Transitions Clinic Network

Best Practices for Engaging the Reentry Population in Health Care

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Adults incarcerated in jails and prisons suffer from a high incidence of chronic health conditions and have significant medical and behavioral health care needs. While health conditions are often exacerbated by incarceration, the reentry period presents additional challenges to ensuring returning community members are engaged in necessary ongoing care. As state policymakers and health care providers develop initiatives to address systemic barriers to care, it is critical to also implement best practice patient engagement strategies to meet the unique medical and social needs of this vulnerable patient population, reducing negative health outcomes for the individuals and communities impacted by mass incarceration.

Reentry Health Needs

People who are incarcerated have higher medical, mental health, and substance use disorder treatment needs than the general population [1, 2, 3]. Additionally, with stricter sentencing laws leading to longer prison terms, people are both aging in prison and developing chronic conditions at an earlier age [4, 5]. Carceral environments further exacerbate health conditions, by, for example, exposing incarcerated individuals to infectious diseases through confined living spaces and lack of access to evidence-based harm reduction resources [6, 7]. Upon release, returning community members are at dramatically higher risk of poor health outcomes. In the two weeks following release, this population experiences more emergency room visits and hospitalizations, and has 12 times greater risk of death, including 129 times higher risk of death by overdose [8, 9]. Individuals returning from incarceration have many competing social demands and are often returning to under-resourced communities that lack sufficient health and reentry supports to meet their complex needs. Coming home from the highly structured carceral health systems that prioritize security over privacy and autonomy, patients can be ill-equipped to manage their medical conditions and navigate overwhelming community care systems [10, 11]. The health conditions of returning community members tend to worsen upon release, impeding employability, preventing financial gain and housing stability, and increasing the risk of recidivism [12, 13, 14].

Key Terms:

Returning community member: a person who is reentering their community following a period of incarceration.
Jail: where people serve a shorter period of incarceration or are detained pre-trial/ pre-sentencing.
Prison: where people serve a longer period of incarceration.
Probation: community supervision instead of or following incarceration.
Parole: community supervision following incarceration.

Every year in the US, more than ***650,000*** *people are released from prison and* ***9 million*** *more return to their communities from jail.*

Upon return, they are some of the ***sickest*** *and most* ***vulnerable*** *members of society.*

Transitions Clinic Network developed this brief to guide ***policymakers*** *and health care* ***providers*** *to effectively care for returning community members.*

Challenges of Care Continuity

A lack of continuity of care between carceral and community health systems causes short-term issues, such as patients leaving incarceration with limited to no supply of necessary medications, and is a significant contributor to long-term adverse health outcomes. Care is disrupted upon release due to **health system isolation, gaps in insurance coverage, limited pre-release planning, and discrimination** against patients who have been incarcerated.

Carceral health systems are isolated from community health care systems and there is little to no sharing of medical information between corrections and community providers [15, 16]. The Medicaid inmate exclusion policy in many states eliminates incarcerated people from federally funded Medicaid coverage, except for offsite inpatient services, and there is a gap in coverage as patients transition from carceral health care to community-based coverage [17]. Coverage through Medicaid is suspended or terminated when one is incarcerated, and patients typically cannot activate Medicaid until back in the community.

Community clinics often will not pre-schedule appointments for patients without active coverage. These gaps in care are especially problematic for patients with high-risk medical conditions requiring time sensitive interventions and the care of multiple specialists. While it is federally mandated to provide basic medical care inside carceral institutions, there is no legal mandate nor incentives for conducting discharge planning to ensure continuity of care [18].

Release planning is complicated by institutional structures of the carceral system, including limited patient interaction; rapid, unanticipated or fluctuating release dates; and the location of release being determined by the conditions of one's probation or parole supervision rather than by where a patient's health conditions will be best treated.

Community-based health systems are not incentivized to be involved with pre-planning for health care reentry and lack access to patient information about who is releasing when and where. Additionally, community clinics may be ill-equipped to meet the complex medical and social requirements of reentry and may struggle to accommodate these high-risk patients in a timely manner [19, 20].

Compounding the systemic barriers to accessing care, patients' experiences of stigma and discrimination within carceral and community health care systems impact engagement in health care services [21]. One study found that when identifying as formerly incarcerated, patients were half as likely to obtain a new patient appointment [22]. Health care discrimination against returning community members augments the racism already experienced by individuals of color (who are overrepresented in the carceral system).

