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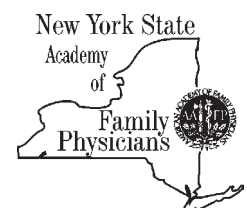
Family Doctor

A JOURNAL OF THE NEW YORK STATE ACADEMY
OF FAMILY PHYSICIANS



FEATURE ARTICLES:

- Caring for Aging Veterans: A Call for Cognition-Informed Care
- Influences on the Doctor-Patient Relationship for Recently Incarcerated Women
- Medical Challenges in Deaf Populations
- Providing Transitional Primary Care to Newly Released Prisoners



Focus:

**Institutional Health –
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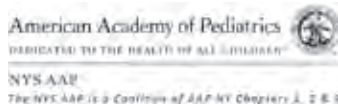
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¹U.S. Department of Agriculture Economic Research Service. Household Food Security in the United States in 2015

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From the Executive Vice President

By Vito Grasso, MPA, CAE

 celebrate 25 years with the NYSAFP this year. During my tenure New York has developed a reputation for producing leaders and influencing policy within the national Academy. I know that tradition precedes me, but I am proud to have been part of a legacy that has continued to this day.

During my most recent Annual Chapter Leadership Forum in Kansas City, I was approached several times by AAFP leaders and by leaders from other chapters who asked, how many resolutions is New York sending to the COD this year? What issues will they address?

We are fortunate in NY to have so many outstanding leaders within the AAFP. Dr. Tochi Iroku-Malize is the latest NY member to be elected to the AAFP Board of Directors. Three of her NY predecessors have gone on to become president of the AAFP.

We have a significant delegation of NYSAFP members serving on AAFP commissions. As the national debate over health care drags on, the voice of the medical community will continue to be an important source of expert and trusted advice. It is important that we have leadership from the New York Academy in that national discussion. It is also important that the Academy's contributions to that national discussion reflect the priorities and perspectives of our members.

New York is one of the largest chapters in the AAFP. We are among the most diverse in membership and have a rich history of submitting resolutions addressing a broad spectrum of medical, scientific, social and political issues of concern to family physicians and patients.

Over time, NY resolutions regarding critical issues have resonated with members of the AAFP Congress. Our persistent resolutions regarding support for a single payer health care system and

protection of women's health were initially rebuffed, then gradually considered and referred and ultimately adopted. Our leadership in these and other important areas has attracted support of other chapters and member interest groups.

We have succeeded in sending effective and accomplished leaders to the AAFP board, the COD, commissions, the National Conference of Chapter Leaders (formerly the National Conference of Special Constituencies) and the National Conference of Resident and Student members. Together with participation in our own governance structure, these experiences have provided a strong foundation for development and refinement of exceptional leadership skills among NY members who have been uniquely committed to shaping their profession, their specialty and their communities through the work of the Academy.

Those who have risen to the successes within the AAFP have been the most visible of the many NY members who have helped define and advance the image and mission of the Academy. There are, however, many more who themselves have contributed to the development of those members who have become national leaders. Each time we have debate in our Congress, our commission meetings, at our board or in the networking opportunities at our state and county meetings, members exchange ideas and share perspectives in the collegial tradition of medicine. Those conversations and debates help form the ideas, opinions and recommendations which NY leaders have always taken to AAFP audiences in various forums.


In my quarter century with the Academy it has been a true pleasure to witness and, hopefully, to contribute to, the development of leaders with diverse backgrounds and perspectives whose success within the AAFP is a reflection of our NY membership as a whole.

New York is one of the largest chapters in the AAFP. We are among the most diverse in membership and have a rich history of submitting resolutions addressing a broad spectrum of medical, scientific, social and political issues of concern to family physicians and patients.



President's Post

By Barbara Keber, MD, FAAFP

ust having completed our annual Congress of Delegates in Troy, New York this past weekend has reaffirmed my belief in the family physicians of this state. We came together as a diverse group of 66 physicians, 19 residents, 10 students and guests to discuss an array of 36 resolutions (a record number) brought before the group. During the proceedings it was evident that all in the room have a passion for this work and their patients. While we differ in opinions, we respect all points of view which find their way into the form of resolutions written to give our organization the policy to be able to work legislatively both in New York and nationally. One resolution brought to the COD was in regard to the state allowing undocumented persons living in our state to become licensed drivers. No sooner was this passed than it was enacted by the legislature during the current session, making this particular resolution moot once signed by the governor.

A summary of the topics brought forth during this session include the following: Prior authorization for medications, sharing of health information among providers, single payer including education for members about single payer and collective bargaining as a part of successful single payer system, access to care, reduction of administrative burden for physicians, data tracking by third parties such as insurance companies, pre-participation physicals for sports, stealthing as sexual assault, education in billing and coding for residents, policy to allocate 12-20% of health care spending in NYS for primary care, racism in healthcare and healthcare education, elimination of race-based medicine, family leave, medication assisted treatment (MAT) for opioid dependence by nurse practitioners and physician assistants as well as the training for MAT during residency, access to naloxone, breastfeeding in the workplace, abortion, mifepristone use in early pregnancy loss, family

centeredness at meetings both in NYS and nationally, opposition to criminalization of providing abortion care, gender pronouns for meeting tags and registration, and strategic planning for the NYSAFP.

In order to be able to accomplish our goals both in the state of New York and also in the nation, we must increase the workforce in family medicine. The national goal is to achieve 25% of the graduates of all American medical schools choosing family medicine as a career by 2030. Many things have to occur for this to be able to happen. We must mentor premedical and precollege students to want to make this choice. We have to increase the number of residency slots to be able to train students, and teaching health centers are an excellent way to accomplish this. Advocacy to accomplish these goals is crucial over the next several years for us to achieve our aims. Reduction of administrative burden, improved resiliency for family physicians, and enhanced payment for primary care especially for family physicians are all keys to accomplishing these objectives.

As your president this year, I will work with our board, staff and members to bring us closer to these targets. It is only by accomplishing them that we can improve access to care, quality of care and patient satisfaction for all those living in the great state of New York.

Thank you for your efforts and your support.

Barbara Keber MD, FAAFP
President NYSAFP 2019-2020

MEDICAL CHALLENGES IN DEAF POPULATIONS

By Sheila Ramanathan, DO

“Haaaaappy Biiiiirthdaaaay to Youuuu!” A cacophony of sounds reached my ears as the general tune of Happy Birthday was sung by a small group of hearing-impaired adults. My patient blew out the candles on his very large cake and started proudly passing out slices. His wife signed to her friend who translated to me asking if I liked chocolate or vanilla. “Chocolate!” I exclaimed, accepting a generous portion. I was at a birthday party my patient had kindly invited me to in order to celebrate his fiftieth birthday. Lighted speakers thudded out music that reverberated on my chest as I snacked on cake and watched hands flying, indicating a half-dozen conversations flowing between the ten or so people seated outdoors on folding chairs. If not for the music, the silence would have been deafening, punctuated by the occasional raucous laughter. As I traveled the ninety plus minutes to get home I mused on how isolating it was. Despite the warm smiles and the kindness of my patient to invite me, I was one of only two non-hearing-impaired people in the room.

Deaf patients make fewer trips to their primary care physician and have more visits to the emergency department.¹ Deaf patients, even among the educated, tend to score lower in health literacy and health knowledge.² This poor access due to language barriers translates to worse outcomes in cardiovascular health as well as pregnancy and birth.³ At the heart of the miscommunication is the thinking that deafness is an illness to be cured, as it is sometimes viewed by the medical community.

Over ninety percent of deaf children are born to hearing unimpaired parents.⁴ Hearing impairment or deafness is seen in one to three of every one thousand children born in developed countries.⁴ It can be devastating for parents to be unable to effectively communicate with their children. Even after surgical intervention with a cochlear implant, children fail to understand the majority of

speech surrounding them when compared to their hearing unimpaired peers.⁵ This is disturbing as it leads to stunted development of language as many parents are told to avoid American Sign Language (ASL) in order to encourage vocal communication. This can create a lifetime of poor communication and understanding of the surrounding world. The number of hearing-impaired adults jumps to 3.6% percent of the general American population, for those including later acquired deafness according to the 2017 US general census. Half of those individuals are over the age of sixty-five.

Promoting ASL as a means of language acquisition to children born to hearing unimpaired parents, is as important as presenting management options such as a cochlear implant in order to encourage language development. Introduction to the deaf community and early teaching of ASL reduces the risks associated with language delay in pediatric patients. A cochlear implant may allow a person to hear sounds and over time assist with language development, however there is still substantial disability with language acquisition and communication. ASL allows for language development during a critical time period and empowers families to have a deeper relationship with their children.

American Sign Language (ASL) is independent of the English language. As such ASL does not actually represent a spoken language. Fingerspelling or signed exact English can be used as a stopgap for when a sign does not exist or is unclear. This happens often in medicine. For example, the sign for “sugar” and for “diabetes” is the same. This clearly can lead to misconceptions as to what diabetes is and how sugar versus carbohydrates play a role.

Grammar rules apply as with any language and hand gesturing is different from

communicating with ASL. When a patient has a stroke or impairment to language generation, signs may be produced in incorrect order or nonsensically. Makaton can be used to supplement communication when patients have had a stroke or are limited in their ability to communicate effectively. Makaton is a language program that uses signs and symbols and is used as a supplement to verbal language. It uses signs from sign language and is standardized as opposed to ASL which may have regional dialects. Makaton is for patients with language or communication difficulties which may improve over time. While it can be helpful, in clinical practice challenges still exist. When a deaf patient came





for her appointment with me after a history of stroke, it required two translators to communicate with the patient. The amount of information that is lost in translation can directly impact the poorer outcomes often seen in deaf patient populations.

Communication is key with the population of approximately half a million users of ASL. For patients who are deaf and blind, ProTactile ASL may be a necessary accommodation as it is a language which is communicated by touch. Written English cannot be expected with patients as many were not educated at schools for the deaf, especially with older populations. After visit care summaries can be much less useful in this population as English literacy cannot be assumed.

As clinicians, this communication breakdown can be equally difficult as command of the English language cannot be assumed. Physicians are required to make accommodations for persons/people/patients with hearing loss as part of the American with Disabilities Act. However, due to the loophole of avoiding an undue burden on healthcare, in-person translation services are often unavailable due to their cost. Call captioning has been revolutionary in order to communicate with the deaf via the phone. It is available to deaf patients for free. Installing these phones in hospitals or health care settings in order for deaf patients to access essential information, creates a welcoming atmosphere. Internet Protocol Captioning Telephone Services are provided free of charge to qualified users through a tax levied on

all phone users. Limitations to the service include internet and phone service as well as knowledge of the English language. Family members or friends, due to HIPPA constraints, are not appropriate translators.

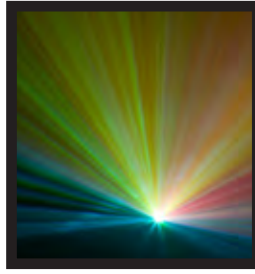
Video interpretation using ASL is a much more cost-effective means of communication than live interpreters, especially since it is readily available at all hours of the day or night and does not require travel time for a live interpreter. However, limitations include lack of knowledge of how to set up the equipment by staff, poor internet connection, and outdated video equipment. Delays in communication can be terrifying to patients that do not understand what is happening to them and cannot communicate the effectiveness of treatment in an emergent setting. In an outpatient setting communication can be frustrating as patients may not hear their name being called, contributing to unnecessary wait times. In a surgical setting, a patient may not only have no access to a translator, but masks can prevent reading lips or facial expressions, further isolating patients. Turning your back to a deaf patient eliminates what little communication can be obtained including facial expression, lip reading, and hand gesturing. The Deaf Health Initiative through Johns Hopkins, is an organization that seeks to make hospitals more accessible to deaf patients and provides numerous resources.

My drive home from my patient's party was over ninety minutes. That was how far he and his wife were willing to commute in order to see me for medical care. Medical access is important, and part of that access is forging a connection with a person no matter the limitations in communication. Simple understanding of the challenges and limitations faced by deaf patients can gradually improve healthcare outcomes in this patient population. Communication is key.

Endnotes

- 1 Barnett S, McKee M, Smith SR, Pearson TA. Deaf sign language users, health inequities, and public health: opportunity for social justice. *Prev Chronic Dis*. ;8(2):A45.
- 2 Pollard Jr, Robert & Barnett, Steven. (2009). Health-Related Vocabulary Knowledge Among Deaf Adults. *Rehabilitation psychology*. 54. 182-5. 10.1037/a0015771.
- 3 Scott R. Smith, Poorna Kushalnagar, Peter C. Hauser, Deaf Adolescents' Learning of Cardiovascular Health Information: Sources and Access Challenges, *The Journal of Deaf Studies and Deaf Education*, Volume 20, Issue 4, October 2015, Pages 408-418
- 4 Mitchell, RE, Karchmer, MA. "Chasing the mythical ten percent: parental hearing status of deaf and hard of hearing students in the United States." *Sign Language Stud*. 2004; 4(2): 138-163.
- 5 Spellum, Arielle. Kushalnagar, Poorna. Et al "Sign Language for Deaf Infants: A Key Intervention for a Developmental Emergency." *Clinical Pediatrics* Volume: 57 issue: 14, page(s): 1613-1615

***Sheila Ramanathan, DO** graduated from Lake Erie College of Osteopathic Medicine and trained in rural family medicine in Watertown, NY at Samaritan Medical Center. She is currently board certified in family medicine and continues to practice rural health care in Hamilton, NY as part of the Community Memorial Hospital system.*



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Cost-of-Care Project Update

According to the Robert Wood Johnson Foundation (2016), “Cost-of-care conversations have the potential to transform care delivery, moving our health care system toward higher value care and enabling patients to make the best choices for their needs.” Further, research indicates that patients and clinicians want to have these conversations but aren’t having them as often or as effectively as they could. A reported 59-80 percent (Sage Journals, 2016) of patients said they want to discuss out-of-pocket costs during medical visits and an overwhelming majority of doctors consider “managing patient costs” important. However, neither party has been fully equipped to engage in these conversations.

NYSAFP is working to “equip” physicians to effectively engage in cost of care conversations with their patients, helping to remove barriers and support a more comprehensive approach to patient care by addressing the financial toxicity of health care costs and their impact.

Since early 2018, NYSAFP has been the recipient of a New York State Health Foundation (NYSHF) grant dedicated to increasing cost of care conversations between family physicians and their patients. The initiative has provided members with a myriad of opportunities to learn more about the benefits of and implementation strategies for cost of care conversations with patients. Over the past year, opportunities have included webinars, CME journal articles, mini-grants with ten family practice offices, conference sessions, a comprehensive resource tool kit (hard copy and online), round table discussion opportunities and state-of-the-art resources provided via e-newsletters and email blasts.

NYSAFP has collaborated with Avalere, a health care consulting company, to develop a podcast series focused on supporting physicians as they implement cost of care conversations as regular protocol in their

practices. The four-episode series features experts from across the country sharing ideas and advice (and can be found on the NYSAFP website):

Episode 1: *Why Should Family Practice Physicians Routinely Talk with Their Patients About the Expected Costs of Care?*

Episode 2: *Quick Tips for Clinicians on How to Talk with Patients About the Expected Costs of Care*

Episode 3: *A Guide to Integrating Cost of Care Conversation into Workflow*

Episode 4: *Recommendations for How to Overcome Common Barriers when Implementing Cost of Care Conversations*

Currently NYSAFP is in discussion with Avalere to develop innovative resources to continue to support physicians including:

- A collaboration with the National Patient Advocate Foundation to develop a patient-focused resource that can be made available at visits to help facilitate cost of care conversations
- A complimentary podcast series geared toward patients

Due to the initial success of these activities, NYSHF has extended the funding through the end 2019. This will give NYSAFP the opportunity to develop a cost of care training program, primarily targeting resident physicians. NYSAFP member, Tochi Iroku-Malize, MD, MPH, MBA, FFAFP, is currently developing the curriculum, and it will include in-person as well as virtual training formats. The rollout plan will target New York State residency programs and will begin later this summer.

If you would like to be involved in any portion of this initiative, please contact Jill Walls, jill@nysafp.org.

Reflections from a Physician with Hearing Loss

By Basya (Bess) Herbert, MD

Hearing loss is a unique disability, an invisible one. When someone speaks to me, their first impression is that I am an immigrant due to my accent which is, in part, true. However, I am also a physician who has a severe to profound hearing loss (HL) on my right ear and no usable hearing on the left.

I moved to the USA in the 1990s when I was in 9th grade. After high school, I went to the University of Rochester as an undergraduate where I succeeded by having a frequency modulation (FM) system and note-takers during my classes. While in medical school at the University of Rochester as well as during my residency, I needed to be creative to fulfill my surgical rotation using real time captioning (CART), an FM system and preparing ahead. At that time clear face masks were not available to facilitate speech reading, as they are now. These masks ease communication between health care providers, patients with hearing loss, and members of the healthcare team. This face mask is called The Communicator Surgical Mask and is available via www.safenclear.com.

