Stopping the Revolving Door:
How Health Centers Can Serve Justice-Involved Populations

Purpose

This publication highlights the ways in which community health centers can help meet the health and social needs of individuals exiting correctional institutions.

Introduction

American correctional institutions hold 2.1 million[1] people at any given time. Most of these individuals will eventually return to the community and have the opportunity to return to being productive members of the American economy. However, disproportionate amounts of them suffer from substance use and mental health challenges as well as physical health conditions that, if allowed to go untreated and unmanaged can prevent ex-offenders from accessing and maintaining employment and housing. In fact, rates of homelessness among people exiting correctional institutions range from 10-25% according to different studies.[2]

One of the most destabilizing events can happen immediately upon release from jail or prison – loss of access to medications and follow up health care appointments to maintain care and prevent conditions from worsening. Access to health care while incarcerated is provided in-house, and because external health insurance is typically terminated when a person is incarcerated, it can be difficult to reconnect to health care upon release. Some states allow benefits to be suspended, meaning ease of re-enrollment post release, while other states require benefits to be terminated post incarceration, meaning that the individual must start from the beginning of the enrollment process.[3] Suspending rather than terminating benefits is the effort states and counties have made to ease the process of re-enrollment in Medicaid programs. Commonly this re-enrollment process is part of discharge planning efforts. Health centers, with their expertise in benefit navigation, are uniquely poised in communities to serve as a bridge to provide much needed health care to people exiting correctional institutions and re-entry into society.

Health Needs of Justice-Involved Population

Justice-involved individuals tend to have complex, co-morbid health conditions, and those with mental health conditions are over-represented in the jail and prison population.[4] According to a report by the Bureau of Justice Statistics, approximately 40% of individuals in a jail or prison between 2011 and 2012 reported currently having a chronic health condition. The same study found that those in prisons or jails were more likely to have ever had a chronic health condition or an infectious disease when compared to the standardized general population.[5] In fact, since 2004, the rates of high blood pressure and diabetes increased among this population; and in 2012, 24% of those incarcerated had multiple chronic conditions at some point.

Another report showed that between 37% of those in prison and 44% those in jails have a history of mental health diagnoses, with the majority reporting a diagnosis of major depressive disorder.[6]

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[1] https://www.bjs.gov/content/pub/pdf/cpus15.pdf

[2] For a summary of studies looking at the rates of homelessness for people exiting jails and prisons: http://www.csh.org/wp-content/uploads/2016/10/References-10-7-16.pdf

[3] http://www.naco.org/sites/default/files/documents/Suspension-termination_2015.pdf

[4] https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[5] https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf

[6] https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

This study showed that those in jail were more likely than those in prison to meet threshold criteria for serious psychological disorder within the past 30 days, and both were more likely to meet the threshold than the standardized general population.

According to the National Health Statistics Report, jails and prisons provide some form of medical services and behavioral health care, though the types of services and methods of delivery vary greatly by state.[1] In many cases, physical health care may not be provided by the same provider as behavioral health care, leading to potential fragmentation of care. Furthermore, even when services are available, many individuals may not engage in care as just over 50% reported satisfaction with health services.[2]

Upon release, individuals can be provided with a 30-day supply of any medication they had been receiving, but without proper coordination of care, the continuity of treatment may be interrupted, and conditions may be left unmanaged. Persons may be discharged with prescriptions, but without health insurance coverage to pay for medications, the prescription is just a piece of paper. Even when an individual is able to access health care upon re-entry, their medical records often do not come with them, leading to an information barrier that can cause providers to duplicate diagnostic services. Those individuals who face housing instability and homelessness upon release may also have difficulty keeping medications safe and accessible.

To better address the health needs of the justice-involved population, health center providers can work to engage individuals in care, provide appropriate, patient centered services, and coordinate with other health care providers to ensure continuity of care upon release from jail or prison. Systems as well as individual linkages need to be developed between health centers and local criminal justice institutions to address continuity of care issues.

Roles Health Centers Can Play

Health centers have begun to take a leading role in providing care for formerly incarcerated individuals. A review of several programs across the country has found three examples of programming at health centers aimed specifically at the justice involved population. This report will highlight three examples of how health centers provide health care to justice involved populations. This is not an exhaustive list, and there are still opportunities for additional expertise and innovative ideas to serve formerly incarcerated individuals.

[1] https://www.bjs.gov/content/pub/pdf/nsphcsf.pdf
[2] https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf

Case Studies

La Clínica North Vallejo and the Transitions Clinic Network

"Many patients come in with a lot of mistrust and negative experiences with the health care system. Community Health Workers and peers help build trust. Their experience lends to their credibility." –Maria Reyes, Community Health Education Manager, La Clínica de la Raza

La Clínica is a 47-year-old community health center based in Solano County, CA with a deep understanding of the social determinants of health. Recognizing a need to better serve people interacting with the state prison and local jail, La Clínica sought grant funding to start a Transitions Clinic[7]. The first patient within the Transitions Clinic program was seen in September 2016 with 70 participants by January 2018. The Transitions Clinic is integrated within one of the La Clínica health center sites in the community to avoid any stigmatization that may occur by separating the re-entry population from the larger patient population.