Racism and discrimination are further compounded by the collateral consequences of legal system involvement– the thousands of policies that restrict people with criminal records from obtaining their basic housing and employment needs [23]. Given these barriers and past trauma to this patient population, clinical policies may further inhibit engagement when they are not patient-centered or are perceived by the patient as punitive, mirroring the punitive criminal legal system [24].

Spotlight California Innovations
TCN Model of Patient-Centered Care

California, where tens of thousands of people release from prison annually, the majority of whom have complex medical needs that require ongoing care in the community, has been the site of advances in reentry care delivery.

The Transitions Clinic Network (TCN) developed a new model of care for the reentry population through partnership between their San Francisco-based primary care team, local community-based organizations, and system-impacted community members. This model developed out of deep listening and shared problem solving, and is grounded in wisdom from the community.

Central to the TCN Model are community health workers (CHWs) with lived experience of incarceration. TCN hires and trains CHWs to **integrate into the primary care system**, **engaging and supporting patients** returning from incarceration and **serving as liaisons** to navigate health and social services. The shared history between CHWs and patients helps build a trusting and engaging relationship, which leads to better health outcomes for patients.
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Principles of Patient-Centered Care
as defined by the community:

- Empower patients.
- Define health and wellbeing broadly.
- Integrate people and communities impacted by incarceration into program design, implementation, and evaluation.
- Provide services tailored to population needs but not separate from community-based systems.
- Transform systems, including hiring, training, and staffing people with lived experience of incarceration.
- Avoid replicating the criminal legal system.

"Despite the evidence supporting community health workers with lived experience of incarceration helping patients transition from incarceration, there are still biases and barriers to us doing this work."

— Joseph Calderon, Senior CHW

Since 2006, TCN has trained over 48 primary care systems nationally to provide culturally appropriate services to people coming home from incarceration. A randomized controlled trial at Southeast Health Center, the flagship TCN clinic site in San Francisco, found that people leaving incarceration with chronic conditions can be engaged in primary care, with the tailored TCN intervention resulting in a **51% reduction in overall emergency room utilization** in a year compared with patients in standard primary care [25].

Further, TCN programs have been found to **reduce patients' preventable hospitalizations by half, shorten hospitalizations by almost one full day, and reduce technical violations of parole and probation** resulting in 25 fewer incarceration days in the first year after release [26].

These studies emphasize the important role primary care clinics can play in serving the reentry population and the impact of hiring CHWs with lived experience of incarceration. The TCN model of care– spanning from pre-release relationship building to ongoing case management in the community– applies best practices to promote meaningful engagement and improved health outcomes.

Spotlight California Innovations
Policy Initiatives to Improve Access to Care

California, with the largest state Medicaid system in the nation (Medi-Cal), has been a leader in developing initiatives to improve coordinated care for low-income residents with complex needs. These advances paved the way for California Advancing and Innovating Medi-Cal (CalAIM), a comprehensive, five-year initiative that includes particular emphasis on justice-involved individuals.

2010
The Patient Protection and Affordable Care Act (ACA)
Expanded Medicaid eligibility, resulting in 80-90% of returning community members in Medicaid expansion states, such as CA, being eligible upon release [27].

2013
CA Assembly Bill No. 720
Authorized the suspension of benefits up to one year during incarceration (rather than immediate termination) and allowed counties to process Medi-Cal applications while applicants are still incarcerated [28].

2016
Whole Person Care Pilots
Person-centered approach to integrated medical, behavioral health care, and social services for Medi-Cal beneficiaries with complex needs. Nine counties focused their pilot programs on justice-involved populations [29].

2018
Health Homes Program
Improved care management and coordination for Medi-Cal beneficiaries with chronic conditions and complex needs.

2018
California Medication-Assisted Treatment (MAT) Expansion
Multidisciplinary teams from 37 CA counties have participated in the Expanding Access to MAT in County Criminal Justice Settings Project [30].

2020
Integrated Substance Use Disorder Treatment (ISUDT)
The California state prison implemented the ISUDT program to provide medications for opioid use disorder in state prisons and support staff for release planning.

