29 Reentry and the Role of Community-Based Primary Care System

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Introduction

This chapter discusses the role of primary care systems in addressing the myriad health needs of community members who have been recently released from carceral facilities in the United States. This chapter reviews the historical role of primary care systems in addressing the needs of this population, the epidemiology of common behavioral and physical health conditions in people being released from incarceration, system-level barriers to effective care, and an evidence-based model for community care.

The History of Healthcare Access for Incarcerated People and Returning Community Members

In the mid-1960s, just over a decade before the Supreme Court's 1976 ruling in *Estelle v. Gamble* created a precedent for access to medical care for people who were incarcerated, major legislation to create and fund the community health system was just emerging. Under the Economic Opportunity Act of 1964, the concept of the community health center emerged and would grow to include federally qualified health centers (FQHCs) designed to provide care in areas with high rates of poverty. In 1965, Congress authorized the creation of Medicaid and Medicare. Medicaid, specifically, was designed to provide federal funding for health insurance coverage for low-income individuals and families in the community, excluding those in prisons and jails (Social Security Act Amendments of 1965).

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This "inmate exception" has contributed to the formation of healthcare systems in prisons and jails that are isolated from community health systems, exempt from Medicaid policies related to mandatory accreditation and external quality oversight, and under-resourced (Fiscella et al., 2017). Additionally, most states had Medicaid criteria that limited eligibility to those who were poor and disabled or with dependent children, effectively excluding a large portion of the recently released and formerly incarcerated population, which are predominantly men without dependent children. Expansion of many state Medicaid programs that occurred in 2014 through the Patient Protection and Affordable Care Act (ACA) provided an opportunity for insurance coverage upon release for incarcerated single people without dependent children. In states that expanded Medicaid to cover low-income adults, an estimated 80–90% of returning community members are eligible upon release, and most retain eligibility for at least a year due to low earnings (Albertson et al., 2020).

However, since constitutional mandates only dictate provision of timely access to a reasonable level of care during incarceration, and Medicaid only covers care post-release, there remains a funding gap to support an organized system of care coordination from the carceral to the community health system (Mallik-Kane, 2005; Rich et al., 2011; Solomon et al., 2014). This resulting gap in care can prove to be catastrophic as evidenced by worsening of chronic conditions, increased hospitalizations, and high rates of death post-release (Binswanger et al., 2009; Wang et al., 2013).

Barriers to Healthy Reentry

High Rates of Chronic Illness

Incarcerated people have elevated rates of chronic medical and behavioral health conditions compared to the general population (Binswanger et al., 2009). Data from the late 2000s show one quarter of people in state prison had been diagnosed with a mental health condition and between a half and two-thirds had a substance use disorder (Mumola & Karberg, 2006; Wilper et al., 2009). A number of chronic physical health conditions are also more prevalent in incarcerated people including hypertension, asthma, HIV, hepatitis C, and some cancers, such as lung and cervical cancer (Binswanger et al., 2009; Rosen et al., 2019). In 2015–2016, 33% of people being released from North Carolina state prison were on medications for one or more chronic physical or behavioral health condition. This figure rose to 49% among individuals aged 35–54 and 70% for those aged 55–64.

Laws that increased the length of sentences and "truth in sentencing" policies that required larger proportions of sentences to be served (Human Rights Watch, 2012) have left more people aging and getting sick while in prison. As evidence, between 1993 and 2013, the population of people over the age of 55 in prison quadrupled (Carson & Sabol, 2016). The prevalence of chronic conditions among incarcerated individuals is noted to be closer to what one would expect to find among people that are 10–15 years older, leading some to suggest there is an "accelerated aging" process behind bars (Greene et al., 2018; Williams et al., 2012). These older incarcerated individuals have poorer health while incarcerated, and, upon release, their multi-morbidities, frailty, and loneliness have been associated with high rates of acute care utilization (emergency department and hospitalization) that are similar to that of patients in the last year of their lives (Chodos et al., 2014; Humphreys et al., 2018). Though these data are rarely disaggregated by race or ethnicity, the high burden of disease among the aging incarcerated population signals a grave racial injustice since Black, Latinx, and Native American individuals are incarcerated at disproportionate rates and likely to be sentenced to longer terms (Alexander, 2010; Wildeman & Wang, 2017).

