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Integrating Correctional And Community Health Care For Formerly Incarcerated People Who Are Eligible For Medicaid

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Abstract

Under the Affordable Care Act, up to thirteen million adults have the opportunity to obtain health insurance through an expansion of the Medicaid program. A great deal of effort is currently being devoted to eligibility verification, outreach, and enrollment. We look beyond these important first-phase challenges to consider what people who are transitioning back to the community after incarceration need to receive effective care. It will be possible to deliver cost-effective, high-quality care to this population only if assistance is coordinated between the correctional facility and the community, and across diverse treatment and support organizations in the community. This article discusses several examples of successful coordination of care for formerly incarcerated people, such as Project Bridge and the Community Partnerships and Supportive Services for HIV-Infected People Leaving Jail (COMPASS) program in Rhode Island and the Transitions Clinic program that operates in ten US cities. To promote broader adoption of successful models, we offer four policy recommendations for overcoming barriers to integrating individuals into sustained, community-based care following their release from incarceration.

January 1, 2014, marked the beginning of the Affordable Care Act's Medicaid expansion, which made health care coverage available for an estimated thirteen million formerly uninsured US adults.[1] As of December 13, 2013, twenty-five states and the District of Columbia had decided to participate in the expansion by broadening eligibility to adults who are younger than sixty-five and whose incomes do not exceed 138 percent of the federal poverty level.[2] The number of people eligible for Medicaid will increase if other states also decide to expand this coverage (states face no deadline for deciding to expand).

Expansion of affordable coverage in the United States is one of the three major goals of the Affordable Care Act, along with decreasing the cost and increasing the quality of health

care. A substantial subset of the population that is newly eligible for Medicaid coverage consists of justice-involved individuals—that is, people who are incarcerated, on probation, or on parole. As many as 2.86 million, or 22 percent, of the anticipated 13 million adults newly eligible for Medicaid will be justice involved.[3]

These numbers should not come as a surprise. The United States has the highest rate of incarceration and the largest number of incarcerated individuals in the world.[4] The statistics are staggering: More than 2.2 million adults are incarcerated, more than one in a hundred are in prison or jail, and more than seven million are under correctional supervision in the community.[5,6]

Jails generally house detainees who are awaiting charges, trial, or sentencing and inmates who have received sentences of one year or less. As a result, jails experience constant turnover. This is a population that frequently cycles between the justice system and the community.

Understanding the demographic and epidemiologic features of this segment of the Medicaid expansion population is essential for understanding how to target enrollment efforts, anticipate health care needs, and prepare the delivery system to meet those needs efficiently and effectively. We considered the impact of expanded eligibility on justice-involved individuals, with a particular focus on people in jail. Jails admitted an estimated 11.8 million people in the twelve months preceding June 30, 2011, the period for which the most recent data are available.[7]

The justice-involved population has a higher disease burden than the general population, yet as many as 90 percent of justice-involved people lack health insurance at the time of their release from incarceration.[8,9] This disparity between disease burden and access can drive up the cost of health care, result in worse outcomes, and cause patients to seek care later than appropriate and in care settings that are often isolated and lack care coordination.

The Challenging Health Care Needs Of The Jail Population

Policy makers and health care stakeholders have a unique opportunity to help meet the needs of this population. To do so, however, they must first understand more about its epidemiology.

Justice-involved people have high rates of physical and behavioral health issues, including infectious diseases and substance use disorders.[8] Very high rates of these diseases and disorders are particularly problematic. Surveys of jails by the Bureau of Justice Statistics have reported rates of substance use in excess of 80 percent.[10] Nearly half of all jail inmates meet formal diagnostic criteria for co-occurring mental illness and substance abuse or dependence.[11] Long-term drug use tends to lead to or exacerbate physical health problems, while decreasing the likelihood of actually receiving care.[12]