As a physician, I notify my patients about my hearing loss at our first office visit. I let them know that I lip-read and need to have them face me when they are talking to me. I ensure that each patient is aware that I have heard them correctly by repeating /summarizing their concerns. While documenting the electronic medical chart, I ensure that the patient has an opportunity to see the information I have written in their HPI note, since I write down exactly what the patient says during each visit. Patients have commented that it is nice to be able to see what I am writing in their electronic medical record.

Colleagues are helpful also. At Huther Doyle Memorial Institute, my medical assistant, Ruthy Lopez, has taken the initiative to notify and discuss my hearing loss with each patient, and has been an advocate on my behalf regarding my hearing needs. At my other work place, Anthony Jordan Health Clinic, I see patients whose first language is Spanish, so Dr. Soon-IL Song, always arranges live interpreters for me. Being open regarding hearing loss is crucial to the best possible communication between me and others.

As a physician with hearing loss, I recognize the difficulties that a patient with hearing loss may face in communication with their health care providers. On January 19, 2019, Mary Chizuk, a retired RN from the VA Healthcare System, Dan Brooks, a financial consultant and the current president of Hearing Loss Association of America's Rochester Chapter, and I presented a workshop at the NYSAFP's Annual Scientific Assembly titled, "Shouting Doesn't Help!" All three of us have HL and require hearing aids.

The main message of our workshop was to provide a better understanding of what would be most helpful for the patient with HL in accessing medical care. Basic items such as lighting in rooms so patients can speech read, eliminating background noise, providing visual written information and using clear face masks, are ways to assist your patients with HL. It's worth noting that after this workshop, several physicians indicated that they never learned anything about patients with HL in their education or training.

There are a wide array of Assistive Listening Devices (ALD) that are available in the marketplace today. When ALDs are available for appointments, both the provider and the patient benefit through a mutual understanding of the healthcare experience, improved compliance with their healthcare treatment plan and inclusion of the patient as a valued member of the healthcare team. Many large venues such as auditoriums and houses of worship utilize a hearing loop for individuals using hearing aids with a telecoil or t-switch. Another ALD is the Pocket Talker which costs about \$100. It is a portable device that can be used by individuals with hearing loss with or without hearing aids and their health care team in the office or hospital setting.



In Rochester, NY there is a Demo Center available for people to view and test different ALDs.

The Hearing Loss Association of America (HLAA) is a national volunteer nonprofit organization. Their website has a wealth of information and is available for patients with HL as well as providers who are interested in providing accessible care for their patients with hearing loss (www.hearingloss.org).

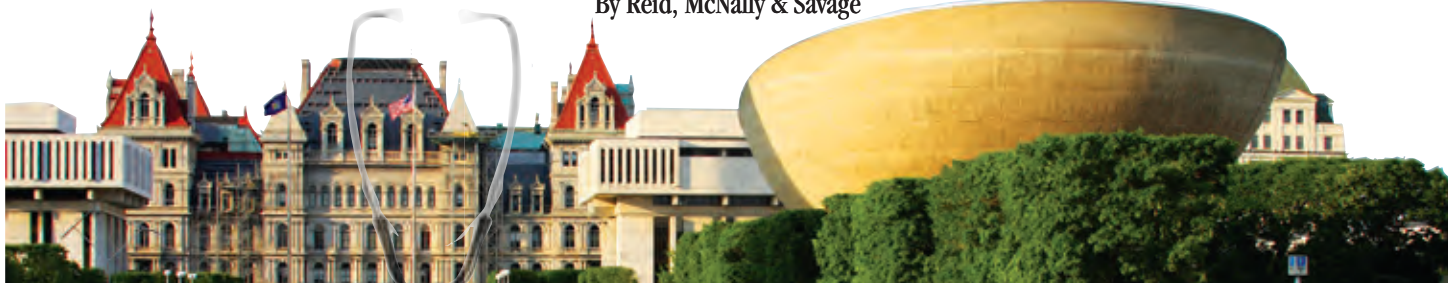
Accepted terminology is now persons/people/patients with hearing loss. Hard of hearing, hearing impaired or hearing disabled are no longer used.

As noted by Dr. Sheila Ramanathan in her companion piece, significant challenges exist in providing care for patients with hearing loss or deafness, as evidenced by several worse health outcomes for this population when compared to the general population. Understanding the challenges associated with this population by clinicians can lead to improved health care equity.

Basya (Bess) Herbert, MD is a family physician with hearing loss acquired in infancy. Originally from the Soviet Union Republic, Latvia, she immigrated to Rochester, NY in 1990. She has been practicing primary care since 2001 at Forbes Family Medicine in Monroeville, PA then at Strong Primary Care Network. She currently is working at Huther Doyle Chemical Dependency Clinic and Jordan Health Primary Care Clinic

Albany Report

By Reid, McNally & Savage



NY 2019 End of Session Update - June 24, 2019

Just before midnight on June 20th, the State Senate completed its work and adjourned the 2019 session. At 7:30am on June 21st, the State Assembly followed suit after more than twenty straight hours of debating and advancing bills. A number of high profile items passed by both houses in the first year of one-party rule in New York including decriminalization of marijuana and vacating some prior marijuana-related convictions, the “Green Light” bill to allow undocumented immigrants to get driver’s licenses, strengthening of state sexual harassment laws, extension and expansion of rent regulations, an increase in labor rights of farm workers, a sweeping measure to combat climate change, and an extension of the minority and-women-owned enterprises law to 2024, among others.

2019 was a highly successful session for NYSAFP. At the start of the session in January, both houses passed and the Governor signed NYSAFP priority bills establishing the reproductive health act, the comprehensive contraception coverage act, the Gender Expression Non-Discrimination Act (GENDA) law, and legislation designating as professional misconduct, engaging in sexual orientation change efforts with minors.

Throughout the session, NYSAFP played a lead role in pursuing the important public health measures enacted in mid-June to eliminate non-medical exemptions of required childhood vaccines for school and daycare attendance, despite very strong efforts by bill opponents. In addition, some insurance reforms were enacted which will ease a number of practice burdens and ensure greater access to needed services for patients.

“This was the most historic and productive legislative session in New York state history.”

– new state Senate Majority Leader Andrea Stewart-Cousins,
via Politico New York

While there were 935 bills passed by both houses this session, outlined below is a summary of the measures advanced by both, which we thought would be of particular interest to NYSAFP. Unless otherwise specified in their descriptions below, these bills have passed both houses and have not yet been delivered to the Governor.

To view the text and sponsor’s memo of any of the bills we have summarized below, you can use the Assembly’s bill search tool at the following link: <https://nyassembly.gov/leg/>

Bills Passed by Both Houses during 2019 Session

Multiple Sectors

Reproductive Health Act

(S240, Krueger/ A21, Glick)

Codifies Roe v. Wade protections on New York’s public health law.

The bill was passed in January and was signed into law by the Governor on January 22, 2019, Chapter 1 of the laws of 2019.

Reproductive Health Decision Making

(S660, Metzger/ A584, Jaffee)

Amends the labor law to prohibit discrimination based on an individual employee’s or a dependent’s reproductive health decision making.

Comprehensive Contraception Coverage Act

(S659A, Salazar/ A585A, Cahill)

Enacts the comprehensive contraception coverage act to require public and private insurance coverage of all FDA-approved contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow up services. It also prohibits a health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage.

The bill was passed in January and was signed into law by the Governor on April 12, 2019, Chapter 25 of the laws of 2019.

Gender Expression Non-Discrimination Act (GENDA)

(S1047, Hoylman/ A747, Gottfried)

Enacts GENDA to prohibit discrimination based on gender identity or expression and includes offenses regarding gender identity or expression under the hate crimes statute.

The bill was passed in January and was signed into law by the Governor on January 25, 2019, Chapter 7 of the laws of 2019.

Prohibition on Sexual Orientation Change Efforts with Minors

(S1046, Hoylman/ A576, Glick)

Designates it as professional misconduct, engaging in sexual orientation change efforts by mental health care professionals with patients under the age of 18.

The bill was passed in January and was signed into law by the Governor on January 25, 2019, Chapter 8 of the laws of 2019.

Health Care Decision Making

(S6356, Rivera/ A1124, Gottfried)

Clarifies that decisions about routine care for hospice patients without a surrogate decision maker do not require prior review by an Ethics Review Committee, and are governed by the provisions in the Family Health Care Decisions Act.

HIV PeP for Sexual Assault Victims

(S2279A, Hoylman/ A1204A, Peoples-Stokes)

Requires the provision of a full regimen (instead of the current 7-day starter pack requirement) of HIV post-exposure prophylaxis (PeP) to sexual assault victims, and provides that victims of sexual assault be informed that payment assistance for this and follow-up care may be available from the Office of Victim Services. Further it provides that such follow-up HIV PeP costs should be billed by the health care provider directly to the Office of Victims Services and reimbursed directly to the health care provider, rather than requiring the filing of a crime victim compensation application.

DOH Review of Correctional Health Services

(S1073-A, Rivera/ A1130-A, Gottfried)

Expands DOH's role in correctional care to cover women's health, transgender health, elderly health, and chronic health conditions such as asthma, diabetes, and heart disease. The bill also gives DOH additional oversight of discharge planning for health care services. Lastly, this bill directs DOH to study staffing levels in correctional settings every two years to ensure adequate staffing levels and identify factors that may contribute to high vacancy rates.

Restricted Clinical Laboratory Licenses

(S5692-A, Rivera/ A7906-A, Gottfried)

Allows individuals employed by a New York State Department of Health authorized toxicology laboratory, operating under the supervision of a laboratory supervisor or director of a clinical laboratory, to obtain a certificate in toxicology. Currently, individuals with a degree in toxicology are ineligible for a clinical laboratory technology license due to a lack of required coursework (2-4 years in a clinical laboratory technology program). This bill would provide a pathway to licensure for those already performing toxicology lab tasks.

Expungement of Records for Marijuana Convictions

(S6579-A, Bailey/ A8420-A, Peoples-Stokes)

Decriminalizes the possession of marijuana by minimizing penalties. Individuals who are found with less than one ounce of marijuana may be fined no more than \$50. Those with one ounce or more may be fined no more than \$200. The bill also creates an option for expungement of records for those who have committed minor infractions of the marijuana law. Lastly, this bill expands upon the definition of "smoking" to include the burning of marijuana.

Hospitals

Obstetric Hemorrhage

(S4498A, Rivera/ A6962A, Joyner)

Requires that hospitals adopt, implement, periodically update and submit to the Department of Health standard protocols for management of obstetric hemorrhage.

Hepatitis C Testing

(S6029, Rivera/ A7671, Zebrowski)

Extends the sunset provisions in Chapter 425 of the Laws of 2013 for an additional six years, until January 1, 2026. Chapter 425 of the Laws of 2013 established a testing and referral requirement for hepatitis C in hospitals for individuals born between 1945 and 1965 unless the individual is being treated for a life threatening emergency or has previously been offered or tested or they lack the ability to consent. It also provides that should a screening test be positive or reactive, the provider shall offer follow-up health care including a hepatitis C diagnostic test or refer the individual to a provider who can.

Long Term Care

E-Prescribing

(S4183, Rivera/ A1034A, Gottfried)

Extends for two more years the exemption from e-prescribing requirements nursing homes and residential health care facilities.

Physician Privileges in Nursing Homes

(S4583, Sanders/ A407, Cahill)

Requires nursing homes to provide potential residents with their policy regarding granting physician privileges prior to executing an agreement.

Physician/ Health Professionals

Risk Management Course

(S3158, Ramos/ A568, Paulin)

Provides for a premium reduction for physicians and licensed midwives who complete a risk management strategies course in obstetrics.

Professional Certification of Doulas

(S3344B, Ramos/ A364B, Paulin)

Authorizes the professional certification of doulas. Defines doula services as continuous emotional and physical support provided throughout labor and birth, and intermittently during the prenatal and postpartum periods.

Loan Repayment

(S4269, Rivera/ A5425, Gottfried)

Directs the Department of Health to form a work group to assess the impact of requiring individual applicants for grants from the Doctors Across New York physician loan repayment and physician practice support programs to use the New York State Grants Gateway.

Consent for Pelvic Exams

(S1092E, Persaud/ A6325C, Solages)

Prohibits the performance of a pelvic examination on an anesthetized or unconscious person who has not provided consent for such examination.

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Informed Consent

(S3353, Ramos/ A4988, Paulin)

Creates a new section of public health law stating that in the case of any health care procedure or examination, the fact that the procedure or examination is performed in the course of education or training does not diminish the requirement for informed consent for the procedure or examination.

License Revocation for Loss of Consciousness

(S5225A, Gounardes/ A4751A, Carroll)

Builds on existing protections in law, by directing the Department of Motor Vehicles (DMV) to immediately deny or suspend the license of any person about whom the DMV has received evidence of loss of consciousness pending a hearing if the applicant or licensee requests one.

Closure of Health Provider's Office

(S5367, Comrie/ A2349, Perry)

Includes requirements for the transfer of patient medical records (including access to records by the patient) upon closure of a health care provider's office.

Liability Exposure

(S6081 Hoylman/A2372 Dinowitz)

Requires a non-settling co-defendant in a tort action to choose whether to reduce their liability exposure by the stated settlement amount or the settling tortfeasor's equitable share prior to the first opening statements of the trial.

Recovery Against Third Party Defendant

(S6552 Skoufis/ A2373 Dinowitz)

This bill would permit a plaintiff to bypass the defendant he or she sued to collect a judgment from a third party defendant who or which has been sued by the defendant for contribution or indemnification as a result of the underlying action.

Orders Not to Resuscitate

(S4841, Rivera/ A1162-A, Gottfried)

This bill would add physician assistants to the list of health care professionals authorized to act in relation to orders pertaining to life sustaining treatments and orders not to resuscitate. This bill would also allow physician assistants to make capacity determinations for purposes of witnessing and implementing health care proxies.

Professional Qualifications for Eye Dilation

(S4469-B, Stavisky/ A3822-D, McDonald)

Establishes qualifications for allied eye care providers to be authorized to administer dilating/anesthetic eye drops under the supervision of an ophthalmologist or optometrist. An individual shall meet the following criteria to be eligible: must be over the age of 18; be under the supervision of a physician; must complete a curriculum and examination approved by SED demonstrating the requisite experience to instill dilating eye drops.

Medical Malpractice Exemption Extensions

(S6547, Breslin/ A8345, Lavine)

Extends exemptions from risk-based-capital requirements for medical malpractice insurers until December 31, 2022.

Pharmacy/ Pharmaceuticals

Pharmacy Recall Notifications

(S5091B, Comrie/ A4781B, Rosenthal D)

Requires pharmacy notification of patients when there are Class I drug recalls.

Partially Filled Prescriptions

(S1813, Rivera/A3918, McDonald)

Allows for the partial fill of a controlled substance at the request of a prescriber or patient.

Senior Drug Guide

(S3291, Comrie/ A2326A, Dinowitz)

Requires the creation of a guide for seniors on drug use warnings and best practices to be created by the State Office for the Aging, in consultation with the Board of Pharmacy and Department of Health. The report would be required to be posted on the Office for the Aging website and promotion and provided upon request.

Public Health

Non-Medical Exemptions to Required Childhood Vaccinations

(S2994A, Hoylman/ A2371A, Dinowitz)

Eliminates Non-medical exemptions to required childhood vaccinations for school and daycare attendance.

This bill was passed by both houses and signed into law June 13, 2019, Chapter 35 of the laws of 2019.

Increase Tobacco Purchase age to 21

(S2833, Savino/ A558A, Rosenthal L)

Increases the age to purchase all tobacco products (including e-cigarettes) from 18 to 21 years old.

Expansion of the Tobacco Use and Prevention Program

(S301A, Hoylman/ A481A, Rosenthal L)

Includes electronic cigarettes and liquid nicotine within the scope of work including in the State Tobacco Use and Prevention Program.

Information on Pregnancy Complications

(S4637A, Montgomery/ A2957A, Richardson)

Requires that the leaflets currently provided to maternity patients include information about serious complications that could lead to death. The Commissioner of Health is required under the bill to consult with any official boards mandated to review and investigate maternal mortality to ensure that information is correct and up to date.

Maternal Mortality Review Board

(S1819, Rivera/ A3276, Joyner)

Establishes the Maternal Mortality Review Board and the Maternal Mortality and Morbidity Advisory Council for the purposes of reviewing maternal mortality and morbidity. The Board shall assess the cause of death and factors leading to death and to develop strategies for reducing the risk of maternal mortality.

Structure of Maternal Mortality Review Board

(S6529, Rivera/ A8338, Joyner)

Requires that members of the State Maternal Mortality Review Board (MMRB) are representative of the racial, ethnic and socioeconomic diversity of women and mothers in the state and those medically underserved areas of the state. The bill also outlines the

collaborative relationship of both the State MMRB and NYC's Maternal Mortality Review Board. The bill also allows the NYC Department of Health and Mental Hygiene Commissioner to make appointment recommendations for ten of the MMRB members.

Expand Expedited Partner Therapy

(S1799, Rivera/ A2998, Bichotte)

Expands the use of EPT for any sexually transmitted infections that the Centers for Disease Control and Prevention recommends its use.