2022
CalAIM includes multiple opportunities to address gaps in care for people transitioning from incarceration to communities:

- An exception to the Medicaid inmate exclusion policy, if approved by the Centers for Medicare and Medicaid Services, will give **access to Medi-Cal for people who are incarcerated**, creating opportunity to engage with patients in care coordination up to 90-days prior to release [31].
- The role of the **pre- and post-release care managers** has potential to engage patients in transition planning and post-release connections, offering a vision of increased patient involvement and improved coordination between siloed systems [32].
- Statewide mandates strengthen expectations for **pre-release care coordination**, including mandates for county jails to enroll patients in Medi-Cal and to provide warm hand-offs to county behavioral health to improve continuity of care [33].
- **Enhanced Care Management** (ECM), a benefit offered by managed care plans in the community, aims to provide tailored intensive care coordination to increase patient engagement [34]. People reentering the community from incarceration are an ECM population of focus, and ECM will create more sustainable funding for CHWs.
- Additional **Community Supports** (also known as In Lieu of Services) aim to address social determinants of health, acknowledging barriers to care and that care interventions must be holistic [35].

Best Practices for Patient Engagement

Despite policy changes developed to strengthen reentry continuity of care, significant gaps remain between carceral and community health systems. While expanded insurance eligibility and enrollment may enhance health care access, it does not ensure ongoing engagement in care, which is critical to improved health outcomes [36]. This was demonstrated with the ACA, when increased access to Medicaid through expansion did not always result in patients consistently utilizing health care services [37, 38]. In California, while the ACA did increase the proportion of individuals enrolled in Medi-Cal services post-release, only 36 percent of returning community members utilized Medi-Cal services in 2016 [39]. Best practices to meaningfully engage patients coming home from incarceration in their health care are built on the principles of patient-centered care and include:

- Promoting systems and health care professionals dedicated to listening, building trusted relationships, and shared problem-solving and decision-making between patients and providers.[40]
- Supporting organizational and professional practices to personalize interactions with patients, emphasizing positive initial encounters to support follow-up.[41]
- Ensuring care coordination starts as early as possible prior to release from incarceration, facilitated by partnerships between carceral and community health systems to facilitate reentry planning.[42, 43]
- "High intensity" interventions in the weeks immediately following release as well as long-term services for health care, social services, housing, transportation, employment, and other supports.[43]
- Integrating medical and behavioral health to provide coordinated care for reentry patients with co-occurring chronic conditions.[44, 45]
- Hiring and integrating into the care team specially trained community members with shared lived experience of incarceration to act as supportive, relatable community health workers. Studies have shown trained community members to be effective for engaging patients leaving incarceration in various health areas, including HIV care and mental health services.[46]

Recommendations to Ensure Policies Align with Practice

State-level policymakers are increasingly recognizing that returning community members are a medically complex patient population with multiple social determinants of health that must be holistically addressed to improve health outcomes. Increasing access to care is a necessary component of improving health outcomes, but, particularly with this patient population, improving access unto itself is not sufficient. Community-led patient engagement is critical to ensuring that individuals choose to utilize the newly available resources and services.

Additionally, the broader social context and history of this population must not be ignored. For generations, the United States has invested in the carceral system instead of in the community health system, systematically disenfranchising the Black and brown communities most impacted by mass incarceration while perpetuating the social determinants of health current initiatives are aimed at addressing. Without intentional, community-driven development and implementation, policies meant to improve the reentry population's health outcomes risk extending the carceral system into the community health system, rendering these policies not only ineffective but further harming the very populations they are aimed at benefitting.

Ensure people with histories of incarceration are included in ongoing policymaking:

People who have been incarcerated must be involved, meaningfully and consistently, in each step of developing policies aimed at improving the reentry population's health outcomes. This means listening to and collaborating with people who have lived experience of incarceration, in ways that are both comfortable and accessible for these most vital stakeholders, while respecting them as experts on the issues affecting their lives. Their insights, ideas, and buy-in are essential to the success of any policy, while policies that are not patient-centered will not enhance patient engagement and will therefore fail to improve health outcomes.

