A Proposal to Provide Health Care in Minnesota Department of Corrections through Partnership with the University of Minnesota Medical School

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GCC 3042 - Just Education: The Role of Higher Education in Disrupting Mass Incarceration

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Purpose:

The aim of this project is to promote prison and community healthcare services through a partnership between University of Minnesota Medical School and the Minnesota Department of Corrections (DOC).

Summary:

Forgotten and abandoned. This feeling, while historically linked with the incarcerated population, has been accentuated due to the COVID-19 pandemic. The national response, or lack thereof, to this virus has pushed thousands of the incarcerated population into the hands of overworked and stressed medical health professionals. The lack of quality health care in prisons across the nation has unjustly wreaked havoc on the most vulnerable populations.[1]

While the pandemic was, and continues to be an ever-present threat to society, its effect across different communities is not uniform. The incarcerated population's lack of access to quality health care is compounded with the fact that prisoners are forced to shelter, eat and work in congregated settings, which does not allow the privilege of social distancing.[2] The health demands of incarcerated communities are unmet in many states, and health care providers must be aware of the full impact of poor health care access in these vulnerable communities in order to fulfill their roles as healers in our society. Physicians and health care providers must offer up their resources and time outside large healthcare systems in order to find and heal those in need. Universities across the nation have taken this call into their own hands and have begun to expose their enrolled medical students to the reality of in-prison healthcare.

While currently absent, a partnership between the University of Minnesota and the Minnesota DOC could go on to produce generations of caring, understanding, and highly-trained health care professionals for the incarcerated populations for years to come. This implementation, which would occur during M3/M4 year clinical rotations, would allow medical students to gain valuable experiences with patients who have high-risk exposure while concurrently providing students with educational opportunities on the major social determinants of health in underrepresented communities.

Not only will a partnership dramatically increase the quality of health care provided in prison facilities, clinical education in the prison setting has been proven to benefit underserved populations by increasing students' exposure to a variety of mental and physical health

[1] Wilper, A. P., Woolhandler, S., Boyd, J. W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The health and health care of US prisoners: results of a nationwide survey. American journal of public health, 99(4), 666–672. https://doi.org/10.2105/AJPH.2008.144279

[2] University, S. (2020, September 25). COVID-19 spread in American prisons. Stanford News. https://news.stanford.edu/2020/09/24/covid-19-spread-american-prisons/.

conditions and by allowing them to battle stereotypes that are built within institutional systems, bridging the gap between health care providers and the incarcerated population.[3]

Medical School Background:

A partnership between the University of Minnesota Medical School and the Minnesota DOC would encourage and prepare medical students to practice medicine outside of a traditional environment. The purpose of such a collaboration would be to help medical students understand that delivering efficient and effective health care to all populations is critical. Additionally, it is important to ensure that all patients are treated by an unbiased medical provider. There is a great responsibility to train medical professionals on the health disparities faced by incarcerated individuals. Compared to the general population, inmates have significantly higher rates of medical challenges, including infectious disease, substance use and addiction, and mental health issues.[4] The inadequate access to all health and medical services offered to the prison population ultimately contributes to the gap in socioeconomic status and exacerbation of injustice beyond the health sector.[5] To address the increased negative health outcomes, individuals who are incarcerated should be provided access to more comprehensive medical and health services. We advocate an effective partnership should establish appropriate healthcare practices in the medical school curriculum.

A primary focus for a successful partnership involves the implementation of correctional healthcare practices in years three and four of the medical school curriculum when students are on their clinical rotations.[6] The inclusion of medical practices in correctional facilities allows medical students to gain valuable experiences with patients who come from underserved and underinsured communities. This population suffers from chronic conditions (eg. asthma, hypertension, heart disease, and infectious disease), communicable diseases (eg. tuberculosis, hepatitis B and C, and sexually transmitted diseases), and mental health issues (eg. mental illness, suicide, and disability).[7] These acute and chronic conditions are exacerbated by a lack of adequate health care and feelings of isolation upon reentry into society.[3] A recent study by Cropsey, et al. found that there are notable gaps for medical services in most community correctional settings, and a majority of inmates report the lack of healthcare needs available to them while incarcerated.[8] The purpose of this partnership is to shed light on the challenges faced