To further illustrate the comorbidity among chronically ill individuals returning from prison to the primary care setting, we have included data from a 2013–2016 survey of Transitions Clinic Network

Table 29.1 Characteristics of transitions clinic network patients from ten states, 2013–2016 (n = 751)

Characteristic	Percentage or mean
Demographics	
Mean age in years (standard deviation)	46.1 (11.2)
Male	85.2
Black	46.9
Hispanic	30.2
Had health insurance at first visit	60.1
Self-reported fair to poor health	46.1
Chronic health conditions	
1–2 chronic physical health conditions	41.3
3 or more chronic physical health conditions	43.9
Chronic mental health condition	52.7
Substance use disorder	49.9
Prison health system utilization	
Received health care in prison	81.1
Had medications for chronic conditions at release	75.8

Source: Shavit et al. (2017) analysis of TCN patients' baseline characteristics. (Republished with permission of Shavit et al. (2017). Permission conveyed through Copyright Clearance Center, Inc.)

(TCN) patients in Table 29.1. Note that to be eligible for the TCN program, patients had to be released from prison in the prior 6 months and either have a chronic condition or be 50 years of age or older.

Health Impacts of Incarceration

While aging contributes to the high prevalence of chronic conditions, the environment inside prisons and jails can also directly contribute to the onset or worsening of these conditions. As seen with COVID-19, prisons and jails can become incubators for respiratory disease outbreaks, as it is nearly impossible to maintain physical distancing in most carceral facilities in the United States (Montoya-Barthelemy et al., 2020). Likewise, limited access to treatment for substance use disorders, harm reduction supplies such as clean syringes for injection and clean needles and ink for tattooing contribute to the spread of hepatitis C and HIV (Stone & Shirley-Beavan, 2018). Prolonged exposure to outdoors on prison yards can lead to increased rates of airborne infectious spores, such as valley fever (Wheeler et al., 2015). Use of solitary confinement is associated with increased risk of self-harm, anxiety, depression, and other symptoms of psychological distress during incarceration (Kaba et al., 2014; Reiter et al., 2020), and spending any amount of time in solitary confinement has been linked with an increased risk of death following release, particularly for suicide, homicide, and opioid overdose (Brinkley-Rubinstein et al., 2019).

Exposure to a health system that does not prioritize a patient-centered focus can have lasting, negative impacts on returning community members' desire to seek care in the community. Despite being constitutionally mandated, medical care for incarcerated people is highly variable, and may be substandard or fail to meet patient needs. For instance, in spite of a high prevalence of opioid use disorder among incarcerated people, a minority of prisons and jails offer medications to treat opioid use disorder (MOUD), leaving most people to experience the difficult and painful experience of withdrawing off opioids while incarcerated. For some, these experiences can influence their future desire to engage in treatment with MOUD (Gryczynski et al., 2013; Maradiaga et al., 2016; Nunn et al., 2009; Woo et al., 2017). Carceral facilities are also designed to prioritize security over treatment, which can compromise the quality of care provided. For instance, in California prisons, "therapeutic modules" (small individual cages) are used often during group therapy sessions for people at higher custody levels.

Medical providers leave exam room doors open and often times custody staff are in the room or nearby, negating any possibility for confidentially.

Healthcare needs and criminal legal system policies can also be in direct opposition. For instance, in at least one state prison system, seeking mental health services becomes part of the permanent prison record that is reviewed at parole hearings, creating a disincentive for individuals to seek vital services they need.

> "People are going to get out (of prison) and still die. Because they've been trained that the medical profession is not there for them."
>
> -Johnny Lewis, Transitions Clinic patient with history of incarceration speaking about the impact of negative experiences within the prison healthcare system.