The dynamic of jail incarceration includes short stays, averaging thirty-eight days; a high percentage of recent substance users; and frequent movement between jail and community.[13] These factors can be destabilizing for this population and contribute to the

risk of reincarceration.[14] Justice-involved people also generally have higher rates of learning disabilities and lower functional literacy than the general population, which makes it difficult for them to navigate the health care system.[15] Many did not obtain preventive care as adults before their incarceration and report using the emergency department as their primary source of care.[16]

Even justice-involved people who are eligible for free health care after their release might not receive the care they need. One frequently cited study found that only 5 percent of HIV-infected people released from incarceration in Texas filled free prescriptions in time to prevent an interruption of treatment.[17]

In addition to disparate health challenges, the justice-involved population suffers from high rates of poverty and unemployment, unstable housing and homelessness, and differing degrees of personal and family problems.[8] Their return to the community after being released from incarceration is marked by high stress, as they juggle competing priorities. They need to reestablish employment, housing, and family and other relationships, with limited financial resources and social support. Seeking health care after release from jail is often a low priority, although there is evidence that treating medical and behavioral health conditions improves the probability of successful reintegration into the community.[14,18]

Successfully connecting people released from jail with the health care system thus must be understood and addressed within the context of a wide spectrum of individuals' survival priorities and reentry needs. Cross-agency collaboration is essential: Organizations that provide community support for people released from jail need to be linked to each other and to medical and behavioral health care providers.

Initiating, coordinating, and maintaining relationships among diverse state and community organizations is difficult. However, certain innovative postrelease programs can provide models for successful linkages.[19,20,21]

Successful Models Of Care

Several care models have been particularly effective in linking justice-involved people to community-based care. Three unifying themes characterize these successful models of care.

First, the models have proved to be clinically effective in engaging this population in sustained care in the community, while improving individual and population health.[19,20,21] Second, they illustrate that increased access to substance abuse treatment can be cost-effective and result in overall medical cost savings.[22,23] Third, the models underscore the potential role that engaging people in health care after their release from incarceration may play in reducing recidivism, particularly for people with behavioral health care needs.[14,18,24]

In Rhode Island, for example, Project Bridge[19] and the Community Partnerships and Supportive Services for HIV-Infected People Leaving Jail (COMPASS)[20] program have had major impacts on cross-sector care coordination for justice-involved people with HIV. Project Bridge personnel go into prisons, identify HIV-infected inmates before they are released, and link them to a hospital-based clinic for their postrelease care. Using an

intensive case management system, Project Bridge successfully retained former prisoners in postrelease medical care by providing support services for their nonmedical challenges. The COMPASS program adapted Project Bridge's approach for highly transient, shorter-term populations in jails.

The outcomes of both programs are consistent with studies that have found a positive association between postrelease case management and positive health and behavior outcomes for former prisoners with serious medical needs.[25]

Another promising approach to coordinated postrelease care is demonstrated by the Transitions Clinic model, which is currently operating in ten cities across the United States.[9,21] Transitions Clinics provide transitional and primary care with case management to former inmates with chronic health needs. The clinics are located in neighborhoods with high concentrations of formerly incarcerated people. They provide patients with care from physicians who have worked with this population, referrals to community organizations for needed social support services, and case management from trained community health workers who were previously incarcerated themselves. This model of care depends on robust information exchange and has been shown to successfully engage this population in postrelease care by addressing both transitional and primary health care needs.[9,21]

These models present an opportunity to help the millions of people moving in and out of correctional settings receive patient-centered care. The use of the models has also been bolstered by an emerging body of evidence that demonstrates the benefits of effectively engaging the justice-involved population in postrelease care.[14,18,24]

Evidence Of Successful Interventions

Given the significant burden of substance use in the justice-involved population, interventions that are cost-effective and provide high-quality, patient-centered care are important tools for coordinating care. This is especially true for the Medicaid expansion population.

A recent Washington State study showed that increased funding during a five-year period for substance abuse treatment for disabled Medicaid adults increased their engagement in treatment and "coincided with a significant [50 percent] reduction in rates of growth in medical and long-term care costs" for this justice-involved population.[22] When substance abuse treatment funding was subsequently reduced, the resulting decreased access to treatment was associated with increased medical cost growth.

