Connections Care Management: Nurses and Community Health Workers Supporting Transition for the Incarcerated Population

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PRESENTATION FORMAT: 15 minute oral presentation

TOPIC/TARGET AUDIENCE: Public health nurses, social workers, community health workers, evaluators and other public health professionals who deliver or administer client services

ABSTRACT: Background: The population of persons frequently incarcerated in county corrections facilities has extensive needs with respect to primary care, mental health, substance abuse, housing, employment and other areas. In correctional facilities the need for acute care often overrides care planning for chronic physical and mental health conditions. Also, transition planning is often limited. The varied nature of these clients' needs calls for an interdisciplinary approach.

Methods: In Connections Care Management, we focus on the incarcerated population with a chronic disease and at least two bookings at Multnomah County Corrections in the previous year. An interdisciplinary nurse-led team comprising a public health nurse (PHN), community health workers (CHW), corrections nurses, behavioral health specialists and primary care providers collaborate to create a plan of care for jail inmates. Once released, a CHW in consultation with the PHN, conducts extensive field work to assist clients in following their care plan and to facilitate connections to a medical home and other social service resources in the community.

Results/Outcomes: Program goals are to help clients adhere to their plan of care, connect to a medical home, reduce emergency department and hospital use, and reduce recidivism. Available data on these outcomes will be presented.

OBJECTIVE(S): Describe an interdisciplinary program staffed by nurses, community health workers and other corrections health professionals to assist chronically incarcerated persons to establish a medical home and transition to the community

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