Workplace Protections

(S4211, Sepulveda/ A5975, Reyes)

Extends existing workplace protections to include lactation as a pregnancy-related condition.

Public Awareness for Concussions in Tackle Football

(S2958-A, Krueger/ A6968-A, Benedetto)

Requires that all tackle football programs in the state provide an informational packet to parents of children participating in the program about concussions and sub-concussive blows, and the injuries that might occur as a result of receiving such blows. The packet will be provided by DOH and will also be available for free on their website.

Behavioral Health

Opioid Response Reporting

(S4650, Sanders/ A1068, Rosenthal L)

Requires the Office of Alcoholism and Substance Abuse Services (OASAS) to provide quarterly reports on the status and outcomes of various initiatives to address the heroin and opioid epidemic.

Suicide Prevention

(S6406A, Sepulveda/ A7564A, Fernandez)

Requires the Office of Mental Health to prepare and submit a written report on the development of plans, programs, and services to prevent and reduce suicide/suicidal behaviors, as well as a report on prevention services and program initiatives directed towards high risk minority groups and demographics.

Insurance

Coverage for Eating Disorders

(S3101, Biaggi/ A1619, Rozic)

Requires commercial insurance companies to provide full coverage for all the aspects of eating disorders treatment, including comparable treatment coverage for adults and children.

Lactation Coverage

(S3387, Kaplan/ A2345, Solages)

Requires Medicaid coverage to cover lactation support, including lactation care and services, and breastfeeding equipment without requiring a referral from a physician, registered physician assistant, registered nurse practitioner or licensed midwife.

Prohibits Mid-Year Formulary Changes

(S2849A, Breslin/ A2969A, Peoples-Stokes)

Prohibits health plans from making prescription drug formulary changes during a contract year except to add generics and a few other exceptions.

Medication Synchronization

(S3118A, Hoylman/ A2785A, Gottfried)

Allows for insurance coverage of medication synchronization for patients with Medicaid coverage.

Shannon's Law

(S3852A, Martinez/ A5502A, Jean-Pierre)

Applies to large group commercial insurance policies and requires coverage of an annual mammogram for those aged thirty-five through thirty-nine upon the recommendation of a physician, and subject to the insurer's determination that the mammogram is medically necessary.

Medication Synchronization

(S4078, Breslin/ A3009, Quart)

Allows for insurance coverage of medication synchronization for patients with commercial coverage.

PA for Certain SUD Treatment Medications

(S4808, Harckham/ A2904, Quart)

Prohibits commercial insurance policies from requiring prior authorization (PA) for certain medications (initial and renewal prescriptions for buprenorphine and long-acting injectable naltrexone) used in the treatment of substance use disorders.

Denial of Coverage when PA Granted

(S5328A, Breslin/ A2880B, Hunter)

Expands the current prior authorization (PA) exception enacted in 2017 for surgical and invasive procedures to include concurrent symptoms and side effects.

Contract Terminations

(S6318, Rivera/ A8084, Buttenschon)

Extends the sunset provisions of chapter 451 of the laws of 2007 for an additional two years, to expire June 30, 2021. The law requires that if a contract between a plan and a hospital is not renewed or is terminated by either party, the parties continue to abide by the terms of the contract, including reimbursement terms for a period of two months from the termination or end of the contract period. The provisions require that notice be provided to enrollees within 15 days of the commencement of the two-month period. However, these requirements do not apply where both parties agree to the termination or non-renewal and the insurer provides notice to the insured at least 30 days in advance of the date of contract termination. It also allows the Department of Health to waive the two-month extension if the contract is being terminated for cause.

PBM Regulation

(6531, Breslin/ A2836A, Gottfried)

Provides for initial registration and later licensure of Pharmacy Benefit Managers (PBMs) under the jurisdiction of the Department of Financial Services and State Department of Health.

Long-acting Reversible Contraception (LARC) Among Adolescents

By Rosa Mendoza, MD

Introduction

Approximately 42% of female adolescents ages 15 to 19 report sexual activity in the United States.¹ Although unintended pregnancies have declined between 2008 and 2011, the United States has the highest adolescent pregnancy rates among developed countries.²⁻⁴ While half (45%) of all pregnancies were unintended in 2011, 75% of adolescent pregnancies were unplanned.³ Elevated rates of unintended pregnancy have been shown to decline through the uptake of effective contraceptive methods such as long acting reversible contraception (LARC), which includes intrauterine devices (IUDs) and subdermal arm implants. LARC is the first line contraceptive method for adolescents as per the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.^{4,5} Though LARC use is increasing among older women, its use among adolescents is only 3.2% to 5.8% and has not increased significantly among sexually active adolescents.^{1,6}

There are multiple important barriers preventing LARC uptake among adolescent females including cost, lack of access and limited and/or unfavorable patient and healthcare provider knowledge and attitudes which render adolescent LARC use controversial. This article will provide an overview of the evidence of the benefits and safety of adolescent LARC use, adolescent awareness, knowledge, and acceptance of LARC and key practical issues related to adolescent use.

LARC Benefits and Safety

Benefits of LARC for Adolescents

LARC is recommended as the first line contraceptive method for adolescents,^{4,5} and have been recommended as such in part due to their multiple advantages including high efficacy, high continuation rates and high satisfaction rates.

LARC is the most effective contraceptive method currently available. Women, including adolescent females on these methods, have a failure rate of less than 1%.⁷ In comparison, patients using the oral contraceptive pill, condoms only, depo, and withdrawal methods have unintended pregnancy rates of 9%, 6%, 21%, and 22%, respectively.⁵ Despite this, most adolescent contraceptive users use short acting methods such as oral contraceptives, condoms or the withdrawal method, all which are associated with a higher failure rate when compared with LARC methods.⁸⁻¹⁰

Multiple studies including a meta-analysis of 12 studies as well as the CHOICE project, a large prospective cohort study, have consistently shown high satisfaction and high LARC continuation rates among adolescents of more than 80% at 1 year of use.^{11,12}

In contrast, consistent use of other hormonal contraceptive methods is significantly lower and according to previous studies, young women are more likely than older women to stop or switch to another short acting contraceptive method.^{10,13} Because LARC methods are not user dependent after initiation, they are easy to use consistently which leads to high efficacy and high continuation rates.

Is LARC Safe Among Adolescents?

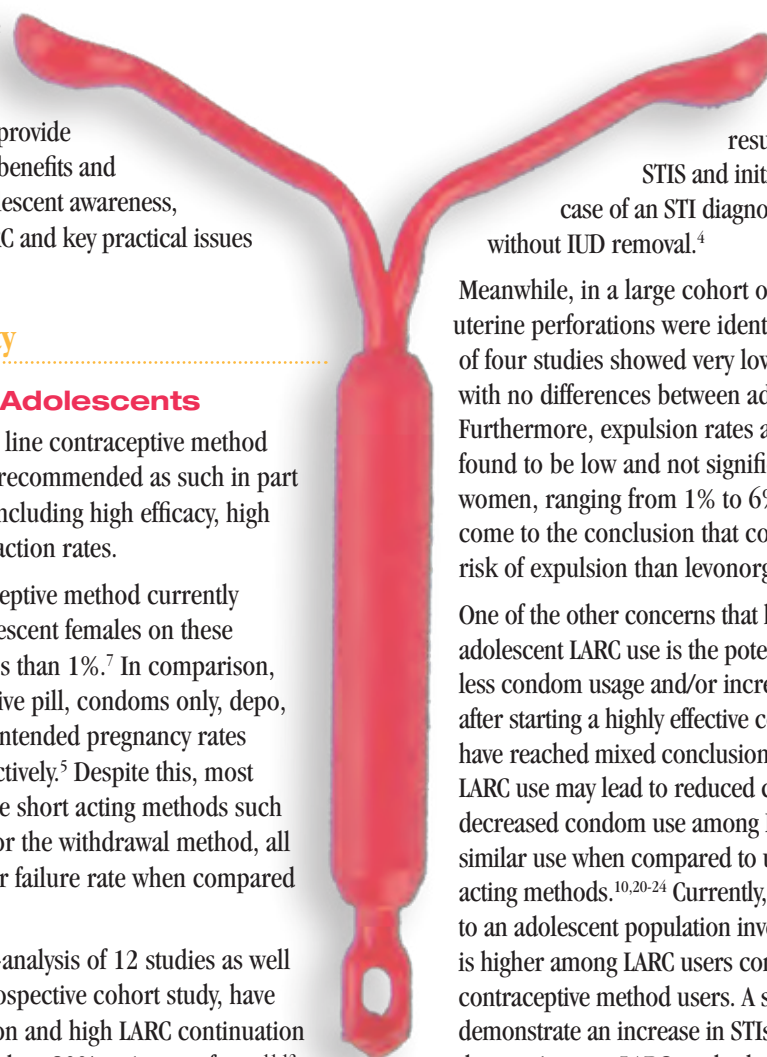
LARC methods are safe among adolescents and have been shown not to increase the risk of pelvic inflammatory disease (PID) and have low risk of complications such as uterine perforations, expulsion or increased risk of sexually transmitted infections (STIs).

Rates of complications such as PID, uterine perforation or expulsion have not been shown to be higher in adolescents compared to older women.¹⁴ The risk of PID is very low when there is no cervical infection (0-2%) and remains low even in the presence of cervical infection (0-5%).^{15,16} In fact, the long term use of levonorgestrel IUDs lower PID risk by thickening cervical mucus and thinning the endometrium.^{17,18}

Consequently, there is no need for health providers to delay IUD insertion to await STI results - it is appropriate to screen for STIs and initiate IUDs on the same day. In the case of an STI diagnosis, the STI can be treated effectively without IUD removal.⁴

Meanwhile, in a large cohort of patients ages 13 to 24 years, no uterine perforations were identified while a systematic review of four studies showed very low perforation rates (0%-0.1%) with no differences between adolescents and older women.^{14,19} Furthermore, expulsion rates among adolescents have been found to be low and not significantly different from that of older women, ranging from 1% to 6%.^{15,19} Of note, several studies have come to the conclusion that copper IUDs have a slightly higher risk of expulsion than levonorgestrel IUDs.^{14,15}

One of the other concerns that has been raised with increasing adolescent LARC use is the potential for an increase in STIs due to less condom usage and/or increase in sexual risk-taking behavior after starting a highly effective contraceptive method. Prior studies have reached mixed conclusions when studying whether adolescent LARC use may lead to reduced condom use, with some suggesting decreased condom use among LARC users while others suggest similar use when compared to users of other hormonal short acting methods.^{10,20-24} Currently, there are very few studies limited to an adolescent population investigating whether STI incidence is higher among LARC users compared to other hormonal contraceptive method users. A study of urban teens did not demonstrate an increase in STIs after LARC initiation, compared to those using non LARC methods.¹⁰



Adolescent Awareness, Knowledge and Acceptance of LARC methods

Are Adolescents Aware of and Knowledgeable About LARC Methods?

Previous research demonstrates that adolescents lack awareness of LARC methods and those who are aware of LARC have very limited knowledge and tend to be misinformed.²⁵ In a 2009 survey of 106 female adolescents, only 30% knew about the IUD and of those less than half could identify key IUD characteristics.²⁶ In another study, only 40% of the study sample knew about the implant.²⁷ Among adolescents who are aware of LARC, there are also many misconceptions and myths such as LARC possibly leading to infertility, weight gain, hair loss, and PID.²⁸

Are Adolescents Interested in LARC Methods?

Prior studies have revealed that when adolescents are educated about LARC and when the cost/access barrier is removed, there is increased interest and uptake of LARC. For example, Whitaker and colleagues found that after a brief education session, 51% of participants (ages 14-18) viewed IUDs positively.²⁹ Most participants of ages 14 to 20 in the Contraceptive CHOICE project, a study that removed both the cost and access barriers, chose LARC (62%) over non LARC methods.³⁰

Practical Issues Related to LARC Use

Is Parental Consent Required?

As per a review of state laws performed by the Guttmacher Institute, 21 states permit all minors in all circumstances to consent to contraceptive services including LARC while 25 states allow consent to such services in one or more circumstances such as health problems, marriage, pregnant or ever pregnant. New York State is one of the states that allows minors to consent to contraceptive services and funds a statewide program that provides minors with confidential contraceptive care. Specific data on current laws in each state can be found at www.guttmacher.org.³¹

Are IUDs More Difficult to Insert in Adolescents and Nulliparous Women?

A large cohort study evaluated the success and safety of IUD placement comparing nulliparous with parous adolescents in two groups of patients, 13 to 18 years and 18 year or older. No difference in the success of placement (96%) was observed among all groups with a very low rate (1.8%) of ancillary measures such as paracervical block or cervical dilation. The low percentage of insertion failures and IUD expulsions were not related to patient age or parity.¹⁹ A more recent study, that evaluated duration of IUD placement among adolescents versus young women, found no differences among the two groups.³²

Do Teens have to be able to Check IUD Strings Every Month?

It is not necessary for the patient to check strings after IUD placement. Providers should focus on counseling on signs and symptoms of expulsion which include pelvic cramping and bleeding.³³

Can LARC be Initiated Postpartum Among Adolescents?

Adolescents who use a LARC method after their first delivery have been shown to have a lower risk of repeat adolescent pregnancy.³⁴ ACOG recommends and supports immediate postpartum insertion (best before hospital discharge) as best practice, to prevent short intervals between pregnancies⁴ which are associated with low rates of maternal education achievement and high rates of preterm birth and small for gestational age infants.³⁵

Conclusion

Increasing the initiation and retention of LARC use among adolescent females has the potential to significantly reduce the number of unintended pregnancies. There is strong evidence that LARC use among adolescents leads to higher efficacy, continuation rates, and satisfaction rates than the use of short acting hormonal contraceptive methods. Despite this, most adolescents have very low awareness and knowledge regarding LARC. We hope that providing this information has motivated health care providers who provide primary care services and/or reproductive health care services to female adolescents, to increase LARC counseling and services among the adolescent population.

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For full listing of endnotes, access this issue at www.nysafp.org

Rosa M. Mendoza, MD is completing the primary care clinician research fellowship in community health at Columbia University and currently working on research regarding condom use and chlamydia infection among adolescent LARC users. She is a graduate of the University of Pennsylvania Family Medicine Residency and the Columbia University Vagelos College of Physicians and Surgeons Medical School. She has a strong interest in women's health especially long acting reversible contraception, perinatal care, medical student/ residency education, community outreach and global health.

TWO VIEWS: AIDING ASYLUM

The Capital District Asylum Collaborative and the Human Rights Initiative at the University at Buffalo are both medical student run organizations that assist asylum seekers with medical and psychological evaluations. These evaluations are a critical component of documenting and supporting the legal case for granting asylum in the United States. At first glance, we believed these were

two branches of the same program. While both share the same objective of easing the asylum seeking process for the individuals that they work with, the two programs suggest different models at distinctly different stages of the asylum seeking process. Both however, provide resources which can assist family physicians and others in conducting this type of work.

VIEW ONE

AIDING ASYLUM: DOCUMENTING HUMAN RIGHTS VIOLATIONS THROUGH FORENSIC MEDICAL EVALUATIONS

By Maria Coluccio, MA; Greg Raczkowski, MS; Anisha Chava; Claudia Aghaie, MA; Brittany Cesar, MD; Caroline A Gorka, MD; Rachel Engelberg, MD; Kim Griswold, MD, MPH

An unprecedented number of individuals are seeking international protection as a result of persecution or human rights violations in their home country. In 2017, the United States became the world's largest recipient of new asylum applications.¹

New York has the third largest number of pending asylum cases in the United States.² As the number of displaced persons increases, family medicine physicians possess a unique skill set that can significantly aid individuals seeking to claim safety in the United States. Clinicians, in collaboration with immigration attorneys and community organizations, can conduct medical forensic evaluations to document the sequelae of torture and persecution for those seeking asylum. Affidavits produced by these evaluations are used to support the legal case for granting an individual's safe haven.

The aim of this article is to describe how both clinicians and medical students can collaborate to meet the needs of these vulnerable populations, and to encourage family physicians to participate in this form of advocacy. Towards this goal, we describe the context of the asylum process in the United States, and identify some concerns from physicians that perform forensic evaluations. The mechanics and operations of our clinic, the Human Rights Initiative at the University at Buffalo, are outlined to propose how medical student-run clinics can be utilized to overcome some of the challenges physicians face when performing forensic evaluations for asylum seekers.