A lack of autonomy during incarceration also may create challenges in utilizing and seeking healthcare services post-release. In particular, highly controlled prison and jail environments leave incarcerated individuals few opportunities to gain self-efficacy in addressing their chronic health conditions (Wang et al., 2017). Carceral facility procedures may promote passivity by providing incarcerated individuals with medications through a daily pill line without giving any education about the purpose, dosage, or directions of the medications. Incarcerated individuals also do not gain practice in going to a pharmacy to fill their prescriptions or navigating health systems to make and attend appointments. Instead, individuals are summoned to medical appointments and escorted by staff. Similarly, diabetic individuals are generally not able to test their own blood sugar, inject their insulin, or even control their diets while incarcerated. These experiences can leave people without the needed skills to self-manage their chronic conditions after returning to the community (Wang et al., 2017).

In incarcerated settings, if individuals face medical neglect, these negative experiences can foster mistrust of the medical system which can extend to the community medical system, serving as a barrier to seeking care upon release. Anecdotally, individuals with histories of incarceration also share stories of being denied health care during incarceration due to providers' assumptions that they were factitious or malingering. Others have shared that they were too afraid to ask for care, worried that staff would label them as troublemakers.

Care Coordination Gaps

Generally, there is a lack of continuity of care between carceral facilities and primary care clinics (Shavit et al., 2017; Wang et al., 2008; Waters, 2019). Returning community members are often released with either no prescription medications or a limited supply (e.g., 7 to 30 days), and only a small percentage are connected to providers in the community prior to release (Mallik-Kane, 2005; Rich et al., 2011). Similarly, when community members are incarcerated, community providers seldom reach out to communicate with staff in carceral facilities. Obtaining medical records from carceral facilities is also challenging—both for patients (who are often required to pay for a copy of their records) and community-based providers—and little infrastructure exists to facilitate transferring these records in a timely manner (Solomon et al., 2014).

Carceral facilities provide constitutionally mandated healthcare services inside their facilities but have no legal mandate to provide warm hand-offs or ensure continuity of care to community health systems. This is in stark contrast to the community standard of care with medical transitions after hospitalization where medical plans are communicated via discharge summaries and patients are scheduled with their providers post-discharge. Poor coordination of care after release from incarceration is further exacerbated by the inmate exclusion under Medicare and Medicaid, which is detailed above, as there is little funding for efforts to coordinate healthcare services from carceral facilities to the community health setting. The lack of formal discharge planning structures within carceral facilities is even more problematic for severely ill individuals who may have a need for a higher level of care in the community (such as a skilled nursing facility) and durable medical equipment (such as oxygen or a wheelchair) and who are receiving specialized intensive treatment (such as cancer patients or severely mentally ill individuals). Disruptions in care or inappropriate placement can cause significant morbidity or mortality. Aging incarcerated people are at especially high risk if not appropriately screened for healthcare needs and placements prior to release (Maschi et al., 2014).

Furthermore, organizational structures of the carceral facilities can create challenges for efforts related to continuity of care. Healthcare services within institutions (such as mental health, physical health, substance use disorder treatment) are frequently siloed making it difficult for community health systems to navigate or partner with carceral facilities. Additionally, carceral facilities often lack systems to consistently and accurately identify parole or release dates and communicate them to community partners. Release dates and locations to which people will be paroled can also change with little notice making it difficult to schedule appointments with community-based providers prior to release.

There are emerging efforts toward funding positions, such as social workers, dedicated to coordinating care during this transition period. These funding mechanisms include Section 1115 Medicaid waivers, such as the Whole Person Care pilots in California where some programs focused specifically on returning community members, and coverage through managed Medicaid programs. Additionally, in the Veterans Health Administration, an increasing focus has been placed on transitional care through the Veterans Justice Outreach programs that try to connect with people before release and assist with benefits and social services, though the focus is usually not on medical transitions in care.

Community Healthcare Access Gaps

Prior to the implementation of the ACA in 2014, community health systems had little financial incentive to proactively care for chronically ill individuals returning to the community from incarceration given the low rates of health insurance and newly diagnosed health conditions. Medicaid expansion widened the opportunity to insure and care for many returning community members. While the implementation of the ACA appears to be instrumental in narrowing disparities, individuals who have been involved with the criminal legal system are still twice as likely to be uninsured than other community members (Farrell & Gottlieb, 2020; Winkelman et al., 2016). Fourteen states have yet to expand Medicaid coverage to low-income adults, leaving fewer options for insurance coverage for these individuals. Additionally, many states still terminate Medicaid coverage upon incarceration, leaving individuals without coverage and needing to reenroll in Medicaid upon their return to the community (Rosen et al., 2014; The Henry J. Kaiser Family Foundation, 2019).