[3] Brooker, R., Hu, W., Reath, J. et al. Medical student experiences in prison health services and social cognitive career choice: a qualitative study. *BMC Med Educ 18*, 3 (2018). https://doi.org/10.1186/s12909-017-1109-7
[4] Incarceration and Health: A Family Medicine Perspective (Position Paper). (2017, April). Retrieved April 25, 2021, from https://www.aafp.org/about/policies/all/incarceration.html
[5] Inequities are killing people on grand scale, reports WHO's Commission. (2010, December 08). Retrieved April 03, 2021, from https://www.who.int/mediacentre/news/releases/2008/pr29/en/
[6] Eaton112. (2018, March 02). Years 3 and 4. Retrieved April 03, 2021, from https://med.umn.edu/admissions/curriculum/years-3-and-4
[7] Incarceration and Health.
[8] Cropsey, K. L., Binswanger, I. A., Clark, C. B., & Taxman, F. S. (2021). The Unmet Medical Needs of Correctional Populations in the United States. *J Natl Med Assoc., 104*(11-12), 487-492.

by underserved communities that have minimal access to healthcare services due to the burden of incarceration. Furthermore, medical students will be able to witness the importance of primary care treatment for incarcerated populations, and more importantly, the direct impact upon their community.

This opportunity also opens the door for meaningful educational opportunities that give students a chance to learn the social determinants of health, particularly the significant health barriers faced by inmates and underserved communities. A recent study by Brooker and colleagues found that clinical education in the prison setting can increase learning exposure to a variety of mental and physical health conditions, sparking career interest in underserved populations.[9] Furthermore, this experience helped increase confidence, self-efficacy, and awareness of work as a prison doctor including battling stereotypes that are structured into institutional systems.

In addition to battling stereotypes ingrained in carceral systems, it is important to call attention to the vulnerability and health challenges that typically affect people in custody. When individuals are released from prison systems, the goal is to reduce recidivism rates. By having proper health care while serving their sentences, prisoner health may improve with the collaboration between the DOC and implementation of a curriculum where medical students can actively learn about and practice unbiased care. Furthermore, by exposing medical students to care of underserved populations early in their training, they will be more informed upon entry into residency where additional education can be implemented into the curriculum as they will be working more with a variety of patients on an individualized basis in their new roles as physicians.

Although 95% of incarcerated individuals will return to their communities upon release, even if a physician has not cared for an incarcerated person within a correctional facility, it is highly likely they will care for an individual who *has* been impacted by incarceration.[20] Proper education and understanding of the long term effects of incarceration is critical in order to provide adequate care and resources for those who are impacted. Providers may need to connect patients to individualized resources with the goal of reducing recidivism and improving health. The connection between criminal justice and health is powerful and is lacking with the current system.[10]

Another important consideration of prison health are recent studies highlighting the impact of telemedicine - both prior to and during the pandemic (primarily due to the ease in accessibility) - on increased feelings of isolation, further worsening health amongst incarcerated individuals. Video visits can promote access and efficacy, especially in rural areas, where distance from

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[9] Brooker, R., Hu, W., Reath, J., & Abbott, P. (2018). Medical student experiences in prison health services and social cognitive career choice: a qualitative study. *BMC medical education*, *18*(1), 1-9.

[10] Simon, L., & Tobey, M. (2019). A National Survey of Medical School Curricula on Criminal Justice and Health. *Journal of Correctional Health Care, 25*(1), 37–44. Retrieved April 12, 2021, from https://doi.org/10.1177/1078345818820109

medical specialists or hospitals may otherwise prohibit health care access. However, issues arise when sub-specialties such as "oncology, rheumatology, and hematology services" that are only recently being implemented with telemedicine,[11] hinder the process of connecting prisoners with the specific and adequate care that they need in a timely manner. There is also the concern that video visits may heighten feelings of isolation as they essentially remove the levels of engagement with the outside world. Bridging the gap between the prisoners and the healthcare system through medical students will allow many of these issues to be targeted and help reduce the disparities that exist within these institutions.

