planning and continuity of care.

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Additional Workflows Targeting Barriers

Coordinating weekend guest medication with a community OTP for a patient with an anticipated Friday release date

Limitations:

- Providing advance notification of Friday releases is only possible if a release date is known in advance (small percentage of overall KEEP-enrolled population).
- Not all OTPs have capacity to reliably provide weekend guest dosing, even with prior notice.
- Patients may need to travel outside of their borough for weekend dosing.

Additional Workflows Targeting Barriers

Providing walking medication at time of release from within the jail facilities

Limitations:

- Patients unexpectedly released from court are not able to leave Rikers with a walking supply of a controlled medication.
- If discharged directly from Rikers, patients remain in holding areas with other individuals prior to release, leading to significant danger and risk of overdose if walking medications are distributed to others.

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Potential Opportunities

- Can hospital emergency departments provide full methadone doses to patients who are recently released from Rikers?
- Can OTPs create a “bridge-like” model of care for patients released on Fridays?
- Can the reach of mobile methadone units be expanded to allow medication dispensing for unplanned, emergency cases?

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Conclusion: Moving Forward

KEEP serves a critical role in providing MOUD services to people incarcerated in the NYC jail system. However significant barriers persist which impact discharge planning and medication continuity.

Key challenges include unpredictable jail releases and fragmented systems which create obstacles to continuity of care.

Solutions and opportunities involve changes to both correctional and community systems that aim at improving immediate response and coordination to better support patients transitioning from incarceration to community care.

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Thanks!

- Questions?

- Michael Matteo, MS, CASAC
  - Director of Reentry and Community Partnerships, KEEP
  - Email: matteom@nychhc.org

Osborne ASSOCIATION

Criminal Health Initiative (CHI)

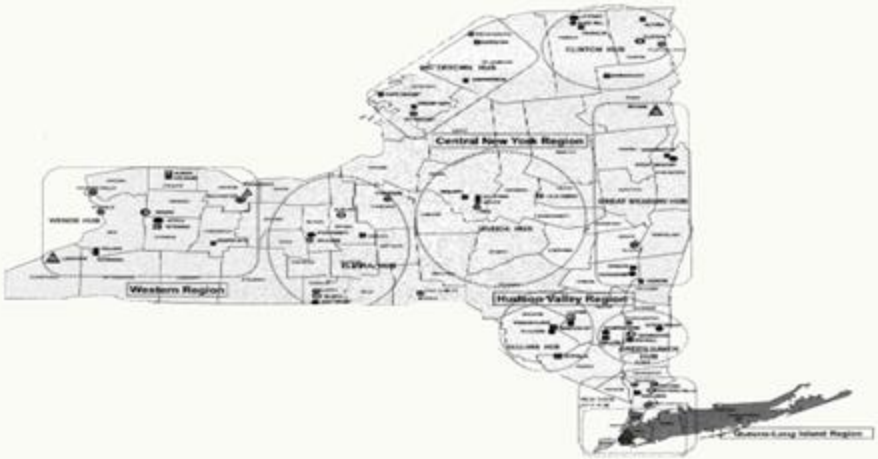
Mervin Otero,
Program Manager

December 12, 2024

What We Do?

- The New York State Department of Health/AIDS Institute is working with CHI Providers to address healthcare challenges and disparities faced by persons involved in the criminal justice system with HIV and or HCV.
- The Department of Health has contracted with ten community based organizations to identify eligible incarcerated individuals coming home within 90 days and engage them in the **In Facility Linkage program**.
- Osborne also provides **Health Services (education)** and **Bronx Reentry** (**community case management)** for those individuals who are infected and coming home to the Bronx.