BACKGROUND: ASYLUM PROCESS

Around the world, countless individuals are harmed or tortured because of their fundamental identities or beliefs. Whether it is because of their ethnic or religious group, sexual orientation, or political association, these individuals live in constant danger of injury or death. Under the 1951 United Nations Convention related to the Status of Refugees, any person has the right to seek sanctuary in the United States by applying for asylum status.³ To be granted asylum however, an individual must prove in a court of law that they have experienced past persecution or have reasonable grounds to fear persecution because of their political opinion, race, religion,

VIEW TWO

AIDING ASYLUM: A CONTINUING CARE MODEL

By Megha Dasani; Sarah Saad; William Calawerts; Kara Burke, MPH and Katherine Wagner, MD

An asylum seeker is defined as a person who from fear of persecution due to race, religion, social group, or political opinion flees their home country and applies for international protection, or asylum status, in another.¹ Overall in 2018 in the United States, there were 42,224 asylum applications reviewed with a 33% success rate.² Health care providers can play a critical role in increasing the success of asylum seeker's applications via conducting a forensic medical or psychological evaluation of the asylum seeker to document objective evidence of physical and mental trauma.³ The Capital District Asylum Collaborative (CDAC) is a student-run organization that works directly with lawyers, physicians, and community organizations in Albany, New York, to perform medical and psychological evaluations that assist their applications for asylum status. In addition to providing that service, this collaborative functions to bridge the gap in healthcare and social needs for asylum seekers while they await their application decision through synchronized efforts between a local legal non-profit, clinicians, community organizations, and other student run organizations at the medical college. This cooperation allows CDAC to offer additional services by assessing the client's social needs, insurance status, and medical needs and connecting them with available local resources.

INITIAL BARRIERS

Many asylum seekers have fled their home country in dire circumstances, with the main goal of safely entering the United States and not much thought about their living situations when they arrive. The initial transition to the U.S. is particularly challenging as language and cultural barriers can make it difficult to connect with the specific social resources that are designed to ease their transition. The fear of possible deportation and future persecution dis-incentivizes many of these clients from seeking assistance and leaves them without having all of their needs addressed. Our goal is not only to assist the client with their asylum application, but also connect with each client through in-person meetings to learn about their needs here in the US. As part of this process, CDAC is working on establishing relationships with local community organizations that are best equipped to address these needs, with the goal of connecting asylum seekers to services which will allow for a smooth transition to their new home in the US.

One



Two



continued on next page

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nationality, or membership in a particular social group. “Members of a particular social group” may include individuals that have been persecuted against because of their sexual orientation, or have experienced other forms of harm through gender-based violence, or targeted gang violence.

In asylum proceedings, the burden of proof rests on the asylum seeker. With or without council, the individual has to provide evidence that they have either experienced persecution or that they have a “well-founded fear” of future persecution within their home country. The decision-making process can be difficult to navigate, and approximately 60% claims are rejected.⁴ Often times, the necessary paper evidence to support their claims is missing. Because of the rapid nature of fleeing from their home country, medical records or police reports are often inaccessible. Depending on the perpetrator, an official record of the persecution may not even exist. In these particular situations, the individual’s story and the physical and psychological experiences they carry with them, are even more important. Forensic evaluations play an essential role in establishing an asylum seeker’s credibility by detailing how one’s physical and mental symptoms are consistent with his or her story of mistreatment. Through these evaluations, trained physicians translate scars and injuries into physical evidence.

These evaluations make a difference. Studies show that the presence of a medical forensic evaluation increases the likelihood of obtaining protection in the United States. One study demonstrated that in contrast to clients who did not receive a medical forensic, asylum seekers in the US who did have a medical evaluation had higher rates of being granted asylum.⁵ However, the demand for forensic evaluation far exceeds the supply of clinicians trained to conduct these services. Although health professionals that perform evaluations describe the experience as rewarding,⁶ these providers experience a range of challenges. Barriers include time constraints in scheduling the evaluations, writing the legal affidavits, and navigating the complex medico-legal process. In response to these increased demands and challenges, medical schools have opened asylum clinics that facilitate medical and psychiatric forensic evaluations for survivors of torture and political violence. Almost all of the medical school clinics are affiliated with Physicians for Human Rights (PHR),⁷ an organization that works at the intersection of medicine, science and law to advocate for, and secure justice and human rights for all people worldwide. PHR provides training and support for the students and clinicians involved with medical school human rights clinics.

THE HUMAN RIGHTS INITIATIVE AT UB

The Human Rights Initiative (HRI) at the University at Buffalo, is an example of a student-run organization that coordinates the pro-bono evaluations and hosts annual trainings for community clinicians.⁸ With Physicians for Human Rights, medical student clinics work closely with immigration attorneys and University and community based clinicians to assist U.S. asylum seekers in their asylum claims.

Over the past five years, the Human Rights Initiative at UB has completed forensic examinations for more than 105 clients. During the past two years, the number of evaluations performed at our clinic has increased by 87.8%. Twenty of our clients have succeeded in gaining asylum

status, with a vast majority of cases still pending. The clinic functions with limited funding, and is run entirely by medical students. Under the guidance of a faculty advisor, a team of medical students representing MS years 1-4, serve on the clinic executive board. The students are primarily responsible for scheduling the evaluations, maintaining relationships with community partners, scribing for forensic exams, and planning outreach and advocacy events.

In order to increase the number of clinicians available, HRI hosts an annual training. Family medicine physicians already have many of the skills that would enable them to serve as forensic evaluators. Through their residency training and practice, clinicians are taught how to elicit narratives from their patients in a safe and considerate manner, and many are trained in trauma informed care.⁹ Physicians can use this same training during evaluations to document the trauma narrative of the asylum applicant. In addition, they are able to provide diagnostic information about the individual’s current physical and mental health status that can support their case. Formal forensic trainings help with the logistics. The trainings are a full day, and following training there are opportunities for newly trained clinicians to shadow experienced physicians. During the training, healthcare professionals are taught how to report the physical and psychological sequelae of torture and assess the consistency between the medical findings and the client’s history. Over the past four years, HRI has trained 75 clinicians in Western New York. HRI has also assisted other medical schools with opening their own asylum clinics and forensic trainings.

An additional barrier that forensic evaluators may face is coordinating the evaluation. Forensic evaluations can take place in a variety of places, from the physician’s practice, to hospitals, to an empty office. One only needs a private room, an exam table, and proper seating for the client, evaluator, interpreter and any trainees. Depending on the encounter, the medical equipment needed for the exam is minimal. Although there isn’t much needed to perform an evaluation, there are many moving parts. HRI helps minimize this burden by organizing the details based on a physician’s availability.

THE FORENSIC EXAM PROCESS

The process of forensic coordination begins when a request form is received, most often from a group of immigration lawyers. Following a request, a forensic coordinator schedules all aspects of a forensic evaluation, juggling medical providers, lawyers, interpreters, and students. Aside from the few hours the provider has to commit to performing the evaluation, most of the work is performed by the HRI executive board and medical students. This includes finding a location, ensuring the proper equipment is available, finding correct interpreters, and communicating with the lawyers and clients. During the evaluation, a pair of trained medical students scribe the encounter. This allows the physician to focus on performing a thorough evaluation without having to pause to write down details.

After performing the evaluation, an affidavit is drafted containing the details of the examination. An affidavit includes the client’s story as it pertains to their history of torture and trauma, followed by a detailed description of evidence supporting the torture and trauma that the client already described. Physical forensic evaluations include pictures

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of scars accompanied by captions that describe the look and feel of the healed wound, as well as how the client sustained the injury. Students and clinicians then detail aspects of the client's story which fit the different qualifying criteria. Psychological evaluations determine the current emotional status of clients, in addition to documenting past mental health issues and problems. The main goal of the affidavit is to provide unbiased evidence that an asylum seeker actually went through the torture and trauma they describe, and supply a general impression that the client would not be safe physically and/or mentally if they were to return to their home country. This process can be time consuming, particularly for practicing clinicians. In order to streamline the process, HRI trains medical students on how to write affidavits and students are responsible for creating the initial draft of the affidavit. The finalized affidavit is reviewed and edited by the clinician. HRI Forensic Coordinators will follow up with the clinicians and students to ensure affidavits are reviewed and completed in time for the trial. The process of having students scribe during the encounter and write the document significantly reduces the time commitment for the physician. Depending on time constraints for the client's trial, affidavits can be completed and sent to the attorney within a couple of days.

An additional benefit of performing forensic evaluations in collaboration with a student-run clinic is that the clinic also serves as an intermediary between the various stakeholders in the evaluation process. HRI's primary function is to serve as liaison between trained medical professionals, legal representation for the asylum seeker, and care coordinators assisting the client; we connect all sides with each other to ensure an evaluation takes place. If problems arise with evaluation scheduling, follow up, or affidavit details, the clinic coordinators can act as mediators to help remedy any challenges.

COORDINATION WITH DETENTION CENTERS

A unique aspect of HRI's clinic is our work with asylum seekers in detention centers. The backlog in U.S. immigration courts has reached a record high, with more than 690,000 open deportation cases.¹⁰ In response to these rising numbers, the U.S. government sought to create fast-track process, which is largely accomplished by placing individuals in detention facilities. Although these processes are meant to prevent the unlawful deportation of asylum seekers, they create additional barriers for many. In addition to a myriad of negative health consequences,¹¹ detention may negatively impact an individual's asylum case. Recent studies have shown that detained asylum seekers are more than five times less likely to secure legal counsel¹² and, as stated previously, immigrants with legal representation are more likely to succeed in their cases. Although student-run asylum clinics have helped reduce the burden of providing forensic evaluations for detained clients, very few work with individuals in detention centers. HRI's work with the federal detention facility in Batavia, NY has proven crucial to our ability to continue to serve the asylum seeking population.

Approximately 30% of our clients have spent time in a detention center. Over the past three years, the clinic noted a consistently increasing demand for forensic evaluations from attorneys representing detained clients. We believe that these changes are due to the change in political environment, which has led to more

detainments across the country of individuals who would likely otherwise be able to live in the community. Higher demand represents both an increase in proportion of evaluations stemming from detained clients, and an increasing overall number of clients. Current immigration policy has accelerated the time constraint for filing materials and scheduling court dates for detained asylum seekers, and asylum seekers detained at the southern border are being redistributed elsewhere in the country. These changes in immigration dynamics have put a considerable strain on HRI's ability to organize a forensic evaluation for each client that requires one, and has resulted in our inability to be able to provide evaluations in several instances. The next few paragraphs will detail some of the differences observed when performing forensic evaluations for detained clients.

One of the most challenging areas of working with a detained client happens prior to an evaluation taking place. Transportation to the forensic evaluation is a major issue for many detained clients as they must be transported by Immigration and Custom Enforcement (ICE) officers from and to the detention center. We provide a transportation letter to the lawyers, that they send to the detention center to confirm date, time, and location of the forensic evaluation for each client. Several times, a client has failed to arrive to a scheduled forensic evaluation because the detention center was unable to transport them. We have worked with lawyers to ensure that the chances of this happening in the future are minimal. Our clinic tries to give enough future notice of the evaluation to the lawyer, so they may contact the detention center as soon as possible. We also ask the lawyers to confirm transportation with the detention centers as we start to approach the scheduled date. This is all performed by the student clinic coordinators, to reduce the burden on both physicians and the clients. By taking these few extra steps, we have ensured that fewer forensic evaluations need to be rescheduled.

Other differences are observed between detained and non-detained clients. While the format of conducting the forensic is similar in both cases, the environment during the forensic evaluation can be very different. Unlike non-detained clients that usually arrive with a care-coordinator dressed in comfortable attire, our detained clients arrive in a detention center jumpsuit with two federal detention officers. In our experience, the male clients are usually hand-cuffed and shackled; this is less prevalent for female detainees, though some women have arrived in handcuffs. Because of the nature of our evaluation, the clinician tries to make the client as comfortable as possible before the forensic evaluation begins so the clinician will request that the hand cuffs to be removed. The officers will stay in the room when conducting the story-taking portion of forensic evaluation. If the forensic evaluation consists of a physical or gynecologic exam, the clinician will ask the guards to step out of the room. The guards will sometimes comply, or request to either stay in the room or keep the door of exam room open so they can still observe the client. In this situation the clinician will use the curtain in the room to ensure the client's privacy. When performing an evaluation on a detained client, clinicians should feel comfortable directing the exam room and respectfully working with the detention officers to ensure the clients comfort and safety. Overall, performing the forensic is the same in both

situations, and includes filling out referral forms for follow up care. The primary difference is in scheduling and in handling the federal officers who may be present for the detained clients.

Family physicians have a unique opportunity to use their training in behavioral health and clinical care to perform objective exams for individuals seeking asylum. We hope we have provided a context for future discussion about the role of family medicine physicians in asylum court cases, and how medical student-run clinics can be a novel approach to minimize barriers in this form of advocacy.

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NEEDS ASSESSMENT EVALUATION

CDAC collaborates with a local, non-profit legal organization which serves the asylum seeking population. They reach out to CDAC with requests for their clients (asylum seekers) to have a medical or psychiatric evaluation conducted by the physician members of CDAC. This request includes a short description of the client's application and story, completed waiver forms, and the client's availability to complete the evaluation. CDAC then coordinates a location and date for the evaluation between the client, clinician, translator if needed, and medical student scribes.

The evaluation consists of a psychiatric or medical history and physical exam in which the medical professional assesses the client in the context of their reported history of applying for asylum. These evaluations last approximately two hours on average. Prior to the start of the evaluation, and after consent forms are signed, a medical student completes a needs assessment survey with the client. This survey covers the basic social determinants of health (ex: access to housing, food, childcare) and provides a baseline for us to individualize our assistance to best address each client's specific needs.

Figure 1 shows the specific questions that are given to clients after their evaluation is complete.

In the survey results so far, most clients have indicated more than one social need. Some of their top concerns include having stable housing, transportation, and childcare needs. Other requests that have not been listed, but were specifically brought up by clients include things like "learning English". In this assessment we tried to include a comprehensive evaluation that would not only identify the needs of the asylum-seeker, but also the needs of their family. In addition to the social determinants of health, it was a priority for us to identify any mental health needs in this population. Unsurprisingly, many clients reported feeling a lack of companionship. An overwhelming majority of our clients are divorced women with histories of domestic violence. CDAC has begun to incorporate information about appropriate organizations, including community specific religious groups, support groups, and women's shelters into our continuing care model.

The second part of this survey focuses specifically on the client's medical needs. This section includes an open ended questionnaire

Figure 1: CDAC Client Needs Assessment Survey

1.	I would like help getting healthier food for my family.	YES	NO
2.	My family needs diapers, clothing, car seats, or furniture.	YES	NO
3.	I want to apply for health insurance for myself and/or my children (family).	YES	NO
4.	I need after school activities or help finding childcare.	YES	NO
5.	I have trouble paying my utility bills (gas electric, oil).	YES	NO
6.	I need legal help with housing or custody/guardianship issues.	YES	NO
7.	I worry my home is unhealthy or where I live is unsafe for me and my family.	YES	NO
8.	I worry I will not have stable housing in the next 2 months or will become homeless.	YES	NO
9.	I need help with my mail and understanding what is being sent to me.	YES	NO
10.	I have others in my home who are ill.	YES	NO
11.	I have difficulty accessing or using public transportation.	YES	NO
12.	My children need a tutor.	YES	NO
13.	I feel that I often lack companionship.	YES	NO
14.	I need help finding a primary care provider.	YES	NO
15.	I need help finding a health care specialist; specialty: _____	YES	NO
16.	I have another need that is not listed here: _____	YES	NO
<p>1. Do you have any health problems? For example, Diabetes, Heart Disease, High Blood Pressure, Cancer.</p> <p>2. Are you currently taking or have you ever taken medications for anything? If yes, what is the name of the medication and what is it for?</p> <p>3. When is the last time you have seen a medical doctor? If you did see a doctor, was it in the United States and what was the reason for the visit?</p> <p>4. If you haven't seen a medical doctor in the past two years, what was the reason?</p> <p>5. Do you have any questions for a doctor about your health? What is your question?</p> <p>6. Have you seen a psychiatrist or mental health counselor before?</p>			

asking clients about their medical diagnoses, last physician visit and questions related to finding a provider. For many of our clients, the last time they received any health care was in their home country, and often several years ago. Fortunately, many of these asylum seekers qualify for Medicaid in New York State which opens the doors for access to treatment, preventative health services, lab and x-ray services, medications, transportation to appointments, prenatal care, psychiatric care, and much more. Despite being eligible for Medicaid, asylum seekers are ineligible for federally funded benefits like SNAP.

CONTINUING CARE MODEL BASED ON REQUESTED NEEDS

One major barrier that asylum seekers face is that they don't fit into the category of "refugees" or "immigrants," so they are not always eligible for the same resources that are available to these populations. There is limited data on what resources are accessible to asylum seekers, and they are often state and community specific. Part of CDAC's mission is to compile a centralized document with all the resources that are available to asylum seekers in the Albany and Capital District region. CDAC recently partnered with the Healthcare System Navigation in the Community (HSNC) service learning program at Albany Medical College to assist in this process. HSNC students work at community sites to assist individuals in overcoming barriers and access resources related to health and healthcare. CDAC is in the process of reaching out to these organizations to better understand if our clients are eligible. Services range from food banks, veggie mobiles, free legal clinics, free healthcare clinics, and free/ discounted public transportation services. We work as a liaison between our clients and these local programs and organizations to facilitate a partnership designed to improve our client's living situations while their asylum applications are being reviewed.

Members of our student run asylum clinic received a two- hour training conducted by key members of the HSNC service learning program to educate them on how best to approach helping our clients meet their basic needs. Recently, our members have begun meeting with clients on an individual basis to discuss their assessment form and prioritize what needs they would like to address first. So far, a couple of clients have been assisted in finding a primary care physician, verifying insurance coverage, getting new insurance cards, and connecting with food resources.