Not only does patient care via telemedicine increase the feelings of isolation that incarcerated individuals experience, it also decreases the quality of health care provided to these individuals in potentially life-threatening way*s.*[9] For example, oncologic surveillance often involves the physical examination of the patient in order to properly determine the disease progression, and if this examination is not properly carried out, then improper care is often administered.[12] The detrimental effects caused by the loss of physician-patient interaction is further enhanced by the "underqualified" physicians being provided to these incarcerated individuals. Physicians providing care to prisoners are rarely held accountable for negative outcomes and often supply negligent care to patients, which is exemplified by the following statement: "At least four doctors who were found to have one or more preventable prison deaths attributed to their care remained on staff in Illinois prisons".[13] If physicians were given the opportunity of clinical training in a prison setting, these negative effects could be significantly reduced.

Department of Corrections Background:

Individuals who have a history of incarceration face barriers to good health before, during, and after incarceration.[20] The current conditions within correctional facilities emphasize the lack of health care and resources accessible to inmates, which has ultimately led to an abundance of barriers. Furthermore, researchers have identified that the lack of access to adequate healthcare has played a major role in the increasing risk of illness and early death in prison populations.

Under the 8th amendment of the US Constitution, The Minnesota DOC is required by law to provide adequate healthcare to offenders.[21] The Minnesota DOC provides healthcare to its inmates through a variety of different avenues.[21] The DOC employs nurses, therapists and dental staff whereas contracted medical vendors provide doctors and psychiatrists.[21] In 2013, the

[11] Andrews, M. (2018, May 01). When inmates need a specialist, they often see the doctor by video. Retrieved April 03, 2021, from https://www.npr.org/sections/health-shots/2018/05/01/607354073/when-inmates-need-a-specialist-they-often-see-the-doctor-by-video

[12] Triantafillou, V., & Rajasekaran, K. (2020). A commentary on the Challenges of Telemedicine for Head and Neck Oncologic Patients during COVID-19. Retrieved April 13th, 2021, from https://doi.org/10.1177/0194599820923622

[13] Eldridge, T. (2019). Why Prisoners Get The Doctors No One Else Wants. Retrieved April 13th, 2021, from https://theappeal.org/why-prisoners-get-the-doctors-no-one-else-wants/

Minnesota DOC spent $68 million dollars on health services for its approximate 9,000 inmates across 8 state prisons.[21] Despite this large funding, there are still many areas in need of improvement. For one, there is not an adequate system in place to treat patients with chronic illnesses such as diabetes in place.[21] Furthermore, mental health services are not consistent. Oftentimes, inmates with mental illnesses are placed in solitary confinement where it may be difficult to receive proper therapeutic treatment.[21]

One study showed that when 15 incarcerated women were asked about their experience with DOC medical professionals, 14 of the 15 had a negative experience and all 15 felt as if they were treated as if they were undeserving of care.[6] This is very concerning and aligns with the statistic that timeliness of services for women was poorer for female inmates than men. The DOC has a policy that requires inmates to be examined within the first 30 days of arrival to a facility. In 2013, this happened for 97% of males while only for 18% of females.[21] The same trend was seen for mental health examinations.

More specifically, the most common medical issues that female inmates seek care for are alcohol and drug dependency, AIDS, STDs, pregnancy/gynecology related, obesity, diabetes and mental health. These medical issues are more prevalent in incarcerated populations than in the general population and disproportionately affect women living in correctional facilities.[14]
Infectious disease exposure is another common issue and is extremely disproportionate for inmates due to the current conditions of the living environment in facilities. High risk of disease transmission is due to, but not limited to, conditions including, “overcrowding; poor ventilation; poor nutrition; shared hygiene facilities; shared personal hygiene items such as soap and razors; poor health care; delayed diagnosis; lack of expertise in infection control; prohibitions against effective harm reduction techniques such as use of condoms; and practices such as amateur tattooing and piercing, unprotected sex, and use of unsterilized drug injection equipment.”[15]
Inadequate living conditions lead to poor long-term health after release. Reduced life expectancy is present for those with a history of incarceration.