Similar relationships between increased access to substance abuse treatment for Medicaid clients and decreased medical costs over the same time period were found in an audit of the Colorado Medicaid program by the state.[23] The state's 2010 report found that the program cost $2.4 million for its first three fiscal years. However, during its first two fiscal years, medical expenditures for clients engaged in needed treatment decreased by $3.5 million.

Additional evidence demonstrates that linking to the health care system people who have been released from incarceration can reduce recidivism. Studies analyzing programs that

link recently released prisoners to medical care, health insurance, or both in Michigan,[24] Florida,[18] and Washington[18] all showed that the programs contributed to reduced recidivism.

For example, the Michigan Prisoner Reentry Initiative is a statewide coordinated care program that helps recently released prisoners access community-based health care and social services.[24] A recent analysis focused on one of eighteen program sites that used community health workers to connect former prisoners with serious medical needs to a medical home, assist them in accessing needed medications and primary and specialty care, and ensure that their medical records followed them from the prison to the medical home (mostly through electronic means). This analysis of 2,400 people who went through the program found that the recidivism rate for participants who had been on parole for two years fell from 46 percent in 2007, when the program began, to 21.8 percent in 2012.

The cost for health care navigation services averaged $172 per parolee served from 2007 to 2012. The state saved an average of $31,000 annually for each prisoner who did not return to prison.[24]

Additional evidence from a study funded by the Department of Justice conducted in Florida and Washington found that in both states, 16 percent fewer jail detainees with serious mental illnesses who had Medicaid benefits at the time of their release returned to jail the following year, compared to similar detainees who did not have Medicaid.[18] However, access to Medicaid alone was not enough. The study noted that improving community transitions requires comprehensive access to stable housing, employment, and community support systems, among other social determinants of health.

Policy Implications

Despite the growing evidence base[14,18] and the tremendous progress made by programs such as the Michigan Prisoner Reentry Initiative,[24] effective links between criminal justice settings and the community remain rare. Barriers to engaging justice-involved people in sustained care in the community after their release from incarceration remain high and must be addressed at national, state, and local levels.

Gauging The Possibilities

However, the examples provided above support two important observations. First, effective engagement in postrelease care is possible. And second, effective engagement and integration of postrelease care will not occur without cross-sector, cross-disciplinary collaborations.

Successful integration into community care for the justice-involved population will require many enabling policies and systems that are conceptually similar to those highlighted by the Centers for Medicare and Medicaid Services in a July 2013 informational bulletin describing ten models of effective engagement and clinical integration for Medicaid patients called super-utilizers of the health care system.[26] These models reflect principles highlighted in

this article, including the integration of providers in both pre- and postrelease care and an emphasis on the social determinants of health.

Justice-involved people are highly stigmatized and marginalized in relation to community structures, including health care systems. However, effective collaborations across justice and community-based health settings and among social, medical, and behavioral health care providers can improve population health and clinical outcomes and reduce costs.

Health insurance alone is not sufficient to effectively link people released from incarceration to community-based care. Coverage is an important precondition for effective engagement in care but by itself does not ensure the availability of a provider; the patient's ability to successfully navigate the health care system; or the presence of, or linkage to, settings capable of providing comprehensive social, behavioral health, and physical care.

Policy Recommendations

We present four recommendations for policy makers, Medicaid agencies, criminal justice institutions, clinicians, and other stakeholders who collectively seek to achieve better care for justice-involved populations.

NEW COMPETENCIES—First, effective engagement requires new competencies in all settings. Effective engagement is culturally competent. It requires people who understand the complex and interrelated health, legal, social, economic, and other pressing needs of justice-involved individuals. Providers in both criminal justice and community-based health care settings generally lack the skills necessary to practice across complex disciplines. At a minimum, they need to be exposed to different competencies across medical and behavioral health fields and to understand that justice-involved people must deal with health, legal, and socioeconomic challenges simultaneously.