Osborne's CHI Program Catchment Area



Areas

NYC Hub

- Queensboro Correctional Facility
- Edgecombe Residential Treatment Facility
- Sing-Sing Correctional Facility

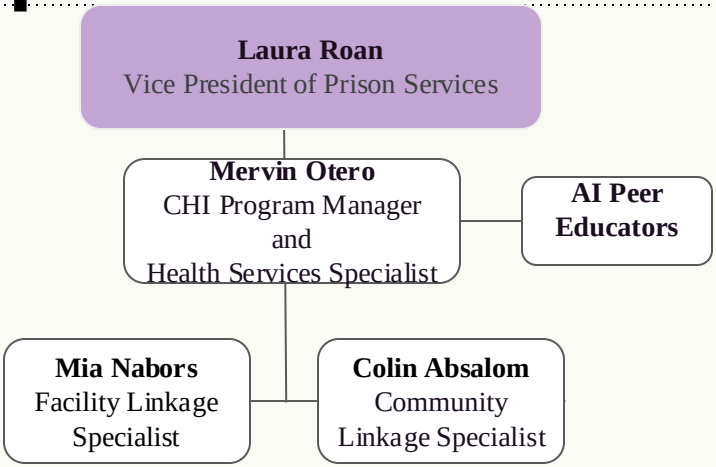
Bronx County for Reentry

Staff on the CHI Contract

Osborne

Program

Program Staff



Osborne

The primary goals of the DOH's Corrections Health Initiative (CHI) are to:

- Address health disparities and inequities by identifying barriers to positive health outcomes and providing relevant prevention, navigation, and support services to incarcerated individuals living with HIV and/or diagnosed with HCV prior to and upon release.
- Facilitate the prompt access to quality, culturally competent medical care and support services for individuals living with HIV and/or diagnosed with HCV while incarcerated and post-release.
- Offer tools and support to strengthen self-management skills and encourage individuals living with HIV, diagnosed with HCV, and those who are HIV negative to identify and apply personal strengths and self-advocacy skills to achieve positive health outcomes.
- Offer HIV/STI/HCV peer training, education, and support in NYS DOCCS CFs.
- Increase awareness about treatment as prevention and biomedical interventions for those who are HIV negative including Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP).

Osborne

The primary goals of the DOH's Corrections Health Initiative (CHI) are to:

- Enhance existing sexual health and HCV education efforts while also assisting with linkage to NYS DOCCS HIV testing, sexually transmitted infection (STI), and HCV screening and treatment.
- Integrate trauma-informed approaches and design interventions and services from a stigma-free framework.
- Promote active collaboration and facilitate networking among agencies addressing the health and social service needs for criminal justice-involved individuals to support continuous and coordinated care both in facility and after incarceration; and
- Expand and strengthen the statewide HIV/STI/HCV provider network servicing incarcerated individuals and re-entrants with continuity of care, prevention education and community reentry services.

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LUNCH BREAK

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PANEL 3: GREATER OPPORTUNITIES FOR CRIME PREVENTION & COMMUNITY HEALTH AND WELLNESS

Moderator: Samantha Balak, Policy Coordinator, From Punishment to Public Health
Pamela Mattel, Executive Director, Coordinated Behavioral Care
Toya Parker, Director, Brownsville Safety Alliance Situation Tables, Institute for Community Living
Steven Hernandez, Chief of Staff, St Ann's Corner of Harm Reduction
Dr. Noe Romo, Director of Pediatric Inpatient Services, Medical Director of Bronx Stand Up to Violence (S.U.V.), Jacobi Medical Center, NYC Health + Hospitals

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Safe Options Support (SOS) Program

Pamela Mattel CEO
Coordinated Behavioral Health


Delancey
Street
FOX 5
OURISTS PUS
NYC SUBWAY


Subway as Crime Surges
Subway robberies more than doubled in January from 2021
Weekday subway ridership is nearly 60% of 2019 levels