The COVID-19 pandemic has highlighted the need for de-carceral strategies due to the fact that the United States has reported some of the highest infection rates of COVID-19. This is a desperate and immediate need in order to reduce incarceration rates and to further protect the incarcerated population, as well as society's well being as a whole.[22] Correctional facilities have not allowed for proper social distancing due to close proximity of the living quarters. The incarcerated population’s lack of access to quality health care is compounded with the fact that

[14] Young, D. S. (2000). Women’s Perceptions of Health Care in Prison. *Health Care for Women International, 21*(3), 219–234. Retrieved April 12, 2021, from https://doi.org/10.1080/073993300245276
[15] Massoglia, M., & Pridemore, W. A. (2015). Incarceration and Health. *Annual Review of Sociology, 41*(1), 291-310. Retrieved April 12, 2021, from https://pubmed.ncbi.nlm.nih.gov/30197467/

prisoners are forced to shelter, eat and work in congregated settings, which does not allow the privilege of social distancing.[16]

Methods:

We propose a partnership between the University of Minnesota Medical School and the Minnesota Department of Corrections (DOC) to develop a healthcare delivery program, with the aim of providing medical care within a state prison in close proximity to the University of Minnesota-Twin Cities campus. Initially a grant-based program, over time funding would transition from wholly to partially grant-funded and become a legislatively endorsed line item within the DOC budget.

Upon development of a curriculum and procurement of grant funding, the University of Minnesota (UMN) should establish a partnership with the DOC through a memorandum of understanding. Program planning should start with the formation of a program implementation group consisting of university faculty and administrators.[17] The implementation group will need to involve the DOC to coordinate onsite integration of medical school courses with requirements for faculty and student screening, training, and security protocols. Program advocates will also need to determine program funding and budgets; course learning objectives, core competencies, credits and schedules; and policies in the event of emergencies such as prison lockdowns. Program advocates will also need to plan recruitment strategies for faculty instructors and students, including holding informational sessions for interested individuals on program length, structure, and requirements, including background checks. Informational sessions should also address training requirements, including ethics trainings, and how faculty can apply to teach, including a statement of interest on serving diverse populations.

The program implementation group can refer to examples of successful medical school-prison partnerships at the University of New Mexico School of Medicine, Nova Southeastern University College of Osteopathic Medicine, University of Texas Medical Branch, and the Albert Einstein College of Medicine/Montefiore Medical Center.[18] These schools have well-established programs and curricula that can serve as models for the University of Minnesota Medical School program.

[16] University, COVID-19 spread..
[17] Walsh, B., & Delaney, R. (2020). First Class: Starting a Postsecondary Education Program in Prison. *Vera Institute of Justice.* Retrieved April 12, 2021, from https://www.vera.org/downloads/publications/first-class-post-secondary-education-in-prison.pdf.
[18] Min, I., Schonberg, D., & Anderson, M. (2012). A Review of Primary Care Training Programs in Correctional Health for Physicians. *Teaching and Learning in Medicine*, *24*(1), 81–89. Retrieved April 12, 2021, from https://doi.org/10.1080/10401334.2012.641492.

The University of Minnesota Medical School program curriculum should be a two-track course offering[19] to address disparate student interest levels. Medical students would elect to participate in the program during their third and fourth years as part of their clinical rotations. One course could target students with limited interest in prison health care, and another could target those with strong interest. For students with limited interest in prison health care, a two to four week prison health care curricula similar to existing ambulatory electives in homeless and geriatric health care could include physician observation and supervised care, supplemented by assigned readings and lectures to include discussions on the ethics of treating vulnerable populations.

Students with a strong interest in prison healthcare could intensively explore health issues common to the incarcerated population through a four to six week program, which would include the screening and treatment of learning disabilities, addiction and psychiatric health conditions in the corrections and post-release environments; therapies for high prevalence transmissible diseases, including HIV, Hepatitis C, influenza, viral enteritis and MRSA; delivery of women's reproductive care in the prison setting; and treatment of chronic disease in the aging prison population.

The program's evaluation would include subjective measures of successful implementation, such as DOC and prisoner responses, and medical students' perceptions, outcomes, and suggestions for improvement. Objective measures would include successful experiential and learning outcomes for participating medical students through course evaluations and a more sophisticated understanding of the difficulties inherent in health care delivery to the incarcerated population. Chart reviews and questionnaires with a verbal option for patients of low literacy would measure perceptions of respectful, quality health care delivery and health outcomes for the incarcerated population receiving the program's health care services. If successful, the partnership could be expanded to other University of Minnesota campuses and Minnesota prisons and prison populations in the state.