CONCLUSION AND FUTURE DIRECTIONS

Continuing care for asylum seekers has been one of our organization's missions since the inception of CDAC. Through a collaborative effort of medical students, clinicians, and local organizations, we've been able to implement a structure to help coordinate services. We hope that our model of care and involvement with this vulnerable population provides insight in how to interact with asylum seekers and address their specific needs. We hope to expand our program by partnering students with an asylum seeker in a long-term relationship and follow up on resource utilization and barriers facing each client to better focus our outreach and resources. Currently, our CDAC chapter is small and limited to students conducting evaluations and

identifying initial resources for asylum seekers. We hope to establish a broad-scale partnership with a single pro-bono clinic that we can refer the clients to, making continuity of care, resource management, and follow up more efficient and effective.

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Upcoming Events

2019

Aug 3 – 4

Summer Cluster
Hilton Garden Inn,
Roslyn

Oct 20

Fall Cluster- Board Meeting only
Hilton Garden Inn
Albany Medical Center

2020

Jan 23 – 26

Winter Weekend
Lake Placid, NY

March 15 – 16

Winter Cluster and Lobby Day
Albany, NY

June 13 – 14

Congress of Delegates
The Desmond, Albany



Healthcare for Criminal Justice-Involved Individuals and The Governor’s Plan to End AIDS

By Sonia Lazreg; Cheyenne Stewart, MPH; Jonathan Tsao, MPH; Antonio Urbina, MD; Georgina Osorio, MD; Terri L. Wilder, MSW

On a daily basis, New York State’s justice-involved population averages 23,000 individuals in jails, 50,000 in prisons, and 36,000 under supervised parole.^{1,2,3,4,5,6,7}

Incarceration exposes individuals to specific health risks and barriers which include harassment, medication interruption, worsening mental health or self-harm during confinement, and others. One of these NYS residents was Mr. Said, an immigrant who was imprisoned for 9 months. During his imprisonment, he was denied continuation of his pre-exposure prophylaxis (PrEP) regimen and HIV testing, despite recent previous high risk activity, and refused the antidepressant and anxiolytics which he used to manage his PTSD diagnosis in the community. Once his medications were finally prescribed, he felt unsafe retrieving them as it subjected him to harassment by correctional officers and other inmates due to his sexual orientation and ethnicity. He was also denied the antivirals that he normally used to prevent herpes, causing a severe outbreak which rendered him unable to eat or be housed with other inmates. When released, he left prison without a medical provider or necessary prescriptions. Fortunately, he was able to eventually obtain excellent outpatient primary care services at a clinic where providers were open to hearing about his experience and addressing his healthcare needs.

Health disparities between those who experience incarceration and the general population are well documented, especially in the areas of HIV, hepatitis, STIs and drug user health. See Table 1. Nearly 25% of all individuals with HIV in the U.S. and one third of individuals with Hepatitis C pass through a correctional facility each year.⁸ While incarcerated, individuals engage in high risk behavior – including drug use and having both coerced (up to 21% for men, 4.5% for women) and consensual (varying between 2% and 30% for men and up to 30% of women) sexual encounters.^{9,10} Timely intervention is necessary to minimize transmission of infectious diseases.

Table 1: Highlighted Health Disparities in Incarcerated Populations

Condition	Prevalence Among Incarcerated	Prevalence in General Population
HIV	5% ¹¹	<1% ¹²
Hepatitis C	18% ¹³	1% ¹⁴
Gonorrhea or Chlamydia	19% ¹⁵	<1% ¹⁶
Meeting criteria for alcohol or drug use disorder	66% ¹⁷	8.4% ¹⁸

In order to fully realize Governor Cuomo's plan to end the AIDS epidemic (EIE), these health disparities must be addressed. Medical providers need to identify justice-involved persons with HIV who remain undiagnosed and link them to health care, provide them access to anti-HIV therapy (ARVs) to maximize HIV suppression and prevent further transmission, and facilitate access to PrEP, a once daily pill that greatly reduces the risk of HIV acquisition, and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative.

There is great opportunity to expand screening, prevention, and educational services during all points of contact with the legal system and during the crucial reentry period. HIV testing rates are highest when offered on an opt-out basis and when inmates know results will truly be kept confidential. STI testing should be expanded to include genital, oropharyngeal, and rectal site screening.¹⁹ Access to PEP/PrEP,²⁰ ARV treatment to attain viral suppression, STI treatment, and condoms must be offered in a manner that is indistinguishable from other healthcare services to ensure patient confidentiality. HIV treatment and prevention should not be given in "HIV pill lines" that clearly mark inmates as living with and/or at risk for HIV and open them up to discrimination and harassment from other inmates and correctional officers.²¹ High risk individuals should leave with PrEP prescriptions and everyone with referral to services upon release from the system.²² Furthermore, peer led-HIV education programs in individual or group formats as well as medication assisted treatment programs have been shown to reduce high-risk behaviors and likelihood of HIV transmission.²³

Family physicians in New York should advocate for these best practices for medical management and public health interventions to be represented in state policy and budgets. The Center for HIV Law & Policy's "Prisons and Jails" resource bank is helpful for staying up to date on decisions and policies that affect the incarcerated with opportunities for advocacy.²⁴

Just as importantly, primary care physicians need to be equipped to provide excellent outpatient primary care that's sensitive to the health risks associated with incarceration once individuals are released, including medical history taking without judgement.²⁵ The National Center for Innovation in HIV Care shares materials that can prepare providers to be this link to care after incarceration.²⁶ Patients like Mr. Said should always be able to get the care they need based on best practices and without discrimination or harassment. Greater institutional care and transitions to outpatient care are needed to improve the health of communities. Primary care physicians should also be up to date with the latest advancements in care. Future biomedical interventions, such as long-acting injectable formulations of antiretroviral therapies for treatment and prevention of HIV, have the potential to further support the healthcare needs of this population. Upon availability, these may eliminate the need for discrete daily drug dispersal and allow individuals to get settled in their communities without immediately seeking medical care and prescriptions for these medications.²⁷

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CARING FOR AGING VETERANS: A CALL FOR COGNITION-INFORMED CARE

By Rebecca J. Stetzer, MD; Andrea L. Hubalek, LICSW; Cheryl A. Davies, PhD; Melissa M. Ertl, MS

Stories about patients with cognitive impairment falling through gaps in the medical system are far too familiar. We have observed that cognitively impaired patients are more likely to miss appointments, forget their medications, and fail to follow instructions, resulting in suboptimal care that is frequently attributed to non-compliance. Unidentified cognitively impaired patients are also heavy utilizers of our medical system, yet often inadequately cared for. Much of this is due to our medical system not being what we consider “*cognition-informed*”. Cognition-informed care describes a medical culture that anticipates and accommodates the needs of patients with cognitive impairment. The interdisciplinary model used at the Veteran Health Administration, Patient Aligned Care Teams (PACTs), allows physicians more opportunity to identify and support these patients. Although this model is not financially feasible for most primary care offices, the principles behind a cognition-informed, interdisciplinary team approach can be widely applied to create a medical culture that better supports our patients with cognitive impairment.

The Scope of the Problem

Our aging population and the increasing number of individuals with dementia is well recognized. Estimates are that between 16-20% of U.S. adults over age 60 have mild cognitive impairment, 20-40% of whom are expected to progress to a diagnosis of dementia.¹ As the need for increased dementia care is recognized, new healthcare systems have been developing approaches to better care for these patients, support their families, and educate their providers on best practices. Another major hurdle to address is the navigation of our increasingly administration-heavy medical systems. Managing appointments and reordering medications can be challenging in the setting of impaired cognition and can create a barrier to care. Some older adults are fortunate enough to have informal caregivers to help

with this navigation. Unfortunately, this is not true for many of our Veterans. Due to the high incidence of traumatic brain injury, post-traumatic stress disorder and substance abuse, Veterans have an increased risk of developing dementia.⁷ These service-related experiences and coping tactics are also risk factors for strained relationships and social isolation, as many veterans do not have family to help them navigate the medical system or care for themselves. To care for this vulnerable population, the medical community can actively look for signs of impaired cognition and make accommodations to the care plan where possible.

Patient Case – Part I

Joe is an 88-year old Korean War Veteran who completed his military service over 60 years ago and since then, has lived on 20 acres of land in the Catskill mountains. He ambulates with a walker, manages several chronic conditions, including dementia, COPD, PTSD, and chronic pain. He has few social connections to family or friends. He relies on a free county van for transportation to and from the VA.

Joe’s dementia was increasingly impacting his quality of life and his experiences in the medical system over the last few years. He had many medical appointments, emergency room visits, and medication adjustments. However, fear of being left behind by the county van led him to repeatedly abandon care early, earning him the label of leaving “against medical advice.” His impaired memory made it difficult for him comply with his medication regimen or keep track of appointments, leading to a label of “non-compliance.” In his personal life, he was a victim of financial abuse by neighbors and a target for financial scams.

Non-compliant or Cognitively Impaired?

Cognitively impaired veterans without social support may have a variety of barriers to care, leaving them vulnerable to suboptimal care. Signs of cognitive impairment include:

- Difficulty tracking appointments, including appointment changes and cancellations
- Difficulty navigating transportation (whether still driving, relying on family/friends, or arranging VA/community senior transportation)
- Difficulty finding different locations for healthcare services (even within a single facility)
- Lack of understanding of their managed healthcare insurances
- Forgetting to take or refill medications (at times only apparent when pill bottles are reviewed or refill history obtained from the pharmacy)
- Being unable to explain the reasons for a planned procedure, or consenting to a procedure incongruent with previously stated goals of care

These “failures” are opportunities for providers and staff to identify the potential for cognitive impairment. When the question of cognitive impairment is raised, it is also an opportunity to screen for high-risk psychosocial factors, such as financial and physical abuse, neglect (including self-neglect), and homelessness.²

Stigma against dementia is common in healthcare settings and may provide another barrier to care. Patients with dementia and their caregivers have been shown to be dissatisfied with their care experiences.³ This dissatisfaction can strain the alliance between provider and patient, making the provision of care much more difficult.

To help increase awareness of these signs, the Albany VA Dementia Steering Committee has implemented a “Memory Minute” monthly email blast with dementia warning signs, actions that can be taken, and links for more detailed information. Education about these warning signs can help all staff, from front office to physician, become an integral part of informal medical culture.

Cognition-informed Care

Cognition-informed care anticipates and accommodates the needs of patients

with cognitive impairment. It describes a medical culture that first considers “non-compliant” behavior, reports of motor vehicle accidents, or other concerning stories to be potential signs of cognitive issues. Once identified, cognitively impaired patients can be provided enhanced care such as assistance with navigation of the medical system, evaluation of psychosocial issues, and discussion of appropriate medication and treatment choices. Table 1 provides an example of a cognition-informed care plan.

Table 1: Components of Cognition-Informed Care

Care Plan Components	Relevant Interventions
Recognition that “non-compliant” behavior may be a sign of cognitive impairment	Cognitive screen: Mini-cog ⁵ or MoCA ⁶ Vision and hearing screening Request psychosocial assessment
Medical Considerations	Identify patient’s goals, prioritize treatments that help achieve that goal Thoughtful medication selection (deprescribe when possible, simple dosing schedule, avoid anticholinergics)
Care Coordination/ Information Sharing	Review care plan, including medication changes, with caregiver (which may require a phone call during or after the appointment) Partner with specialty providers and interdisciplinary team Streamline medical appointments
Safety	Address any psychosocial risk factors including potential abuse Evaluate living environment (alarms, cooking, adaptive equipment) Assess driving and firearm safety
Community Resources	Collaborate with community agencies, which can be identified by the local Office for Aging (https://aging.ny.gov/) Offer support and education to caregivers (the Alzheimer’s Association is a great resource for all types of dementia https://alz.org/)

There are a number of ways the medical care plan can be tailored to support those with cognitive impairment. Increased coordination of care and sharing of information among providers can help achieve proper follow up and avoid duplication of services. Medication considerations should include minimizing anticholinergics and medications with cognitive side effects, simplifying dosing regimens,

being attentive to rules of assisted-living facilities (such as no pill-splitting), and scheduling appointments at intervals that allow staff to assist with ordering refills. While important for everyone, addressing sensory impairment is crucial for those with cognitive impairment. Hearing impairment is a risk factor for dementia⁴ and along with visual impairment, interferes with daily functioning. Suspected cognitive impairment should also prompt renewed screening for abuse and neglect, firearm safety, driving, adaptive equipment, and ability to manage finances.

Goals of care conversations about advanced directives and code status may be difficult for patients with cognitive impairment, particularly as it advances, and families frequently feel uncomfortable making these decisions for their loved ones. Focusing on what patients want, rather than what they don’t want, can be a more useful framework. Functional or symptom-specific goals can be framed within the SMART framework (specific, measurable, achievable, relevant, and time-bound) and guide treatment priorities. Recommendations for advanced directives outlining code status and potential limitation of advanced life support can be made by the physician based on these goals and priorities.

Instructions for any medication changes, referrals made, and next appointments should be clearly written out for the patient and if applicable, also communicated with the patient’s support person/caregiver. If the support person is unable to come into the appointment, permission should be obtained from the patient to call them during or after the appointment.

Patient Case - Part II

Joe’s Patient Aligned Care Team (PACT) recognized the care gaps and adjusted the approach to his care. His care plan advanced to include home nursing visits to fill his pill organizer, appointments scheduled at intervals that allowed staff to order his refills, alerts to front office and triage staff to appropriately direct complaints/questions to his primary care team, and the coordination of a capacity evaluation before surgical procedures. In addition, the VA stepped in to safeguard his finances. His treatment plan has now optimized care for his medical conditions and allows him to remain living at home, which he identified as his top priority.

Conclusion

Caring for cognitively-impaired patients presents a fundamental challenge for family physicians who must balance patient autonomy and active participation in their care with a more directive approach for those who have difficulty navigating for themselves. These patients need a specialized approach; they need a cognition-informed medical culture that anticipates their needs. The details of this will vary according to the individual office and patient population needs, but always begins by recognizing noncompliance as a potential need for additional support.

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CONTROVERSIES IN PRESCRIBING

By Kelly Kirkpatrick, DO; Cleopatra McGovern, MD; Ivonne McLean, MD; Gabrielle

Introduction

Data from 2011 showed that 45% of pregnancies in the United States were unintended.¹ The total cost of unintended pregnancies remains high, with estimates in 2010 indicating the US government spent \$21 billion on births, abortions, and miscarriages resulting from unintended pregnancies.² Unfortunately, many women wanting to prevent unintended pregnancies face an overwhelming array of barriers including socioeconomic inequalities, gaps in insurance coverage and challenges accessing health care.^{3,4} In agreement with multiple US medical organizations (including AAFP and ACOG), we believe one way to prevent unintended pregnancies is over-the-counter (OTC) availability of oral contraceptive pills (OCPs) and emergency contraception (EC).

ORAL CONTRACEPTIVE PILLS

OTC availability of OCPs is widely available outside of the US, currently offered in over 100 countries worldwide.⁵

Safety

OCPs are safe for most women.⁶ Absolute contraindications are a personal history of venous thromboembolism (VTE), a personal history of breast cancer, migraines with aura, smoking over age 35, and existing uncontrolled cardiovascular, hypertension, diabetes or liver disease.⁷ VTE is one of the most cited safety concerns surrounding OCP use. However, it is important to note that the risk of spontaneous VTE with OCP use is very rare (3-10.22/10,000 women-years),⁸ especially when compared to the risk of VTE in pregnancy (5-20/10,000 women-years), or postpartum (40-65/10,000 women-years).⁹ OCPs have also been shown to be safe if accidentally taken while pregnant without any increased teratogenicity.¹⁰

Data on the rate of patients with contraindications to OCP use in the general public are limited. Drawing from studies of women seeking contraceptive services, rates of absolute contraindications ranged from 2.38% to 4.6%.^{11,12} Rates for progestin-only oral contraceptive pills (POPs) were even lower; less than 2%.¹³ This low rate of contraindications to POPs has led some advocates to recommend them as the first form of OCP available OTC. There is some concern that POPs are not as effective as estrogen-containing OCPs, however, the existing literature does not substantiate these concerns.¹⁴

While contraindications to OCP use among women in the general population do exist, multiple studies have shown that women are able to accurately self-screen themselves for contraindications using standardized checklists. One study of patients at a family planning clinic had a >90% concordance between patient self-identified contraindications to OCPs based off a standardized checklist compared to clinician-identified contraindications during an office visit.¹⁵ Similar findings were seen in a study of women randomized from the general population and a study based out of the UK.¹³ In all of these studies, patients were more likely to report contraindications compared with healthcare providers. Importantly, the high clinician-patient concordance and tendency of patients to over-estimate rather than under-estimate risk holds true for adolescent populations (aged 14 to 21)¹⁶, suggesting that OTC access to OCPs should be available for both adolescent and adult patients.