This involvement should not end at policy development but must continue through implementation. Particularly in the field of reentry health care, the evidence supports that those with lived experience of incarceration are uniquely qualified to improve the health of others leaving incarceration [47, 48, 49]. For example, rather than generally-trained care managers implementing pre-release planning or post-release enhanced care management, best practice patient engagement principles and evidence support having services provided by culturally competent CHWs with lived experience of incarceration who can span the continuum of care from incarceration to community and help overcome stigma for patients transitioning from incarceration. If patients cannot relate to or trust their health care teams, they are unlikely to engage in ongoing services.

Policymakers, health plans, and primary care clinics are positioned to advocate for the value of CHWs with lived experience to best serve their peers and to advocate for the elimination of barriers to them doing so. CHWs with lived experience of incarceration face barriers to accessing patients who are incarcerated, including lack of information sharing, limited time for patients to meet with health care staff, limited telehealth infrastructure, and background checks that restrict health care workers who have been previously incarcerated. State decision-makers should create standards for involving CHWs with lived experience of incarceration in the implementation of pre-release in-reach and enhanced care management, including requiring

facilities to revise their security policies to permit CHWs with incarceration histories, in their professional capacity as health care workers, to perform in-reach to incarcerated patients. For enhanced care management funded by managed care plans, states could require health plans to address, in their submitted models of care, how they are incorporating people with lived experience, and utilize that incorporation as a metric when considering which programs to fund. Given the systemic barriers to CHWs with incarceration histories performing the critical work of patient engagement, as well as the deep-rooted history of discrimination in the health care field against individuals who have been incarcerated, policies aimed at benefitting this population must explicitly call for the inclusion of CHWs with lived experience of incarceration as those best positioned to serve this patient population.

On the provider side, community primary care clinics can respond to the complex needs of the reentry population by implementing evidence-based care practices, including hiring staff with lived experience of incarceration on their enhanced care management teams. In addition to improving patient outcomes, the community-based health care system can play a role in reversing the harms of mass incarceration by creating job opportunities and hiring practices that are not only inclusive of people with criminal records, but that leverage the lived experience of incarceration as an asset for serving patients.

Prioritize the role of the primary care system in care transitions:

To close the gaps in reentry health care, the carceral system and the community health system must effectively collaborate. The community primary care system is key in serving underserved patients, engaging patients in long-term health care, and supporting the reintegration of returning community members into existing community-based health care services. Warm hand-offs from corrections to the primary care system for medical care must be mandated, or the process both risks ongoing delays in primary medical care for people with chronic health needs leaving incarceration and perpetuates the lack of information sharing between carceral and community health systems. Policies should include an explicit expectation that pre-release services not only include a warm hand-off to post-release behavioral health, but also to the entity responsible for a patient's primary health care, which includes the sharing of medical records.

Policy proposals that do not provide financial or programmatic support for the community primary care system will fall short of goals to improve the health of the reentry population. Using incentive funds to invest in the redesign of the community-based primary care system, such as health systems building capacity by adopting evidence-based models of care to serve the reentry program, could help care managers to more effectively engage and serve people coming home from incarceration. Additionally, if policymakers do not specify which system is to be responsible for which component of the transitional planning, and what sector of workers are to perform the enhanced services, it is possible to foresee circumstances in which reentry health care becomes more, not less, disjointed than it currently is, and where funding is utilized to expand the carceral health system instead of to strengthen the community health system so that it may better meet the needs of returning community members.

Create continuity in funding mechanisms for care management services provided pre- and post-release:

Having different funding mechanisms for care management services provided pre-release and post-release would be a shortcoming of policy proposals aimed at increasing care continuity, as it is challenging for community-based providers to manage multiple funding streams along with the other challenges of providing effective reentry case management. For example, in California, it is proposed that pre-release services are billed fee-for-service and community-based services are billed through Medicaid managed care plans at the county-level, which do not become active until following release. A transition of services from fee-for-service to managed care plans taking place in the community following release would create potential for additional gaps in services, requiring more hand-offs from one service to the next. For instance, enhanced care management providers could be serving a patient immediately following release under fee-for-service, then be unable to further serve the client if they are not contracted with the member's managed care plan. Billing for enhanced care management is further complicated by having to contract with multiple payers, and policies should aim to simplify, rather than complicate, these billing mechanisms.

Best practices dictate continuity of care across systems and utmost collaboration between corrections and community-based providers. Continuity in funding for services provided pre-release and post-release would support community-based providers who can provide longitudinal care to follow patients through their entire transition into the community, as well as minimize the gap in health care coverage patients currently experience upon release.