Challenges:

Providing standard health care to inmates continues to pose challenges for state departments of corrections. Many recurring issues from providing quality health care to patients include, but are not limited to, insufficient community-based support services, limited access to current technologies, lack of funding and expenses for community standard of care, inconsistent electronic medical records, and the generalized mistrust and fear coming from incarcerated individuals.

[19] Wakeman, S.E. & Rich, J.D. (2010). Fulfilling the Mission of Academic Medicine: Training Residents in the Health Needs of Prisoners. *Journal of General Internal Medicine: JGIM*, *25*(S2), S186–188. Retrieved April 12, 2021, from https://doi.org/10.1007/s11606-010-1258-4.

As discussed above, telemedicine, for example, is a tool that supports correctional health care through remote delivery and has cost benefits that reduces time and security for doctors to travel to correctional facilities.[20] This remote, real-time format encourages and provides physicians an opportunity to consult with patients without having to enter the prison environment. However, with the abundant features of telemedicine programs, the lack of current technologies, along with financial and time constraints, impedes the progress for inmates to access appropriate healthcare.[21] Before telemedicine became available in prison facilities, most care and consultation were delivered outside the prisons. The hidden cost of training and communications barrier associated with equipment use and technical support add to another roadblock of prison telemedicine. Although telemedicine programs are cost-effective and worth an investment, many state prisons face financial constraints. With many foreseeable challenges embedded in prison technology, such limitations and barriers hinder inmates' access to valuable care, as any standard care relies heavily on the use of effective technology.

Another cause of poor health care in the prison systems is the distrust that incarcerated individuals feel towards the medical system in general and physicians in particular. Many incarcerated patients suffer from mental illnesses and frequently are victims of sexual assault, violence, and have significant history of mistreatment from health professionals, all of which heighten the individuals' feelings of vulnerability as well as significantly hinder the ability to develop a mutual trust between themselves and the physician.[22] The presence of trust is necessary for incarcerated individuals in order for treatments to be accepted and effective. The problem arises when physicians lack the proper training to empathize with individuals in a vulnerable population such as those seen in prisons, and thus overall patient care is severely limited. However, if physician's are properly trained and exposed to these conditions while completing their medical school rotations, their ability to empathize with the incarcerated individuals and the gap of mistrust seen in the physician-patient relationship can be significantly improved.

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[20] Doarn, C., Justis, D., Chaudhri, C., & Merrell, C. (2005). Integration of Telemedicine Practice Into Correctional Medicine: An Evolving Standard. *Journal of Correctional Health Care, 11*(3), 253-270.
[21] Doarn, et al, Integration.
[22] Scarlet, S., Dreesen, E. (2017). Surgery in Shackles: What Are Surgeons' Obligations to Incarcerated Patients in the Operating Room?. *AMA J Ethics*. Retrieved April 13, from 10.1001/journalofethics.2017.19.9.pfor1-1709.
[20] Simon, L., & Tobey, M. (2019). A National Survey of Medical School Curricula on Criminal Justice and Health. *Journal of Correctional Health Care*, *25*(1), 37–44. https://doi.org/10.1177/1078345818820109
[21] Nobles, James. *Health Services in State Correctional Facilities*. Office of Legislative Auditor State of Minnesota, Feb. 2014, https://www.auditor.leg.state.mn.us/ped/pedrep/prisonhealth.pdf.
[22] U.S. News & World Report L.P. (2021). *Incarceration Tied to Early Death in U.S., Study Suggests*. U.S. News & World Report.
https://www.usnews.com/news/health-news/articles/2021-02-23/jail-incarceration-rates-tied-to-premature-death-study-suggests.

Conclusion

In conclusion, healthcare in correctional facilities would be extremely beneficial to University of Minnesota medical students, as well as those who are incarcerated, for a multitude of reasons. This program would allow medical students to gain the experience working with people who are in prison and to better prepare them for future patients that may have been impacted by incarceration. Additionally, this program would address and bring attention to the intersection of healthcare and prisons and, most importantly, create an opportunity for those incarcerated to receive care in a way that allows them to build relationships with Minnesota community members.