EC AND OCP

Surick, MD and Emilie Wasserman, MD

Studies also show that pharmacists are able to effectively screen patients for contraindications to OCPs. Several US states currently allow pharmacists to provide OCPs to patients without a prescription, however the efficacy of these programs are often limited due to the failure of insurance providers to reimburse pharmacist services.¹⁷ In Washington State, where pharmacist provision of OCPs is legal, studies have shown that pharmacists successfully used checklists to identify women without contraindications to OCPs in conjunction with blood pressure and BMI measurements.²⁵

Efficacy

To date, no research has specifically shown that the provision of OTC OCPs leads to a decrease in the rate of unintended pregnancy. However, research has shown that patients at high risk for unintended pregnancy are interested in, and would be willing to use OCPs if they were available OTC.^{3,18} Studies also indicate that availability of OTC OCPs typically result in equal or greater rates of continuation of OCs at follow-up. One study out of Kuwait, where OCPs are available OTC, showed equal rates of continuation of OCP use between women who had consulted a physician prior to OCP initiation compared to women who had not.¹⁹ Another study in El Paso compared patients who procured OCPs in US clinics to those who procured them OTC in Mexican pharmacies. The patients who obtained medication by prescription were significantly more likely to discontinue use at 9 months (25.1% vs 20.8%)²⁰, however this difference was no longer noted when women were prescribed 7 packs as opposed to 3 packs at a time, suggesting that any impediment to physically obtaining OCs poses a threat to effective use.

Cost

A real fear regarding OTC access is an increased cost to patients. Currently under the Affordable Care Act (ACA), most private insurers are required to cover OCPs without a copay or deductible.²¹ However, this coverage may be lost if OCPs are granted an OTC status and women attempt to obtain them without a prescription. Despite the advances in coverage provided by the ACA, cost still exists as a barrier

to accessing OCPs for many women, with adolescents and uninsured women being the most heavily impacted by prohibitive costs.²² In several states, Medicaid plans cover OTC emergency contraceptives, a model that would likely need to be expanded to OCPs in order to see real increases in OTC OCP utilization.²³ Cost modeling suggests that this system would result in cost savings for insurers due to the prevention of undesired pregnancies.²⁴



Loss of Preventive Services

Some providers fear that if OCPs are dispensed OTC, then fewer women will present for well-women exams and other preventative services, including Pap smears and routine screening for sexually transmitted infections (STIs), yet no direct evidence is available to substantiate this claim. STI testing and cervical cancer screening are not requirements for the initiation of these medications.²⁵ Efforts to increase provision of preventive health services to women should operate decoupled from family planning services and should not be used as an additional barrier or coercive tactic. At this time, there is no data that assesses the long-term preventive health outcomes of OTC OCPs. One study comparing women who obtained OCPs OTC in Mexican pharmacies compared with women who obtained them from public clinics in the US showed that both groups had high rates of accessing preventive health services; >88% had a cervical pap test in the past 3 years and >77% reported having received STI screening.²⁶

EMERGENCY CONTRACEPTIVES

Levonorgestrel (LNG) and ulipristal acetate (UPA) are both forms of oral emergency contraception (EC). LNG is the only EC available OTC in the United States, but UPA is a more effective medication in a wider variety of clinical scenarios. The Copper IUD is the most effective form of EC but, it must be placed by a medical provider, and therefore is excluded from this discussion.

Safety

Like OCPs, EC (LNG and UPA) is safe for most women. There are no contraindications to either medication and they have not been linked to any serious complications or death.^{7,27} Although LNG and UPA work via different mechanisms, studies have shown few differences in safety. In

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Controversies, continued

large non placebo controlled studies, patients have reported symptoms including headache, dysmenorrhea, abdominal pain and nausea at similar rates for both LNG and UPA.^{28,29} These side effects are also non-unique; many of them overlap with early pregnancy. There is also no evidence that EC harms a pregnancy that is already established.³⁰

In addition to being safe and well tolerated, oral EC is easy to use. In 2013, four years after Plan B (LNG) became available over-the-counter for women 17 years and older, a study of 345 women aged 13-17 demonstrated that 92% were able to review packaging for Plan B and use it as directed within the first 120 hours after intercourse.³¹ This compounded the original studies which demonstrated overall safety. Legislation should reflect what studies demonstrate: people who become pregnant can generally read and understand information required for safe usage. LNG was deemed safe for OTC prescription without age limitations in 2013. There are no significant differences in safety that should make LNG available OTC, but not UPA.

Efficacy

UPA has been shown to be both more clinically- and cost-effective than LNG in preventing pregnancy.^{32,33} Advance administration has been shown to double the rate of use.^{34,35} UPA is approved and effective for 120 hours after unprotected sex, while LNG is only effective up to 72 hours after unprotected sex. UPA is more clinically effective than LNG for women with a BMI >25 or weight > 75kg. Per CDC statistics in 2016, 71% of the US population has a BMI >25, and therefore providing UPA over-the-counter will be more effective for the majority of the US population.³⁶ Based on this information, ACOG recommends prescription of UPA over LNG in all clinical scenarios given its greater efficacy at all time points and at all weights.³¹ The European Medicines Agency recommended UPA become available OTC in 2014, and has had a 38% increase in use in those countries with consumption data available.³⁷ Prior barriers to EC overall, such as lack of awareness have decreased significantly over time, with an increase in women's awareness from 75% in 2004 to 93% in 2017 in the Kaiser Women's Health Survey.³⁸ Given its greater clinical effectiveness and similar safety profile, UPA should also be made available OTC.

EC Myths, "Decreased Contraception, Increased STIs"

A concern with more accessible EC is that this will decrease the ability of physicians to counsel patients on their sexual history and/or limit the ability to prescribe long term contraceptive methods. But, research shows that advance provision both increases uptake, and does not decrease use of other contraceptive methods, including condom use.^{30,35} With "typical use" of both OCPs and the Depo- Medroxyprogesterone acetate injection by patients, there are significant gaps during which time EC use is appropriate and effective.^{39,40,41} A Cochrane review showed advance provision of EC did not lead to increased rates of sexually transmitted infections (OR 1.01, 95% CI 0.75 to 1.37), or increased frequency of unprotected intercourse, and women who received EC in advance were equally as likely to use condoms as other women.⁴² Even in adolescents, using EC does not increase the rate of STIs or unprotected intercourse.⁴³ One downside of providing EC OTC is the missed opportunity for

the medical provider to also offer post exposure HIV prophylaxis within the 72 hour window for eligible individuals. But, this does not outweigh the benefit of providing EC, and can be addressed through other public health campaigns.

Cost & Pharmacy Barriers

LNG costs between \$35-\$50 per pill when purchased OTC. Both LNG and UPA under the ACA have mandated coverage as a contraception when prescribed by a physician.⁴⁴ Cost and insurance coverage have been shown to be direct barriers to all forms of contraception.⁴⁵ But, even if a patient can afford the medication, availability at pharmacies is limited; in one survey, UPA when prescribed by a physician was only available same day at 10% of pharmacies surveyed, and only 72% of patients were able to get the prescription within 24 hours.⁴⁶ Even in countries where UPA has been made available over-the-counter such as Australia, research has shown pharmacist's lack of knowledge led to under-prescription of UPA despite its greater effectiveness.⁴⁷ Given these factors a major component of increasing accessibility to EC through OTC prescription of both LGA and UPA needs to include insurance coverage when the medication is purchased OTC (this is currently being done by some Medicaid programs²³) and pharmacist education.

Special Populations

Special populations have both a harder time accessing, and a greater need for EC use. For many marginalized populations, there is a deep distrust of the healthcare system; by asking patients to assess their own contraindications, and improving their ability to access medication, they will benefit directly. Some specific special populations to consider include bisexual individuals⁴⁸, non-binary and transgender individuals⁴⁹, sexual assault survivors, and people involved in the criminal justice system. Among those who have been sexually assaulted, many never present to emergency departments or doctors offices although they have an indication for EC; up to 5% become pregnant.⁵⁰ Access is especially important for patients upon entrance to the criminal justice system. In one survey, 29% were eligible for EC, and 45% of eligible individuals were interested in using EC.⁵¹

Conclusion

In 2012, only about 12% of women using contraceptives relied on a long-acting reversible contraceptive method, or LARC, meaning large numbers of women continue to choose OCPs and EC for preventing unintended pregnancies.⁵² In the backdrop of interventions aiming to increase LARC usage as not only a solution to unintended pregnancies, but also to poverty,⁵³ clinicians and medical educators must be aware that not all patients want LARC, and other methods for pregnancy prevention need to be available. Limited contraindications exist for both OCPs and EC, and research shows women can effectively screen themselves with equal, or better efficacy than providers, which makes over the counter provision of both methods a safe and effective way to expand contraceptive access. Advocating for our patient's bodily autonomy means helping to decrease the existing barriers to access, and increasing patient knowledge about all forms of family planning.

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Primary Care for People Formerly Incarcerated

By Daniel Neghassi, MD

In this era of mass incarceration, family physicians should be familiar with the health concerns of patients with a history of exposure to correctional facilities. Incarceration can have wide-ranging effects on both individuals and communities. The scope of this article is primary care for adults formerly incarcerated in prison or jail, with a focus on statistics, rules and resources specific to NYS when available. This population faces unique social and medical challenges, as well as discrimination and other barriers to equitable healthcare.

Definitions

Encounters with the criminal legal system can result in sentences that include incarceration in correctional facilities and/or various types of community supervision. (Because the accuracy of the term *criminal justice system* is debated, the term criminal legal system will be used in this article.)

Correctional facilities include jails, which are run on the local level by counties or cities, and prisons, which are administered by states and the federal government.¹ People are incarcerated in jails for misdemeanor convictions or certain low-level felony sentences; they may also be in jail awaiting trial (if they could not afford bail) or for violating the terms of community supervision. Prisons are for felony convictions with sentences longer than one year.

Probation and parole are both types of community supervision. Probation is determined by a judge at the time of sentencing, and can either be in addition to, or an alternative to, a jail sentence. Parole is an arrangement to serve the rest of a prison sentence under supervision in the community, determined by a parole board based on a variety of factors. A person on probation or parole must comply with rules that vary depending on individual circumstances. These requirements can include restrictions on leaving a district, a schedule of checking in with a probation or parole officer, employment, a curfew, and a monthly fee.² Violations can result in re-incarceration at the discretion of the probation or parole officer.

Demographics

Approximately 52,000 New Yorkers are incarcerated in state prisons and 11,000 in federal prisons.^{3,4} While there are 24,000 New Yorkers in jails at any one time, many more are incarcerated over the course of a year. For example, from January to December 2015, there were 224,000 admissions to jails.³ Nearly three-quarters of those in jail have not been convicted.⁴ Approximately 96,000 NYS residents are on probation and 43,000 are on parole.⁴ While the incarcerated population per capita in NYS (570 per 100,000 residents 15-64 years old) is lower than the US as a whole (1,023 per 100,000), it exceeds rates seen in almost any other country in the world.³ Furthermore, the differences among racial groups is stark: Black, Native American and Latinx New Yorkers are incarcerated at 6.3, 3.8 and 2.4 times the rate of White people in NYS prisons, respectively.³ Men comprise 90.4% of the jail population and 95.5% of the prison population in the state.³ Other groups that are overrepresented in correctional facilities include LGBTQ people and veterans.^{5,6}

Social Factors and Barriers to Healthcare

People who have been incarcerated disproportionately face socioeconomic challenges. They often lived in and return to communities with high rates of poverty and unemployment.⁷ In addition, they are more likely to have a history of trauma and abuse and experience physical abuse at rates 13 to 27 times higher than the general population.⁸ One study revealed that 98% of women in jail report at least one trauma before incarceration; the most common types were intimate partner violence (71%) and trauma during childhood (62%).⁹

The barriers to attaining desired health outcomes for this patient population include interruptions in health coverage and healthcare, poverty, housing insecurity, lack of education and employment opportunities, and interruptions in social connections.^{8,10} Lack of continuity of care is compounded in cases of recidivism, which continues to be common. Disruption of health insurance is almost a given. Federal law mandates suspension of a patient's Medicaid coverage if they are in jail, even if awaiting trial.¹

For those who are prescribed medication during incarceration, a 14-day supply of medications and a 30-day prescription is supposed to be provided upon release from prison in NYS. However, this is not consistently done for all patients, and even with the appropriate prescriptions, the cost of the medication may be prohibitive without health insurance.¹⁰

After release from prison, people often have a number of considerations that they may prioritize above seeking primary care. These include establishing stable housing, obtaining food, reconnecting with family, and working or looking for work.¹⁰ Strict probation or parole requirements may also interfere with a patient's ability to make or schedule medical appointments. Seeking employment and housing is often made more challenging by discrimination on the basis of having a criminal record.¹⁰

Similarly, patients who have had contact with the criminal legal system can encounter discrimination within the healthcare system, which can affect where and how care is accessed. Researchers in one study found that 42% of the cohort reported discrimination in healthcare settings due to their criminal record and that the study participants who did experience discrimination were more likely to have frequent emergency department utilization.¹¹ In another study, investigators posing as potential new patients called family physician practices; some callers revealed a recent release from prison. Callers who disclosed a history of incarceration were less likely to be offered an appointment (43% vs 84%).¹²

Approach to Clinical Care

The approach to clinical care of this population should acknowledge that those formerly incarcerated are more likely to have been a survivor of abuse, and that incarceration is itself a traumatic experience, especially solitary confinement.^{8,13} Trauma informed care (TIC) refers to methods of providing high quality services to those who have experienced traumatic life events.¹⁴ TIC includes universal precautions, which are measures that apply to all patients because a clinician would not necessarily know who has been affected by incarceration or other trauma. TIC also includes trauma-specific care for patients who have revealed a history of traumatic life events.

Universal precautions include offering patient-centered communication and care, such as asking every patient what can be done to make the visit more comfortable. Another subset of universal precautions is approaching each case with the understanding that traumatic experiences can lead to various coping strategies (such as substance use including nicotine), exacerbations of chronic conditions due to physiologic stress response, and lower adherence to treatment regimens.

Trauma-specific measures come into play if a patient discloses a history of incarceration or other difficult life events. In this case, the clinician should remember to thank the patient for sharing, provide an empathetic response, and have resources available to offer the patient. If the patient discusses the circumstances that resulted in incarceration, they should not be documented as it can result in biasing future healthcare providers who read the chart. Given the discrimination that this population may face, clinical and non-clinical staff should also be trained to offer non-judgmental communication and care.

Although there is no consensus, many experts advise screening for experiences with incarceration in the primary care setting.¹⁰ This screening can be completed with a structural vulnerability checklist or

Table 1: Sample Questions and Phrases to Use and Topics to Avoid 10,13-16

Sample Questions and Phrases	Rationale
Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that someone's safety is at risk.	Confidentiality statement
There are a few things I make sure to ask all my patients because they are common experiences that can affect their health. If there's anything you don't want to discuss today, we can skip it.	Normalizes Respecting patient choice whether to discuss difficult experiences
Many of my patients and their relatives have experienced incarceration in the past and this can affect how healthy they are. Has this ever happened to you or a loved one?	Normalizes by stating this is a common experience Provides rationale for the question
How has your experience been since you were released?	Open-ended question that may elicit both positive experiences and challenges since returning to the community, which are clinically relevant.
Topics to Avoid	Rationale
Asking details about a patient's history of criminal convictions or reason for incarceration	Usually not clinically relevant Can be an emotionally difficult subject to discuss for both clinician and patient Can perpetuate bias in the patient's chart
Asking details about traumatic experiences without training, or if already discussed before with another healthcare provider	Can be a retriggering experience for the patient without therapeutic benefit and with potential harm

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Primary Care for Formerly Incarcerated, continued

social determinants of health screening tool that can be administered by a social worker, nurse, medical assistant or clinician. Questions should be framed in a way that assures confidentiality, normalizes, provides rationale, and asks for permission.^{15,16} Checklist tools and prefaced questions reduce patients' perception that they are being stereotyped or singled out.¹⁷ See Table 1 for examples.

Medical Conditions

Incarceration is a risk factor for multiple medical conditions, including communicable diseases, psychiatric conditions and substance use disorders.⁷ Screening and management guidelines are usually specific to populations during incarceration rather than following release. Because adherence to screening guidelines vary substantially in correctional facilities, medical records should be requested, and screening in the outpatient setting should be considered if tests were not done or if results are not available.

Communicable Diseases

Hepatitis B virus, hepatitis C virus, human immunodeficiency virus, other sexually transmitted infections, and tuberculosis are among communicable diseases that are found in higher rates among people who are incarcerated, and testing is recommended by the USPSTF.⁷ Details of their prevalence and treatment are covered elsewhere in this issue.

Psychiatric Conditions

Estimates for the prevalence of psychiatric diagnoses among people who are incarcerated, including mood, anxiety and psychotic disorders, range from 37 to 60%.⁷ During incarceration, those with psychiatric conditions have higher risk of being the victim of violence, self-harm behaviors including suicide, and solitary confinement. They also have higher rates of recidivism, homelessness and unemployment.¹ Psychiatric symptoms are increased during and following incarceration.⁸ While individuals might already be taking psychiatric medications before incarceration, their medication regimens are often discontinued or pared down to match what is on the correctional facility's formulary, leading to poor outcomes.¹⁶ Family physicians should help patients engage or re-engage in mental healthcare, by screening and evaluating for depression, anxiety, psychotic disorders and suicidal ideation, continuing psychoactive medications, and arranging linkages to specialists and social services.