Community health systems also often limit access to care for returning community members through organizational barriers or bias. Many return to communities where healthcare access was difficult before they went to prison and where community health systems remain underfunded and with

a multitude of structural barriers to access. While there is a markedly elevated risk of death immediately following release from incarceration, especially in the first 2 weeks (Binswanger et al., 2007), primary care health systems may not be able to accommodate new patients in a timely manner. For instance, a 2012–2013 audit study of primary care clinics in 10 states found a median wait time of 9 days at FQHCs for new Medicaid patients (Saloner et al., 2014). The same study found that while 80% of FQHCs made appointments for new Medicaid patients, this was true of just 56% of non-FQHC providers.

Individual biases among health system staff may also be a barrier to healthcare access and utilization. One study in Canada found that once patients identified themselves as returning from prison, they were half as likely to be given a new visit appointment if they mentioned an incarceration history (Fahmy et al., 2018). While this study focused on the ability to get access to primary care through new visit appointments, these biases could also influence the quality of patient-provider interactions and relationships and discourage individuals from returning for future visits. Furthermore, a majority of returning community members are people of color who also have to contend with individual racism in the health system and generally have more limited access to well-resourced health centers due to residential segregation (Bailey et al., 2017).

Clinic policies can also be experienced as punitive and may prevent patients from returning for additional services. For instance, a strict 15-minute late policy for appointments can limit access to returning community members who may be late due to learning how to navigate public transportation or being triggered or overwhelmed in public. Likewise, the length of the traditional 15-minute visit limits providers' ability to build trusting relationships understand the complex medical histories that patients returning from incarceration often have. Traditional health systems focusing solely on physical health may fail to meet returning community members' behavioral health and social determinants needs.

Collateral Consequences and Social Determinants

People returning from incarceration face myriad collateral consequences that negatively affect their social determinants of health including housing, employment, food security, and social support. There are over 44,000 collateral consequences in the United States codified into laws and policies (National Inventory of the Collateral Consequences of Conviction, n.d.). These laws bar people with certain convictions from working in specific positions and fields, receiving government benefits such as food assistance and subsidized housing, and participating in democratic processes, such as voting. The lasting impact of a criminal record itself has been shown to affect employment opportunity, with a disproportionate impact on Black job seekers (Pager, 2002). Collateral consequences create additional and formidable challenges for returning community members to meet their basic needs and manage their health.

A prominent example of collateral consequences is the difficulty of securing permanent housing after release. Indeed, many returning community members experience homelessness or are unstably housed (Wang et al., 2012; Zelenev et al., 2013). An analysis of the 2008 National Former Prisoner Study found that people on parole were ten times more likely to experience homelessness than the general population, with the highest prevalence among recently released individuals with intersecting marginalized identities (e.g., people of color and women of all racial backgrounds) (Couloute, 2018). Challenges with housing result from a combination of legal barriers, institutional policies, and individual discrimination. In the 1980s and 1990s, a series of federal laws and directives from HUD required state and local housing authorities to evict tenants and deny applicants based on criminal histories, and granted these agencies with broad discretion to ban individuals suspected of any crimi-

nal activity (Walter et al., 2017). While HUD has rolled back most of these provisions, many housing authorities have not updated their policies (Purtle et al., 2020; Walter et al., 2017). For those able to afford housing independently, discrimination by private landlords based on criminal history remains a barrier (Evans et al., 2019).

The collateral consequences of incarceration in turn harm physical and mental health of returning community members. While factors such as housing, employment, and family support can be protective of health post-release, their absence is associated with poorer mental and physical health (Semenza & Link, 2019). In some cases, these barriers have measurable impacts. For instance, homelessness is associated with poor medication adherence and engagement in care among returning community members living with HIV (Zelenev et al., 2013). In addition, individuals returning from incarceration who are struggling to meet their basic needs are unlikely to be able to prioritize seeking medical care (Dong et al., 2018).