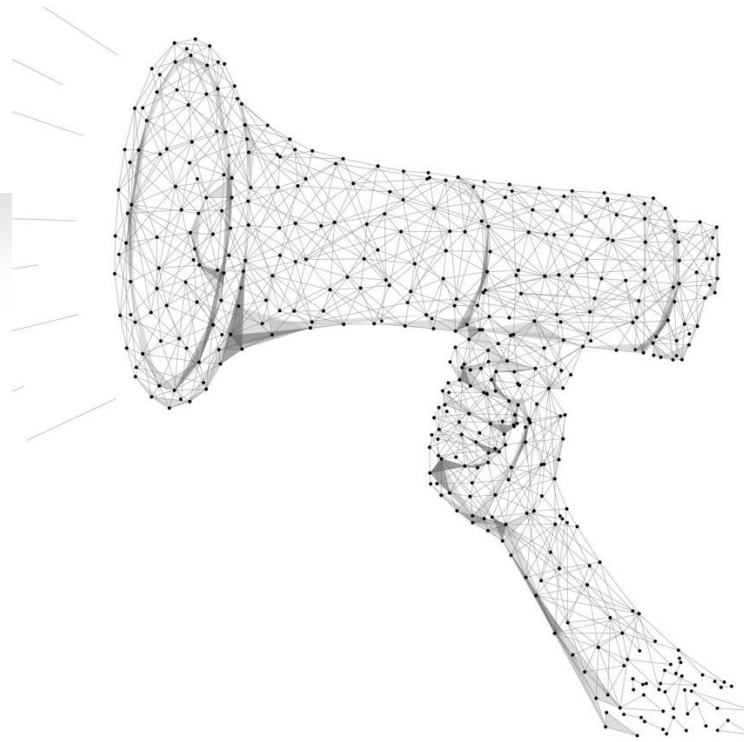

NEXT STOP,
PURGATORY


NYC SUBWAY
HOMELESS DEATH
January-February
6 Deaths In 2022
2 Deaths In 2021
2012 - 2020
From 170 To 613


JUMAANE WILLIAMS (D) | NEW YORK CITY PUBLIC ADVOCATE
NYC TO REMOVE MENTALLY ILL PEOPLE FROM STR
ADAMS: 40% OF SUBWAY MURDERS LIKELY BY THOSE WITH MENTAL HEALTH

Safe Options Support Program

- Social Problem
- Media Attention
- Government Spotlight
- Public Health Intervention




Exit
John Street
Broadway
Fulton Street
Escalator
Uptown &
The Bronx
4 5
SAFE OPTIONS
SUPPORT TEAMS


IMPROVING SUBWAY SAFETY
PROTECTING NEW YORKERS

Targeted Problems to be Solved

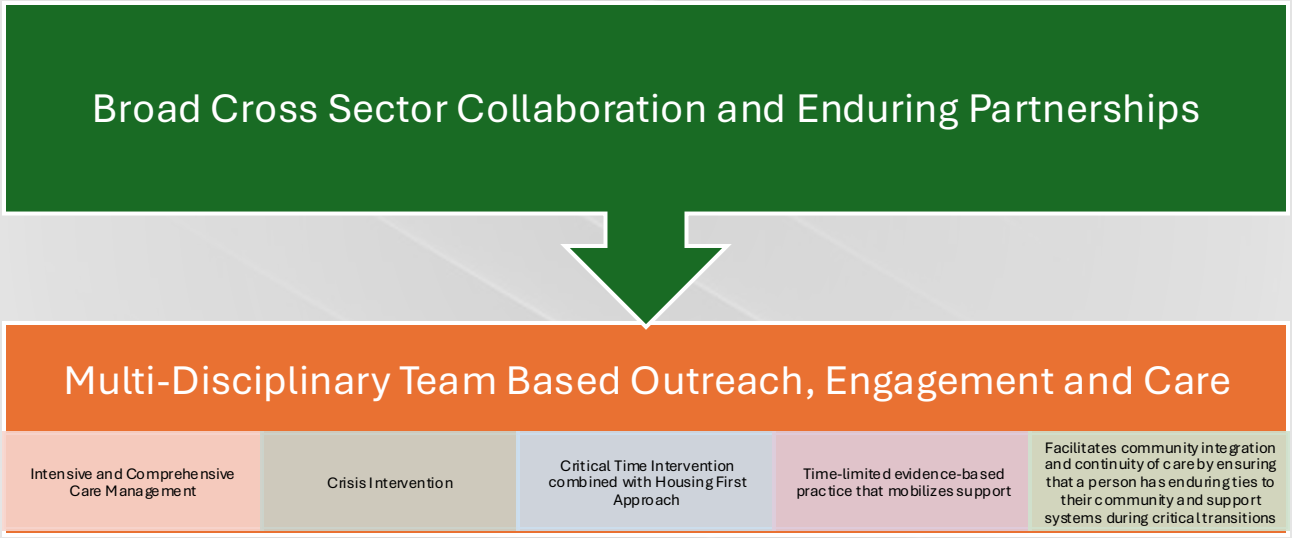
Fragmented systems creating multiple bottlenecks and barriers
Disconnected service providers across multiple silos
Duplicative administrative and clinical infrastructure
Inefficient access to care
Poor outreach and engagement of other sectors
Lack of actionable data availability and transparency

Radical Collaboration

Transformative approach that transcends conventional boundaries and challenges traditional notions of cooperation. It emphasizes breaking down silos, embracing diverse perspectives, and fostering an environment where every voice is not only heard but valued. It goes beyond mere cooperation and seeks to cultivate a culture of innovation, empathy, and continuous improvement.