Substance Use

Disorders related to consumption of alcohol and illicit drugs are very common with an estimated combined prevalence of 80% in NYS prisons.¹⁸ Treatment is often not available during incarceration, which can lead to higher rates of relapse and heavy use.

Opioid use disorder (OUD) warrants further discussion because of its increasing prevalence and risk of overdose death. Up to 20% of people in prison meet criteria for OUD.⁸ Opioid and other drug overdose poses the highest risk of death among those recently released from incarceration. A study in Washington State found that the risk of overdose death in the two-week period following release is 129 times higher for people who were released from prison compared to the general population, largely due to opioid overdose.^{7,8} Medication treatment for OUD is available at Rikers Island jail in New York City, but not in most other correctional facilities in the state. In the primary care setting, physicians should screen for use of alcohol, opioids and other illicit drugs, offer prescriptions and instructions for naloxone if indicated, and prescribe or refer for treatment for OUD.

Smoking cigarettes is not permitted indoors in correctional facilities in NY. Of those that do quit tobacco use during incarceration, relapsing is very common after release.¹⁹ Screening for nicotine use and cessation counseling should be offered universally.

Other Health Concerns

Chronic medical illnesses and reproductive health are other concerns to keep in mind. Higher prevalence of cervical cancer, hypertension, asthma and arthritis have been found in correctional facilities compared to the population at large.²⁰ Interruptions in medical care, high-salt, high-fat diets provided in prison and increased stress may lead to exacerbations of chronic illnesses such as diabetes and congestive heart failure.^{10,16} Moreover, reproductive health is often not adequately addressed during incarceration. For example, many women are not permitted to have their contraceptives continued while in prison or upon release. Screening and caring for these concerns is recommended as per the general population.

Community Resources

Connecting patients who are formerly incarcerated to community resources is an important part of care. Specific programs exist in many parts of the state. See Table 2 for selected community resources.

Table 2: Selected Community Resources

Organization and Website	Services	Location
The Fortune Society, fortunesociety.org	Re-entry program with comprehensive services	NYC
Center for Alternative Sentencing and Employment Services (CASES), cases.org	Re-entry program with comprehensive services	NYC
NYS Division of Criminal Justice Services County Re-entry Task Force Initiative, criminaljustice.ny.gov	State-funded county-run programs with connections to various local services	Nineteen counties across NYS
Center for Employment Opportunities (CEO), ceoworks.org	Job training and placement	Albany, Bronx, Buffalo, NYC, Rochester
AAFP Neighborhood Navigator, navigator.familydoctor.org	Online database of various social and medical services	Throughout the US

Advocacy

For family physicians who want to get involved, there are a number of reforms that can improve the health and livelihood of persons encountering the criminal legal system.¹⁶ For example, expanding programs that are tailored to individuals that have been incarcerated or have experienced other trauma could improve the quality of primary care for patients. One such program has been shown to reduce emergency room visits for this patient population as compared to usual care.²² Family doctors can also advocate for post-release linkages to healthcare to meet the ideal standards of hospital discharges to help diminish poor outcomes for this population.¹⁰

Reducing the number of people who are incarcerated could have implications on community health.²³ In April 2019, NYS passed legislation that limits the use of cash bail and will decrease the number of people in jail without a conviction. This will go in effect in January 2020, and can potentially reduce the population that is exposed to communicable disease and violence as well as risk of social harms such as unemployment.

Criminalization of drug use diverts people with substance use disorders away from treatment and increases stigma.²³ Alternatives to incarceration should be explored and implemented. For those who are incarcerated, medication treatment for OUD should be widely available during and after incarceration.

In New York City jails, solitary confinement is associated with a three-fold increase in acts of self-harm.⁸ NYS rules and practices surrounding solitary confinement are not consistent with United Nations minimum standards for incarceration.²³ A bill to end solitary confinement was introduced to the NYS Legislature in 2019.

Conclusion

Family physicians should recognize that their patients may have a history of incarceration, which may or may not have been disclosed. When delivering primary care to people formerly incarcerated, family doctors can assist them by being aware of the barriers and health challenges that they face, using TIC-consistent practices, and ensuring that recommended screenings are up-to-date.

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Introduction

Newly released prisoners have poor health outcomes upon re-entry into the community. Eighty percent of newly released prisoners have chronic medical problems, psychiatric diagnoses, or substance abuse issues.¹ Newly released prisoners also pose a risk of infection transmission to the community as they carry high rates of TB, hepatitis C, HIV, and sexually transmitted diseases.² The risk of mortality is excessive within this vulnerable group. Compared to the general population, newly released prisoners have a 129 times greater risk of fatal drug overdose and over 12 times higher all-cause mortality within the first two weeks of reintegration.³ They face unique barriers in seeking care, including stigmatization, unstable housing, family disruption, poverty, low literacy rates, and unemployment, and are often not referred to clinics for ongoing care.⁴ One in three prisoners are released without medications, and over 15% of them without medical records.⁵ Primary care physicians hold a vantage point to help curtail health disparities for this marginalized group and can advocate for transitional care through robust screening and a multidisciplinary approach. Several models have been developed to address the lack of continuity by offering a multidisciplinary approach, including Project Bridge, Hampden County Correctional and Community Health Program, and Transitions Clinic Network, which are detailed throughout this article. A common thread among these programs is intensive case management alongside community-based medical care. Their successes show that we can provide interventions which substantially improve health outcomes among patients re-entering communities. This article reviews strategies for primary care physicians to address specific disparities and health care needs for incarcerated people as they reintegrate, including discharge planning, establishing care, screening for incarceration, screening for infectious and non-infectious diseases, and dynamic case management.

Discharge Planning, Establishing Community-Based Primary Care, and Screening for Incarceration

Return to the community is characterized by remarkable stress as competing priorities for survival make it difficult to secure primary care; there is high risk of mortality, increased hospitalization, and emergency room usage in the weeks immediately after reentry.⁶ While access to medical care is mandated for prisoners, this constitutional protection ceases upon release. Carefully planned discharge from incarceration can improve linkage of the newly released prisoners to health resources. Prerelease collaboration between correctional and community medical facilities and postrelease coordination between medical and social services can improve health outcomes for newly released prisoners. In Rhode Island, for example, The Miriam Hospital in Providence established Project Bridge in 1996 after securing funding from the Health Resources and Services Administration (HRSA) to combat discontinuity of care by working closely with the penal system to ensure comprehensive discharge planning for HIV-infected prisoners.⁷ The program received the HRSA

Russell E. Brady Award in 2002 and the Rhode Island Department of Health Community Partnership Award in 2008.⁸ Project Bridge identifies HIV-infected inmates prior to release and connects them to hospital-based clinics for postrelease care and social support services. The program has successfully kept patients engaged in HIV management with 98% of clients receiving medical care within a month of release and 93% remaining in medical care six months later.⁹ This high retention to care, even 6 months after release, demonstrates the benefits of communication between correctional, healthcare, and social work providers.

Extensive discharge planning like Project Bridge is uncommon, creating a challenge for community based physicians. When a newly released prisoner presents to establish care one of the first steps is to obtain medical records. An assessment of health needs should be performed, especially refilling of prescriptions; most inmates are released with no more than a two week supply of medications or none at all.¹⁰ Approximately 40% of inmates are diagnosed with new conditions and initiate medical care in controlled prison environments, and subsequently, many do not develop self-management skills. They require education on the risks of stopping prescribed medications and being lost to follow-up.¹¹ Social service referrals are necessary to navigate urgent non-medical concerns that may disrupt care.

PROVIDING TRANSITIONAL PRIMARY CARE TO NEWLY RELEASED PRISONERS

By Tasmia Ahmed, MD

A barrier to pertinent medical monitoring is the failure to elicit an incarceration history. Given the stigma of incarceration, newly released prisoners may be unwilling to disclose information. When serving communities subjected to high rates of imprisonment it may be beneficial to implement a checklist to screen for social determinants of health, such as incarceration status, housing, or food insecurity. A blanket checklist given to all patients can help avert perceptions of stereotyping.¹² Incarceration status should be reassessed periodically. Triggers to reassess patients for reincarceration are missed appointments, unfilled prescriptions, and recent homelessness.¹³ Building rapport by making it clear that sensitive topics are being broached to prevent recidivism and health consequences of prison can encourage collaboration and create a safe clinical setting.¹⁴

Screening for Chronic Disease

Physicians should screen and treat newly released prisoners following U.S. Preventive Services Task Force (USPSTF) recommendations for the general population.¹⁵ Rates of chronic medical conditions among incarcerated people are higher when compared to the general population.¹⁶ Prevalence of liver disease is 9.6% higher in the inmate population.¹⁷ More than a third of inmates had respiratory conditions and more than double the rates of diabetes and kidney disease. One study found that state prison inmates were 90% more likely to have suffered a heart attack.¹⁸

Linkage to care is only part of the solution, and does not guarantee retention or improved health outcomes. A report from an urban transitions clinic found that despite linkage with community health centers many newly released prisoners did not attain optimal chronic disease outcomes and fewer than half were retained in medical care six months after release.¹⁹ Social stressors and lack of health literacy makes compliance difficult for newly released prisoners.²⁰ Mallik-Kane et al. found 1 in 70 newly released prisoners were hospitalized for an acute illness within seven days of release and 1 in 12 by 90 days.²¹ To address discontinuity of care and destabilizing social issues contributing to poor health outcomes, the Hampden County Correctional Center (HCCC) in Ludlow, Massachusetts developed a proactive public health model of prison care in 1992 that has physicians, case managers, and nurses dually based at the facility and in the community. In 2002, the annual budget for the HCCC Health Services Department was approximately \$6.8 million with funding secured through numerous grants and contracts with local and state public health departments, private foundations, and national organizations such as the Centers for Disease Control and Prevention.²² In 1998, the HCCC was named Health Care Facility of the Year by the National Commission on Correctional Health Care and in 2000 was awarded an Innovations in American Government Award from the Ford Foundation.²³ By offering comprehensive treatment plans, social services, and education in prison that continues postrelease with the same healthcare team there has been significant improvement in show rates for community clinic appointments and reduced emergency room visits.²⁴ This level of care is difficult to sustain in many communities although strides have been made to help other jurisdictions adopt the model. Until replication is possible, engaging regularly with medical homes is a viable alternative for addressing medical and social aspects of reentry.

Screening for Infectious Disease and Sexually Transmitted Infections

Infectious disease is a major concern in overcrowded and closed penal environments. There is an increased prevalence of infectious disease among newly released prisoners, contributing to 24% of sexually transmitted infections (STIs), 35% of tuberculosis (TB), 29% of hepatitis C, 17% of AIDS, 13% of HIV, and 15% of hepatitis B cases.²⁵ Screening and treatment of infectious disease not only improves individual health outcomes, but also reduces transmission to the communities to which newly released prisoners are returning to.

Tuberculosis

The incarcerated population carries a disproportionately high burden of TB; in 2016, this cohort consisted of 0.4% of the total US population but contributed to 4.2% of cases.^{26,27} Studies estimate the prevalence of latent TB in correctional institutions may reach 25%.²⁸ Drug resistant strains of TB are more likely; U.S. National TB Surveillance System data indicate a fourth of inmates are subjected to incomplete treatment while incarcerated.²⁹ As a result, correctional facilities are considered to be institutional amplifiers or reservoirs of TB.³⁰ Patients presenting with an incarceration history should be screened for TB and drug regimen selection needs to take into account the tumultuous social situations faced by newly released prisoners, likelihood of adherence, hepatotoxicity risk, drug-drug interactions, prior treatment for TB, and the likelihood of drug resistant TB.³¹

Hepatitis C

Hepatitis C (HCV) infection is a frequent problem. One in four inmates are infected with HCV, and two in three with history of injection drug use are anti-HCV positive.³² Between 14-25% of inmates inject drugs in prison and tattooing with unsterilized needles is a common occurrence.³³ HCV testing is warranted in newly released prisoners and continuous screening may be appropriate. Those with HCV should be offered vaccination against hepatitis A and B if non-immune, as well as, testing for HIV co-infection.³⁴ Newly released prisoners with HCV require continuous education to reduce risks associated with disease progression and to prevent transmission to the community.

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are rampant within correctional facilities, which poses significant risk of transmission to communities when inmates return. Compared to the general population, rates of chlamydia trachomatis and Neisseria gonorrhoea infections are three to five times higher.³⁵ Approximately 1.5% of inmates, about three times greater than the general population, are HIV positive.³⁶ Other sexually transmitted disease such as syphilis, trichomonas, herpes simplex virus, and human papilloma virus are also more prevalent.³⁷ The CDC recommends universal screening for syphilis, gonorrhoea, and chlamydia for inmates; the World Health Organization recommends condom availability in correctional facilities.^{38,39} However, neither recommendation has been universally adopted. HIV-infected inmates typically have access to antiretroviral therapy while incarcerated. On average, 51% of all HIV-infected inmates receive treatment and 40% achieve an undetectable viral load.⁴⁰ Unfortunately, upon release these gains are often lost as access to care drops drastically. As mentioned previously, Project Bridge addresses barriers to follow-up by promoting social stabilization through extensive case management and ensuring continuity of medical care; data shows 90% of participants continued follow-up for 18 months.⁴¹ STD education and prevention counseling are essential given that upon release studies have found over 80% of

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Providing Transitional Primary Care, continued

18-to 29-year old men reported having sex with a female partner by the end of the first week, a third of HIV-positive men reported unprotected sex with an HIV-negative partner, and, in one city, a third of women reporting an incarcerated partner in the past year tested positive for an STI.^{42,43} Community clinics can stem STIs endemic to newly released inmates through screening and offering treatment when appropriate, counseling on the need for adherence to medications with assessment of possible barriers, educating on how to decrease risky behavior and transmission of disease, monitoring for comorbidities, and establishing ongoing connection with social work services. Through such efforts both newly released prisoners and their communities can benefit from positive health outcomes and reduced disease transmission.

Screening for Mental Illness

In the mid-1950s, state mental hospital deinstitutionalization resulted in a funneling of patients with mental illness into the criminal justice system.⁴⁴ A US Bureau of Justice Statistics special report estimated that 64% of jail inmates had psychiatric disorders, a National Alliance Mental Illness survey found 40% of patients with mental illness reported arrest because of psychiatric symptoms, and prevalence rates for mental illness among female inmates were double compared to male inmates with 31% and 14.5%, respectively.^{45,46,47} It has been described that more than two-fifths of state prisoners and more than half of jail inmates meet criteria for mania, a little less than a quarter of state prisoners and a third of jail inmates report symptoms of depression, and approximately one-sixth of state prisoners and a quarter of jail inmates meet criteria for a psychotic disorder.⁴⁸ As the correctional and mental health system are separate entities with minimal collaboration, most patients with mental illness transitioning back to their communities are not provided postrelease psychiatric care.⁴⁹ Consequently, the recidivism rate is higher than other released prisoners; in the Los Angeles County Jail, 90% of inmates with mental illness are repeat offenders, with 31% having been incarcerated ten or more times.⁵⁰ This pattern of crimes being committed by individuals with unstable psychiatric disorders represents a failure of the healthcare system.⁵¹ Inmates with mental illness also experience longer periods of incarceration. In Riker's Island Correctional Facility, the average stay of all inmates is 42 days whereas for the mentally ill it is 215 days.⁵² Recidivism along with longer imprisonment means inmates with mental illness are exposed more frequently to prison-related health risks. There is evidence that receiving mental health treatment during reentry is associated with lower recidivism rates.⁵³

The American Association of Community Psychiatrists advocates sharing responsibility for transition planning across systems and organizations.⁵⁴ The Assess, Plan, Identify, and Coordinate (APIC) model is a tool developed by corrections and behavioral health experts to guide postrelease discharge for people with mental health and addiction needs.⁵⁵ It promotes assessing needs and risks, planning for treatment and services, directly linking to required services, and coordinating transition planning to ensure implementation.⁵⁶ The APIC model guidelines may be incorporated

to ensure a timely treatment plan is collaboratively developed by medical staff, the patient, case manager, and when possible, the patient's relatives. Engaging newly released prisoners in their care builds trust and linking them to rehabilitation services can deter disruptive or addictive behavior and decrease recidivism.^{57,58}

Screening for Addiction

Mental illness and addiction are closely connected; approximately three-quarters of state prisoners and jail inmates who suffered from a mental health problem meet criteria for substance dependence or abuse, and two-thirds of crimes were in some way related to substance use.^{59,60} Among those without a mental illness diagnosis, over half of state prisoners and over two thirds of jail inmates meet criteria for alcohol and other substance dependence or abuse.⁶¹ Studies indicate that the relative risk of death from any cause during the first two weeks post-release is over twelve times higher compared to the general population with the leading cause of death being drug overdose.⁶² Inmates with opiate addiction may be abstinent while incarcerated. However, this period reverses tolerance, putting newly released prisoners at risk of fatal overdose when they attempt to use at pre-imprisonment doses.⁶³ One method to combat fatal heroin overdose is to provide newly released prisoners with Naloxone, and in one study based in New York City, all overdose victims who were administered Naloxone survived.⁶⁴ Medication assisted treatment (MAT) is encouraged for opiate dependent inmates entering Riker's Island Correctional Facility; research has shown the jail's program has resulted in reduced crime, reduced HIV and hepatitis C transmission, and better than average rates of recovery from drug use.⁶⁵

Additionally, it has been found that up to 80% of inmates continued treatment at local clinics after release.⁶⁶ Despite these findings, most correctional facilities do not offer MAT. As a result, when newly released prisoners present to community based clinics it is imperative to refer patients for intensive drug counseling and MAT. Screening should note evidence of intoxication, dependence, overdose, and withdrawal; establish motivation for change; assess barriers to involvement in treatment; assess how receptive the patient is to treatment; and if possible, acquire collateral information.⁶⁷ It is critical to administer screening and assessment instruments in a way that is non-judgmental and encourages honesty.⁶⁸

Importance of Case Management and Social Services

The importance of case management and social services cannot be overstated. Medical management is less effective if transition care does not take into account the volatile environment newly released prisoners face upon release. The Transitions Clinic Network (TCN) is a consortium of fourteen primary care clinics in eleven states and Puerto Rico that strive to improve health outcomes for newly released prisoners by referring to community organizations and developing multidisciplinary medical teams. The initiative's research activities are funded by a Health Care Innovation Award from the Centers of Medicare and Medicaid Innovation.⁶⁹ TCN is unique because teams

include a physician with experience working with formerly incarcerated patients and case management from a community health worker (CHW) with a history of previous incarceration.^{70,71} The CHW ensures intake appointments are scheduled within two weeks of release and provides assistance with housing, employment, legal aid, substance abuse, health-care system navigation, and chronic disease self-management support.⁷² One study reported that newly released prisoners who participated in TCN clinics had decreased emergency room utilization.⁷³ The successes of TCN demonstrate that the health status of newly released prisoners can be improved during reentry by employing community resources and interprofessional health services.