Most curricula for providers do not address these complexities, and even fewer teach these competencies in clinical settings. Newer models of care such as accountable care organizations (ACOs) and patient-centered medical homes promise to incorporate some of these competencies to help deal with social determinants of health. ACOs in particular present an opportunity for providers to work across settings to meet financial and quality benchmarks for an attributed population of patients. There is an urgent and often unmet need among this population for both integrated mental health and substance use treatment and for integrated behavioral health and primary care.

ROBUST COLLABORATION—Second, clinically and socially effective engagement in care can be achieved through robust collaboration between criminal justice personnel and community health care providers. The innovative efforts discussed in this article demonstrate that investments in linkage to care, information exchange, and coordination between corrections and community health care settings are feasible and cost-effective. Policy makers at the local, state, and federal levels have key roles to play in reducing the barriers to sharing information and coordinating care between the corrections and community health care sectors.

At a minimum, policy makers need to facilitate the development of partnerships among corrections professionals, health plans, and community providers. These partnerships at the city, county, and state levels will be new, will take time and effort to develop, and will require an understanding of each sector's respective priorities and constraints. Stakeholders should establish common objectives rooted in the triple aim of improving population health, health care quality, and cost reduction.[27]

SYSTEMIC BARRIERS—Third, systemic barriers to the amplification and scalability of effective engagement models must be addressed. One significant systemic barrier is the lack of functional information exchange between justice settings and community-based health care systems. Information systems in criminal justice settings currently lack the capability to support coordinated care. Many people who leave the criminal justice system—and their new, community-based health care providers—must wait for weeks, if not months, for accurate copies of their medical records.

New systems for exchanging health information are beginning to address this pressing challenge. However, regulatory alignments and policy guidance are also needed to ensure the appropriate transfer of information between the criminal justice and community health care domains. As standards governing the implementation and use of electronic health records continue to be developed, careful attention should be paid to the implications of such criteria in correctional and transitional settings.

Standards such as "meaningful use" do not apply to criminal justice settings. This raises the concern that correctional settings will increasingly lag behind health care settings in terms of technology and that the two will become less—rather than more—able to exchange information.

WIDE-RANGING BENEFITS—Fourth, investment in reducing systemic barriers to collaboration across clinical and nonclinical settings can be expected to yield benefits beyond solutions for the unique engagement and transitional care issues of the justice-involved population. In fact, the benefits will be relevant to a wide variety of clinically and socially complex subpopulations. Policy makers should recognize the opportunities for cost savings in both the health care and the correctional health sectors that the coordination of services could produce. These opportunities could ultimately benefit all taxpayers as well as a population that has demonstrable clinical and social needs: justice-involved people.

Conclusion

State and federal policy makers will need to provide clarification and enabling guidance to providers in the corrections and health care sectors regarding the information transfer and coordination activities that will need to occur to achieve efficient and high-quality care as people in this newly covered population transition not only between health care settings, but also between distinct sectors of our society.

A critical component for the success of states engaged in expanding their Medicaid programs is addressing the challenges involved in converting new access to care into

receiving higher-value health care. Justice-involved people constitute a substantial proportion of the Medicaid expansion population. Failure to understand their pressing needs, difficulties in juggling priorities, and unique epidemiology will make it difficult to meet the goals of health reform. So will failure to understand key elements of existing models that link individuals in this population to the community-based health care system.

There is great potential for collaboration between criminal justice and community-based health care systems. Such collaboration will be required to achieve the clinical and cost objectives of a high-value health care system that serves the greatest possible number of people—including those who are or have been involved in the criminal justice system. By learning from and building on the evidence and the models of care that have been developed, as well as identifying the necessary elements of their transformation, the nation's expansion of access can result in better care and overall improvement in other determinants of health among formerly incarcerated people, including employment and recidivism.

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NOTES

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