The cornerstone of La Clínica's Transitions Clinic program is their ability to engage with both patients and local partners. The community health worker begins engagement while potential clients are incarcerated, sometimes offering virtual case management services in the county jail, which helps build a relationship and facilitate connections upon release. The case manager is able to determine the individual's health needs including whether they have a primary care provider, their chronic conditions, and any mental health or substance use treatment needs. Part of this process also involves working with a Human Services Specialist to ensure individuals are connected to health insurance to facilitate access to care, and working to get the individual access to any benefits they are eligible for.

Potential participants for the program are identified through relationships with local partners, including the Center for Positive Change, part of the local probation office, though they are seeing more clients coming to the program through word of mouth. Program eligibility is somewhat flexible, though most participants have one chronic condition, including medical, mental health, and/or substance use conditions, and have been incarcerated in the last six months. Individuals who were already patients at La Clínica and met the criteria were allowed to participate.

The program staff consists of a part-time primary care provider, part-time Community Health Education Manager, part-time database manager, and one full-time community health worker with a lived experience of interacting with the justice system. Their personal experience allows them to fill the role of a peer support worker and helps to build trust with clients as they conduct outreach.

In addition to grant funding for this program, the local Medicaid health plan has supported this initiative and will be tracking emergency department visits as an outcome measure. The local safety net hospital has also partnered with La Clínica on the Transitions Clinic program, which has already demonstrated improvement in outcome metrics they are tracking.

To date, the program has received 77 referrals, with 91% of clients successfully assessed and engaged in services at La Clínica upon release. There has been a marked improvement in the health status of (43%) of the participants, including better control of blood pressures, and mental health illnesses (50%), through the resources, services, and referrals provided. Unsurprisingly, many individuals engaged in the program initially identified housing and food security as major unmet needs. Program staff work to identify potential housing options in a tight housing market,

[7] http://transitionsclinic.org

and continue to provide care to individuals once housed, though acknowledge that there is a lack of appropriate housing options available.

Unity Healthcare

"We have providers, who if it is their desire, can work 2 days in the jail and 3 days in the community… they can say, 'Come see me at this location' and on release they become the primary care provider. [Health Centers] are in a good position to do that, we're in the community, in shelters." –Janelle Goetcheus, MD, Unity Healthcare

Unity Healthcare is a health center program grantee committed to providing health care in Washington D.C. Established in 1985 as a health care for the homeless program, Unity Healthcare has expanded to over 20 physical and mobile locations throughout the District.[8] Since 2010, Unity Healthcare has contracted with the local jail to provide comprehensive health care for those who are incarcerated.

When individuals are booked and are brought to the jail, providers from Unity meet them upon arrival for an evaluation as part of the intake process. A portion of Unity's primary care providers work within the D.C. jail full time, while others spend two days per week in the jails and three days in a community setting. Providers who split their time between the jail and the community are able to build relationships with individuals that can be continued upon release.

The D.C. jail also has psychiatrists available through Unity with other mental health services and mental health step-down units. Unity has found that over one-third of the individuals they see in the jail have significant mental health issues that may be better served in a hospital setting. To provide more adequate care, there is a Licensed Clinical Social Worker on site and designated "safe cells." Despite these strides, challenges persist with provider capacity and Unity is exploring options related to telemedicine. A large number of individuals in the D.C. jail were incarcerated for substance related infractions. The D.C. government has implemented a substance use treatment program to focus on recovery among the population.

Upon release, protocol dictates that individuals are provided a 30-day supply of their medications. In that time, they are expected to establish a relationship with a primary care provider to continue their care. For those in the D.C. jail who continue seeking care with Unity, electronic health records are shared between the jail and the health center. This helps to mitigate the significant challenge health providers working with this population face in providing continuity of care as there is frequently no coordinated way to access an individual's medical records from their time in jail or prison. Providers must often duplicate diagnostic tests and restart the treatment planning process.

As Unity has a large network, their efforts extend beyond the walls of the jail. Providers also work with those who have re-entered the community from both the local jail and prisons around the country (as Washington D.C. does not have a prison). A large number of these individuals face homelessness or housing instability upon their release. Many reside in local half-way houses or re-entry focused housing. Unity strategically provides mobile services in close proximity to these communities and provide transportation assistance for those who need assistance getting to appointments. Unity also partners with other housing and service providers around the District to provide holistic care to individuals re-entering the community.

