

## **Incarceration/Re-Entry and Urban Violence**

By the end of the Urban Health training, learners will possess the knowledge, skills, and attitudes needed to take care of incarcerated and recently released individuals, articulate the challenges they and their patients face in making progress towards health care goals, and be a leader in advocating for solutions to those challenges.

### **Knowledge:**

By the end of the curriculum, residents will be able to describe the prevalence of incarceration in the United States, including the demographics of the incarcerated, both nationally and locally.

By the end of the curriculum, residents will articulate the limitations of healthcare delivery in institutionalized settings, including the challenges which make it difficult to comply with evidence-based medicine and CDC guidelines.

By the end of the curriculum, residents will be able to define commonly used terms in the judicial system so as to be able to read and understand the literature related to correctional health.

By the end of the curriculum, residents will be able to describe the following non-health related barriers to transitioning back to the community and these affect access to health care: job procurement, stable housing, transportation, child care.

By the end of the curriculum, residents will be able to describe programs which address geriatric or palliative care, such as compassionate release and medical parole.

### **Affective:**

By the end of the curriculum, residents will “strongly agree” with statements such as:

“I have the skills to contribute meaningfully to improving the care provided to recently incarcerated individuals.”

“I know how to help a currently or recently incarcerated patient establish and reach a health goal.”

### **Process:**

Each resident will have rotated through the jail or prison setting, participated in a focus group with recently released individuals, attended content lectures, participated in a focus group with a federal judge, visited some clinical sites where recently released individuals seek health care, and volunteered with a transitional program.

### **Skill:**

At the end of the curriculum, each resident will identify a systems problem which affects health care delivery during incarceration or the transition time back to the community. They will then independently hypothesize a strategy to address the problem and present their work to an “expert” in the field for feedback.

By the end of the curriculum, residents will effectively incorporate working with case managers/patient navigators into their routine clinic practice, as measured by program leadership speaking with the case managers.

### **Educational Purpose and Goals**

We aim to impact residents’ knowledge, behavior and attitudes towards substance use among their patients, focusing on universal screening and evidence-based practices for early intervention. Additionally, we will encourage

referrals to specialized treatment programs where appropriate, and will develop mechanisms to facilitate such referrals. Moreover, residents will become comfortable treating opioid addiction with Suboxone in the primary care setting.

### **Patient Care**

1. The resident will be able to conduct a patient-centered history to obtain the overarching, personal dimensions of the patient's addiction problem and its context
2. Demonstrate proficiency in using validated instruments to screen for risky substance use and/or SUD in medical patients.
3. Become familiar with eliciting DSM-IV criteria through patient interview to make substance abuse or dependence diagnoses and apply the criteria appropriately.
4. The resident will be able to perform a relevant physical examination and identify evidence, for example, of cirrhosis of the liver, withdrawal manifestations, and organic mental symptoms.
5. The resident will be able to succinctly summarize and synthesize in the patient's chart the biopsychosocial aspects of the patient's addiction problem.
6. The resident will be able to articulate what stage of change the patient now exhibits.
7. The resident will be able to identify a management plan based on the patient's current stage of change
8. The residents will become familiar with the spectrum of pharmacologic agents used in the treatment of substance use disorders and factors to be considered in their prescription. Examples of such agents include agonist treatments such as Suboxone in the treatment of opioid dependent patients, naltrexone for the treatment of opioid dependence, or alcohol dependence, acamprosate, and disulfiram as other approaches for alcohol dependence, and varenicline for nicotine dependence.
9. Residents will gain a global view of addictive disorders as representing chronic dynamic, medical conditions which are treatable, but require ongoing monitoring and variable degrees of intervention over the course of the disorder.