If made possible through available reimbursement structures, health plans can engage patients in managed care prior to release from incarceration. In instances where pre-release services are solely funded by fee-for-service funding structures, health plans should work closely with providers who are working with patients pre-release to ensure information sharing and seamless transition of care to the providers who will work with the patients in the community.

Fund the full spectrum of reentry services:

The perpetual punishment of conviction lasts long after one releases from incarceration, and, nationwide, there are more than 44,000 collateral consequences of conviction that make it incredibly difficult for an individual to rebuild their life and reenter their community [50]. Individuals with histories of incarceration are 10 times more likely to be homeless, and face significant barriers to stable housing, employment opportunities, financial stability, educational advancement, transportation, family reunification, technology skills, and more, impacting their health and ability to engage in health care [51, 52]. To improve health and quality of life for returning community members and other populations with complex needs, it is beneficial for health care initiatives aimed at transforming care access to include non-clinical community supports to address social determinants of health. One-time, short-term supports (such as transitional housing, a housing deposit, or food supports following hospitalization) are a start in supporting patients' stability to engage in care, but state Medicaid systems should leverage existing systems to expand these services to address more multifaceted ongoing reentry needs.

Policymakers should consider how to incentivize robust community supports across entire states, while focusing not only on the reentry period but on serving people involved in the full spectrum of the criminal legal system to proactively address root causes of incarceration and poor health outcomes associated with incarceration. Additionally, while there is overlap in the populations, the interventions for engagement in the jail and prison populations should occur at different points. For those incarcerated in prisons, there is more opportunity to engage pre-release because those individuals are generally serving longer sentences and release dates are typically planned. For those incarcerated in jails, engagement should occur in the community because those individuals are generally serving shorter sentences or have not yet been sentenced, and there is little to no release planning. For the short-term jail population, investments should focus less on enhancing jail-based programming and release planning, and more on investing in bolstering the community-based mental health, housing, and primary care systems, to halt the revolving door from the community to jail.

Further, opportunities should be explored to implement enhanced care management and community supports for people at risk of incarceration rather than only following release, such as through probation programs or programs for pre-trial diversion. Research shows that health care disparities also exist in the population of people sentenced to probation; community supports to meet basic needs could be beneficial to possibly prevent worsened health outcomes and prevent incarceration in this at-risk population [53].

Key Recommendations:

- Include returning community members in program development and policymaking, including ongoing CalAIM stakeholder discussions.
- Incentivize the integration of people with lived experience in program implementation and evaluation through policy and funding.
- Integrate CHWs with lived experience of incarceration in pre-release care coordination and community-based Enhanced Care Management (ECM).
- Provide funding incentives for primary care clinics to adopt evidence-based models to care for the reentry population and to hire staff with lived experience of incarceration.
- Create consistent funding streams for services provided pre-release and post-release to reduce gaps between carceral and community systems.
- Build capacity of the carceral system and primary health care system to collaborate pre-release and engage in warm hand-offs at time of release.
- Incentivize robust Community Supports (CS) that address the breadth of ongoing non-clinical reentry needs patients have post-incarceration.
- Implement ECM and CS for people at risk of incarceration to address health disparities and divert from prison/jail.

An Unprecedented Opportunity to Eliminate Health Disparities

Standard models of health coverage and care provision do not serve all populations equally; the reentry population has suffered poor health outcomes from systems that do not serve their unique medical and social needs and that fail to address the trauma and stigma associated with incarceration. Recent policy developments such as CalAIM present an unprecedented opportunity for policy- and systems-level changes to better support the reentry population, which will serve as a model for other states.

These initiatives must be informed by the known best practices and evidence-based models for engaging adults with chronic health needs releasing from incarceration into ongoing primary care services – including involving justice-impacted communities in systems change, leveraging the power of CHWs with lived histories of incarceration and reentry, enhancing collaboration between carceral and community health systems for reintegration, and shifting care environments to be less punitive and more healing and patient-centered. State decision-makers, health plans, and the community primary care system should take every opportunity to shape policies and systems by these best practices with the goal being meaningful engagement and the elimination of health disparities.

Authors: Divakaran, Bethany; Shavit, Shira; Steiner, Anna.

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www.transitionsclinic.org TCNinfo@ucsf.edu

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