Conclusion

With the current trend towards mass incarceration, health care systems need to be prepared to serve hard hit communities. Reentry is a volatile period characterized by high mortality as newly released prisoners attempt to meet basic needs and experience fragmented medical care. Primary care physicians can advocate for this vulnerable patient population by assessing for prison-related health risks and linking newly released prisoners with case management and social services to address barriers in complying with interdisciplinary treatment plans. This requires a capacity and commitment to working in interprofessional teams to best serve the patient, as demonstrated by Project Bridge, HCCC, and TCN. Other modalities that can be considered to close gaps in care for newly released prisoners are conducting home visits, incorporating telemedicine, organizing mobile health clinics for neighborhoods experiencing high rates of incarceration, and mandating community health screens as part of parole. By combining efforts across systems and organizations in a complementary fashion to offer a wide array of services, newly released prisoners can receive optimal care as they transition back to their communities.

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INFLUENCES ON THE DOCTOR-PATIENT FOR RECENTLY INCARCERATED WOMEN:

What can the Family Physician do to Improve Care?

By Dana Schonberg, MD, MPH; Ariana H. Bennett, MPH; Hannah L. Helmy, PhD, MPH; Marji Gold, MD

Introduction

There are currently over 6.5 million people who are incarcerated, under parole, or on probation in the United States, with a nearly fivefold increase since 1978 due to the medical system's failure to effectively treat people with substance use and severe mental health diagnoses.¹⁻³ The recent American Academy of Family Physicians (AAFP) position paper on incarceration and health highlights the important role that family physicians can play in improving the health of individuals and families affected by the carceral system, including easing the transition back to the community after incarceration.²

Unfortunately, there are many barriers to care faced by those returning to the community after incarceration. Individuals leaving jail and prison face many competing demands including those of finding housing, employment/income and reuniting with family.^{4,5} Obtaining insurance, finding a doctor and making appointments are just some of the known barriers.^{2,6} Even if an individual is able to prioritize their health and successfully navigate the health care system, they must then overcome additional barriers to care such as stigma and lack of compassion from some health care professionals.^{7,8}

Given the importance of the doctor-patient relationship and the pivotal role that family physicians can play in improving the health of those re-entering the community, it is important to learn what factors affect the doctor-patient relationship and what family physicians can do to improve care for women returning to the community after incarceration.

Methods

We conducted semi-structured interviews with women 18-45 years old who had been incarcerated within the past 3 years. We recruited through word of mouth and fliers at an organization that provided services to people re-entering the community after incarceration. Interviews were initially conducted to learn about women's thoughts about contraception and reproductive health services. Interviews were offered in English and Spanish, audio-recorded, and transcribed verbatim.

Codes were developed to better understand factors that affect the doctor-patient relationship in the community. One author (DS) coded all transcripts and a second author (AB) coded 6 transcripts to ensure that coding was complete and there was agreement between coders. Discrepancies were resolved through discussion until consensus was reached. NVIVO software version 11 was used to facilitate the organization of data and identify emerging themes. Recruitment and analysis continued until thematic sufficiency was achieved.

Results

We interviewed 10 women. The median age was 27 years and median time elapsed since incarceration was 21 months. Almost all women identified as belonging to a racial minority group and half had a high school diploma/GED or higher. Participant demographics are in Table 1.



RELATIONSHIP

Table 1. Study Participants' Characteristics

Number of Participants	10	
Age	Median (Range) 27 years (18-44)	
Time since release	21 months (0 - 33)	
Race/Ethnicity	N	(%)
Hispanic	4	(40%)
Black	2	(20%)
White	2	(20%)
West Indian	1	(10%)
Multiracial	1	(10%)
Born outside the US	1	(10%)
Educational Attainment		
Less than High School Graduate	5	(50%)
High School Graduate or GED	1	(10%)
Some College	3	(30%)
College	1	(10%)
Employment		
Working Full time	2	(20%)
Working Part time	3	(30%)
Not Working	5	(50%)
Insurance Coverage		
Uninsured	1	(10%)
Public Insurance	7	(70%)
Private Insurance	2	(20%)
Pregnancy History		
Number of women who have been pregnant	9	(90%)
Number of women with children	8	(80%)
Number of women with at least 1 abortion	5	(50%)
	Median (Range)	
Number of pregnancies	2 (0-38)	
Number of children	1 (0-4)	

Physical Environment

When speaking of their experiences receiving health care in the community, women discussed how the physical environment of the doctors' office impacted their experience receiving health care. A few women spoke of clinics which they considered unsanitary, and one woman did not return for care because of lack of cleanliness.

R3: *I'm pretty big on like being sanitary and stuff like that. Everything, this lady, first of all she had like sheets covering the doors and it was like really like dirty and like her tools, like she had to wash them with water and it was like really like you don't have fresh tools? ... So I didn't go back there. (Age 25)*

Another woman discussed how the location of her doctor's office negatively affected her experience receiving health care.

R4: *I had to get used to the whole New York [City] thing of doctors' offices not being like in doctors' office buildings, but like in apartment buildings and like they... rent [the apartment] out as the doctor [sic] office. That's always kind of a creepy situation. (Age 29)*

Access and Convenience

A few women spoke of the need to schedule appointments around their work schedule. One woman discussed how she could only be seen during urgent care hours and therefore was unable to establish a relationship with a primary care physician.

R4: *Their times are nine to five and I'm working and I go to school, so it's very hard for me to like schedule. Saturday is their emergency day that I usually get in, but my doctor's never there. It's always like a random doctor. So then it's like you kind of feel like you just get thrown around a lot. Nobody really knows you or really knows like what's going on with you... But I'm hoping to build like a really good relationship with a primary care physician. (Age 29)*

Even when participants were able to make an appointment, many experienced long waits to be seen by a health care provider. One woman spoke about how she avoided seeing the doctor because of long waits.

R3: *It's like you can get there when the door opens and you're still like going to be there for like five hours for some reason and it's crazy. It's really crazy. [Our relationship is] almost non-existent, yeah, like I went maybe like three times and that was just because I was really like almost on my deathbed sick. (Age 25)*

Rapport with Doctor

A few women noted experiences after incarceration in which doctors did not take the time to talk with them or establish rapport.

R3: *He's just really quiet. He's not like, "So how are you feeling today?" He's not like one of those doctors. He's just like one of those where he stares at the screen, does this, and then just like slips you the prescription of whatever it is that he feels you need to be prescribed. Doesn't talk to you... you're there and like, hear the crickets. (Age 25)*

R4: *My primary care physician's very... short and brief and abrupt and I don't know if she thinks I have too many problems [laughs] or something*

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Influences on Doctor-Patient Relationship, continued

or you know, it seems like I'm -- it's always an inconvenience when I'm in there. (Age 29)

Participants noted that they appreciated when a doctor took the time to really listen to them and address all of their concerns.

R4: *Before I even go in to do anything we sit down at her desk. We have a whole conversation. We do everything...and I love her. She's so thorough with you know, what I'm worried about, what I need to be worried about, what my next steps are...So that's something that I really appreciate...When you walk out of a doctor and you're like "Oh my god. They really like care about me, like they really took care of me." (Age 29)*

Many participants appreciated when doctors asked questions about their health in general and spent time discussing things that were beyond their "chief complaint."

R10: *She's like another mom to me...She cares about me like and her [other] patients as well, so we have a good relationship...Like she asks me questions that have nothing to do with why I'm there. Like let's say I can go there for a stomach virus, she ask me do I breathe good? How many cups of water do I drink a day? ...you know, she really look out. (Age 18)*

Continuity of Care and the Impact of Incarceration

Many participants discussed the importance of having a doctor who knows them. Women noted that they did trust doctors with whom they had established relationships, and many valued seeing a doctor who knew their complete medical history.

R5: *My other doctor knew everything, she would pull it out of my record but she knew everything about me already...And with her, I just talk about whatever. (Age 44)*

For most, jail acted as a disruption to medical care, and continuity of care in particular. Most women lost their insurance due to incarceration and, upon re-enrolling in Medicaid, were assigned primary care physicians whom they did not trust to provide good care.

R4: *When I first got home I was on parole, so I had to be on Medicaid. The first doctor I got...He just gave me like these creepy vibes...I guess because I didn't pick one in time, they like assigned him to me. (Age 29)*

One woman was assigned a new physician by her caseworker. A third

woman described feeling pressure to switch to a new doctor affiliated with her substance use treatment program.

R7: *I'm very familiar with my doctor and I didn't want to switch. And because my program is...affiliated with their [own] doctors, so they're basically telling me like I have to switch my doctors here...So they made me go to their doctor which to me was crap, the doctors there, they're like slow as shit. (Age 32)*

Many noted that the new doctors they had upon re-entry lacked concern and a few participants believed these doctors were financially motivated to provide services.

R1: *I don't really care [for my new doctor], because people be there just for money...they don't care... because like you see there's a student...so they pull them...to talk to me, and then she just be there to say oh let me just sign this form for you, and that's it.... It's just for money. (Age 18)*

Discussion

Most of the women that we spoke with held some level of distrust with the health care system in the community. Women felt that some doctors were financially motivated and lacked concern. Distrust of the health care system is common among all marginalized populations, including those involved with the carceral system. Trust in the health care system, as well as other formal institutions, can be affected by the trauma of incarceration as well as negative experiences with health care providers in the past.^{7,9-11}

Furthermore, trust in the health care system can be affected by stigma from health care providers due to a history of incarceration.⁸ As trust is such an important component of the doctor-patient relationship, family physicians must work to increase trust in order to help keep people who are returning to the community after incarceration engaged with the health care system.¹¹

Although the women that we spoke to held distrust of doctors that they met after incarceration, many valued continuity of care and trusted doctors with whom they had long-standing relationships. Long standing relationships have shown to increase trust in a physician,^{12,13} although the value given to a relationship may be more important than the actual duration of time of the relationship.^{14,15} Much research has looked at the importance of continuity care for those leaving jail, but this research is aimed at the importance of continuous access to health care and coordination of services after release as opposed to continuity of care with the same family physician. Given the importance of continuity of care with a trusted provider, assistance



should be offered to those who desire to continue to see primary care physicians with whom they had prior trusted relationships.

Unfortunately jail itself acted as a disruption to medical care, and continuity care in particular, as women lost jobs, lost or were dropped from insurance, and relocated due to incarceration. Termination of insurance coverage during incarceration and the assignment of a new doctor upon re-enrollment often puts women in situations where they don't trust their new doctor.^{8,16} Having choices when selecting a physician improves trust in the doctor-patient relationship,¹² and may be especially important for people re-entering the community after incarceration.^{7,13} Discharge planning varies widely and people often re-enter the community with little coordination between the prison/jail and community health systems.^{5,9,17} Correctional facilities should not only assist with re-applying for Medicaid,^{2,9} but should also help individuals to choose a doctor when re-enrolling, preferably one with whom they already have a relationship.

Unfortunately, even with greater coordination and assistance, not all women will be able to return to see their trusted family physician, and others may have never experienced a trusted relationship with a doctor. The women that we spoke with identified other ways to improve the doctor-patient relationship for these circumstances. For one, having clean facilities, a flexible schedule, and short waiting times are important.^{5,7} It is also important that a doctor be able to establish rapport by asking questions that may be unrelated to the reason for the visit, to show concern and empathy for patients, and to listen and take the time to address concerns. These desired physician traits are not unique to those patients involved with the carceral system,^{11,14,15} and many of these qualities are traits that family physicians already embody. To improve the doctor-patient relationship and ensure the highest quality care, family physicians and others providing care to formerly incarcerated patients should receive training in empathic behaviors and be provided with the resources needed to improve rapport with patients. Family physicians should ensure that they provide a welcoming clinic environment to those with a history of incarceration, free of stigma. Systems should be in place which minimize wait times for patients and allow flexibility in scheduling so that a patient can see their own physician even for urgent issues.

As we only conducted interviews with women receiving services at a re-entry program, our findings may not be representative of factors affecting the doctor-patient relationship for men or for people re-entering the community who are not linked with services. Nonetheless, our study does highlight how a poor doctor-patient relationship can act as a barrier to care and identifies ways to help engage women with health care by improving the doctor-patient relationship. Given the priority placed on continuity of care and longstanding relationships, family physicians are ideally situated to provide care to women after incarceration. As incarceration can disrupt access to medical care, and trusted health professionals in particular, family physicians can work with correctional facilities and re-entry organizations to ensure that women are able to continue to see their trusted primary care physicians after incarceration.

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Dear Members of the New York Academy of Family Physicians,

With the chill before dawn, I share the news of the closure of New York Cities' first family medicine residency program.

Serving Sunset Park and Bay Ridge in Brooklyn since 1974, Lutheran Medical Center's Family Medicine Residency was built in the image of its iconic director, Eugene Fanta MD.

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The steps in the transition from community focus, its acquisition by a Manhattan private university (NYU), and the closure of the program, parallel other trends seen in our unravelling health care system.

Primary care is the answer to our failing health system.

Barbara Starfield's research has shown that a population's health and health care efficiency are optimized by family medicine.

In the months to come, our hope is that our state and national academies will take notice and take action.

It is time for the funding of Graduate Medical Education to follow the needs of the communities served.

Sincerely,

Pat Page

Patrick Page MD
Grand Junction, Colorado
Lutheran Medical Center, 1980-1983

To the Editor:

Thank you for including medical aid in dying (MAID) in your focus on controversies in family medicine. Dr. Morelli's letter clearly expresses the passion felt by some who adamantly oppose making such an option available to terminally ill patients. I respect her view and her right to opt out. The NYSAFP, however, prides itself on being "a consistent and uncompromising advocate for patients in the public arena." Our state chapter's support for medical aid-in-dying legislation is based on the principle that all New Yorkers should have the freedom to make end-of-life choices that are best for them and their families and consistent with their personal values and priorities. Physicians in our state should also be able to include MAID in our practices without the threat of prosecution.

I was present at the AAFP Congress of Delegates last October when our new position on MAID was adopted. The conversation was respectful and while not every physician could support the concept, the final position of "engaged neutrality" was intended to acknowledge that ethical physicians can disagree. Colleagues from states where medical aid in dying is authorized shared personal experiences and provided data to reassure that the law is working as intended. In adopting a neutral stance, the AAFP delegates acknowledged our differences, but refused to label our members who practice medical aid in dying as unethical. In addition, AAFP delegates expressly committed to advocating for every member's freedom to participate in medical aid in dying or opt out according to their individual values and beliefs.

After studying medical aid in dying as an end-of-life option, the AMA's Council on Ethical and Judicial Affairs (CEJA) noted in its report that, "While supporters and opponents of physician-assisted suicide share a common commitment to compassion and respect for human dignity and rights, they draw different moral conclusions from the underlying principle they share. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer ... another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion."

Medical aid in dying poses an ethical dilemma because it represents two competing goods – the desire to extend life and the desire to relieve suffering. There is no simple answer. All physicians who care for the dying deserve our support as they grapple with hard decisions under difficult circumstances. I appreciate the NYSAFP's position on this issue as one that allows family physicians and the general public to make their own decisions that are consistent with their personal ethical values and beliefs.

Thank you,

Heather Paladine

Heather Paladine, MD
Residency Director
Family Medicine Residency Program
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