### **Medical Knowledge**

1. Describe appropriate pharmacotherapy for alcohol dependence, opioid dependence, cocaine, and tobacco dependence.
2. Learn DSM-IV criteria for substance use disorders
3. Be able to describe the medical consequences of tobacco use, alcohol use, illicit drug use, and prescription drug misuse.
4. Be able to describe the chronic disease model of SUD, know the success rates of the various modes of SUD treatment, and how these compare to success rates of treatment for other chronic diseases.
5. Be able to describe supportive confrontation and motivational interviewing and how it may be used in clinical practice

### **Interpersonal and Communication Skills**

1. The resident will be able to integrate patient-centered and doctor-centered communication skills to produce a biopsychosocial understanding of the patient's addiction problem.
2. The resident will be able to use similar skills in relating effectively to other team members in the addiction units.
3. The resident will be able to communicate a sense of hope and optimism for the benefits of treatment to patients with addictive disorders. .

### **Professionalism**

1. In sometimes difficult patients with addiction problems, the resident will be able to always exhibit respect, understanding of the patient's vantage point, acknowledge the patient's plight, and find something praiseworthy about the patient.
2. The resident will be able to become the patient's ally, provide support and counsel in a primary care setting, and provide information and other resources needed by the patient.
3. The resident will be able to be sensitive to cultural, disability, lifestyle, and gender differences in addiction medicine patients.
4. The resident will be able to articulate, understand, and practice in a way consistent with ethically sound, patient-centered practices.

### **Practice Based Learning and Improvement**

1. The resident will be able to critically appraise the literature and apply this with the patient.
2. The resident will be able to make self-assessments of his/her impact with addiction patients, and they will be able to identify their own attitudes and emotions that might interfere with high quality care.
3. The resident will be able to teach other residents and students the basic issues outlined here about addiction medicine.

### **Systems Based Practice**

1. The resident will be able to recognize and address the systems aspect of the addiction patient's problems in their biological, psychological, and social complexity.
2. The resident will be able to refer to addiction specialists when appropriate.
3. The resident will be able to recognize the cost impact of addiction problems as well as to conduct cost-effective care for these patients.
4. The resident will be able to appropriately involve families and significant others in the patient's care and decision-making.
5. The resident will be able to help patients identify resources in the community often needed and used by patients with addictive disorder.

## Targeted Needs Assessment

### Key Community Advocates:

- Baltimore Mayor's Office
- Federal Judge involved in re-entry efforts
- Director of re-entry services for Maryland Department of Public Safety and Correctional Services
- Associate Director of the Johns Hopkins Urban Health Institute

### Key National Advocates:

- Founders & Co-Directors of the "Transitions Network" (UCSF, Yale)
- Clinician Investigators Performing Research on this Patient Population (University of Colorado, UCSF)

### Key Community Clinical Providers:

- Medical Director of a Baltimore methadone clinic
- Medical Director of Correctional Medical Services
- Baltimore Healthcare for the Homeless Medical Officer

### Rotation Goal

- Possess the knowledge, skills, and attitudes needed to take care of incarcerated and recently released individuals.
- Articulate the challenges they and their patients face in making progress towards health care goals.
- Advocate for solutions to those challenges.

### Educational Methods

Noon conference: didactics and invited guest speakers (key community leaders and content experts)

Non – Clinical: Shadow experiences in correctional system

Clinical: Outpatient clinic, Inpatient wards, CMS

Facilitated discussion with formerly incarcerated individuals

### Evaluation

#### Cognitive & Affective Objectives:

Pre-test/Post-test (written format)

O<sub>1</sub>—X—O<sub>2</sub>

#### Skill Objective:

Post-test only (PowerPoint & oral format)

X—O

### Implementation

#### Noon conference didactics (3<sup>rd</sup> Wednesday of the month)

- ❖ Self-Reflection
- ❖ Small group (informal, pizza ordered) with formerly incarcerated
- ❖ Facts/Figures (statistics, prevalence)
- ❖ Geriatrics Behind Bars, Palliative Care
- ❖ Female Prisoners
- ❖ Policy "Hot Topics" (California early release, Prisoner rights, etc)
- ❖ Invited guest speakers (key community leaders, content experts)

Objectives for each session, list of Referenced Materials, 1-2 Sources for Further Reading

### Continuity Clinic

#### PGY2 "Immersion Experience" (2 weeks)

- ❖ Shadow experiences with public defenders, arraignment hearings, parole officers
- ❖ Clinical time with CMS (jail and prison)

Reading Material: The Other Wes Moore