- Convener and Uniter
- Multi-Layered Approach
- Expert-Led Implementation Team
- Cross-system data sharing agreements

SOS Approach



From Partnerships To Ecosystem Of Care

- NYS Office of Mental Health
- NYS Office of Addiction and Support Services
- Behavioral Health providers
- People with lived experience
- Homeless Outreach and Service Providers
- Shelter and Housing Providers
- Medical Respite
- Hospital system/ED/Psych Units
- Inpatient Psychiatric Hospitals
- Social Care Community Based Organizations
- Faith- and community-based organizations
- Law enforcement (e.g., police officers, transit)
- Fire Departments and Emergency Medical Services (EMS)
- City Metropolitan Transportation Agency (stations for subway, buses)
- Electronic Health Record Vendor

Performance Indicators

Encounters	Enrollments	Involuntary Removals
Hospitalizations	Housing	Housing Stability

SOS Impact

Successful transitions from homelessness to stable housing.

14
Total teams covering 24/7/365

2,090
Enrollments

6 out of 10
Members enrolled in Medicaid

40,534
Canvassing encounters in Subway / Transportation Hub

570
Permanent Housing Placements

1,725
Shelter Placements

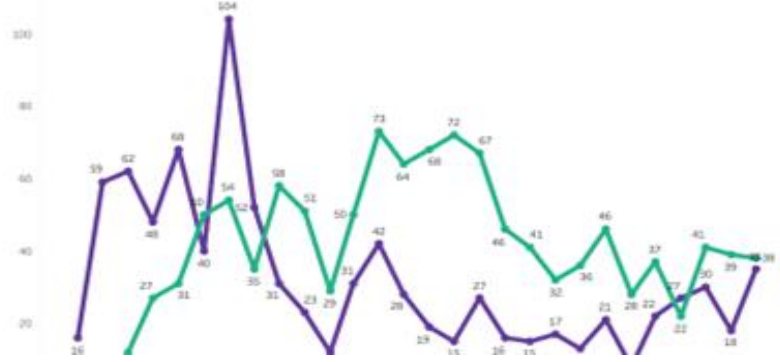
SOS OMH Weekly Report

(April, 2022 - Current)

Report Name	Latest Data Refresh	Report Run Date
SOS OMH Wee..	9/24/2024	9/24/2024

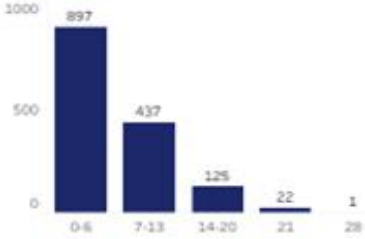
Currently Enrolled Members	Total Enrollments	Total Disenrollments
618	2,105	1,482

Enrollments by Referral Source Category

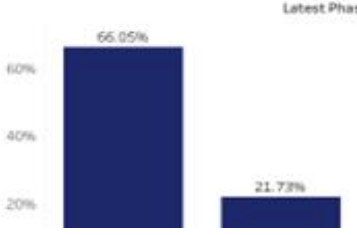


Disenrollment Reason	
Completion/Graduation	249
Deceased	22
Declined Services	182
Incarceration	19
Long-term Hospital Admis..	20
Lost Contact	637
Moved out of Catchment A..	116
Referred to a Higher Level ..	96
Transferred	141
Grand Total	1,482

Length of Stay for Disenrollments (in Months)



Disenrolled Member Count by SOS Phase (reason = Declined or Lost Contact)



Complex Areas Needing Attention

- Housing Stock and Eligibility Barriers
- Policies intended to Reduce Homelessness
- Partnerships
- Fragmented Care Management
- Data and Interoperability

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THANK YOU FOR PARTICIPATING!

Head over to the event webpage for a recording of the convening:
https://p2ph.org/dcjp2ph-conference/

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