[8] https://unityhealthcare.org/mission-and-leadership/

Colorado Coalition for the Homeless

"We believe that Housing is Health Care – We see it every day. People can't address the health and mental health needs on the street – they do, but it is often through emergency services." –Carrie Craig, MSW, LCSW, Director of Housing First and ACT Services, CCH

Colorado Coalition for the Homeless (CCH) provides over 59 programs involving health care, housing, and supportive services to people in and around Denver. In 2016, they along with several city and county partners launched an innovative initiative called the Denver Supportive Housing Social Impact Bond (SIB) Initiative. Financed through an $8.6 million public/private investment, the program aims to provide permanent supportive housing and wraparound support services to 250 of Denver's most frequent homeless users of the criminal justice system.[9] The unique financing model means that investors will be repaid if the programs achieve the agreed-upon outcomes of housing stability and reduced use of the county jail. Because they have a full-services Health Care for the Homeless (330h) health center that is co-located with housing on-site as well as housing developments elsewhere in the community, CCH can offer services to program clients using modified Assertive Community Treatment (ACT) approach. Paired with deeply subsidized rental vouchers and an apartment to live in, clients of the Denver SIB can begin their road to stability.

Carrie Craig, Director of Housing First and ACT Services at CCH noted that assertive community treatment (ACT) ACT-like models are the most appropriate service approach for high utilizers of multiple systems, including the justice system, who are often tri-morbid with physical and mental health challenges along with substance use disorders. The service teams are multidisciplinary, with nurses on the team and psychiatric nurse practitioners along with mental health clinicians and case managers. ACT services are highly individualized and are delivered in the comfort of a person's home. The services provided by CCH for this program are partially reimbursable by Medicaid (Colorado is a Medicaid expansion state), and the investment in the program covers the funding gaps, though the goal is to move to greater proportions billed to Medicaid after sorting through issues relating to rates and adjusting to a more "whatever it takes" service model rather than bundled rate limit of one visit per day (many clients have untreated mental health disorders and are much higher need).

CCH does a lot of work to mitigate the impact that decades of justice system involvement has on clients' lives. There is increased communication and coordination with the Denver Police Department as part of the project. The program has increased coordination with judges, and CCH service teams advocate for clients in court and if possible pay outstanding fines and offer community service opportunities. They have a law firm partner offering free legal services for clients, and they will accompany clients to probation or parole meetings to demonstrate progress achieved through the program.

This program is being evaluated by the Urban Institute in a five-year randomized controlled trial study. According to Urban's first brief on housing stability outcomes, published in October 2017, the program was meeting interim benchmarks of housing stability and 64% had not returned to jail during the interim study period. The final report on reduction in jail recidivism for this program will be available in 2021. CCH's SIB program is growing, with a new, single-site supportive housing development that is located very near their Stout Street Clinic. With the ACT-like service approach delivering critical mental and behavioral health care in clients' homes and the health

[9] https://www.urban.org/research/publication/denver-supportive-housing-social-impact-bond-initiative-housing-stability-outcomes

care services located very nearby, the platform for recovery, success, and community engagement will take shape.

Conclusion

The organizations highlighted in this report have taken significant steps toward meeting the health care needs and housing needs of justice involved populations. This may be credited to their dedication to building and sustaining partnerships in their community and working with jails, prisons, housing providers and other stakeholders who share their mission and vision.

Recommendations:

- If your state terminates, rather than suspends public benefits, advocate for them to consider suspension rather than termination of public benefits. Share information about the cost savings for county and state budgets when this occurs
- Learn about service models like Transitions Clinic Network
- Engage stakeholders in the justice system – police and probation departments, discharge planners at the jail, specialty court administrators. Build systemic linkages with these partners.
- Consider how a health center's expertise in health coverage navigation can assist returning citizens
- Establishing a record-sharing system (EHR) between health center and jail for justice-involved patients who wish to continue primary care at health center. Ensuring confidential and privacy practices of shared confidential patient health information.
- Participate in your community's homeless Coordinated Entry System so that patients who have exited correctional institutions may have access to shelter and permanent housing. Learn more about how to do this by reading CSH's brief on health centers and homeless system partnerships: http://www.csh.org/wp-content/uploads/2017/05/Coordinated-Entry-and-Health-Centers-1.pdf
- Learn about how to create health center and supportive housing partnerships:
    - Health and Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers
    - Resources for Building Health Center and Housing Partnerships: Literature Review and Resource Bank
    - FUSE Tutorial for Health Centers: This online virtual training goes through the various ways health centers can partner to deliver supportive housing for homeless frequent users of jails and other public services.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) # U30CS26935, Training and Technical Assistance National Cooperative Agreement (NCA) for $450,000 with 0% of the total NCA project financed with non-federal funds. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.