Worsening Health after Release

All of the challenges noted above contribute to poor health outcomes for returning community members, especially in the period immediately following release. As a result of gaps in continuity of care, returning community members may not receive ongoing treatment in a timely manner, or may run out of medication (Wildeman & Wang, 2017). There can be worsening of many chronic conditions, such as HIV, after release from incarceration (Springer et al., 2004). Returning community members are twice as likely to be hospitalized in the first 30 days after release, with mental health conditions being the most common reason (Wang et al., 2013). People returning from prison are 12.9 times more likely to die in the first 2 weeks after release compared to individuals of similar demographics living in the community (Binswanger et al., 2007). Importantly, four of the top five causes of death are preventable or treatable in a primary care setting: overdose, cardiovascular disease, suicide, and cancer. This underscores the key role a primary care setting plays in caring for people post incarceration.

Transforming Health Systems to Care for Chronically Ill Returning Community Members

While the challenges facing returning community members are great, community health systems can be transformed to meet the needs of this population (Wang et al., 2012, 2019). In this section, we lay out key features of community health systems that have successfully implemented programs to care for returning community members. This summary is based on our experience providing technical assistance and training to clinics in the Transitions Clinic Network.

Defining Patient-Centered Care

The Transitions Clinic Network model of care was developed in 2006. Healthcare providers at Southeast Health Center, a federally qualified health center, collaborated with Legal Services for Prisoners with Children, a local advocacy organization, City College of San Francisco, a local CHW training program, and local community members impacted by the criminal legal system to develop a patient-centered model of care for people returning from incarceration. With the goal of implementing patient-centered services in existing community health centers, several guiding principles were identified through a series of focus groups (see box below).

Guiding Principles for Patient-Centered Care

- Include individuals and communities impacted by criminal legal system in design, implementation, and evaluation of programs
- Take a broad definition of health and well-being
- Adapt systems to be patient-centered
- Empower patients
- Favor reintegration
- Avoid replication of criminal legal system

Transitions Clinic Network Model of Care

As a result of these focus groups, a model of care was developed with the goal of transforming the existing primary care medical system to improve the health and well-being of people returning from incarceration. The Transitions Clinic Network model of care is implemented in existing primary care clinics in communities disproportionately impacted by the criminal legal system. By leveraging and transforming existing resources, people returning from incarceration can receive rapid access to healthcare services in the same clinics that serve others in their communities. The TCN model of care includes: community health workers with histories of incarceration as central members of the primary care team, enhanced linkages with criminal legal entities and community reentry partners, healthcare providers trained to care for people impacted by the criminal legal system, and patient-centered services to meet the broad range of behavioral, physical, reentry, and wellness needs of patients (see box below).

The Transitions Clinic Network model consists of:

- Team-based primary care with CHWs with histories of incarceration as central members of the team.
- Healthcare providers trained to provide culturally relevant services to people returning from incarceration.
- Enhanced patient-centered services that meet the broad needs of people with histories of incarceration, such as medications for opioid use disorder, hepatitis C treatment, and trauma-informed care.
- Strong linkages with criminal legal system and community reentry partners.

Since 2006, the TCN has grown to reach over 40 clinic systems in 14 different states and Puerto Rico. All clinics in the TCN have adopted this evidence-based model of care for returning community members and adapted it to their unique setting.

This model of care was associated with a 51% reduction in visits to the emergency department in a randomized controlled trial, a 50% reduction in preventable hospitalizations, and reductions in parole and probation violations in a propensity-matched study (Wang et al., 2012, 2019).

Patient-Centered Services

Adapting community health systems is critical to meeting the needs of complex chronically ill individuals returning from incarceration. This includes greater integration of mental health and substance use treatment into primary care. Historically, physical health care and mental health care have been siloed, as reflected in the lack of "co-training" of their practitioners, and different regulatory, administrative, and payment structures (Crowley et al., 2015). It was not until 2008, in the Federal Parity Law, that health insurance plans were required to cover behavioral health and physical health services equally.

As an evidence-based strategy that promotes patient-centered integration for patients with an opioid use disorder (Fiellin et al., 2013, 2014), primary care providers should be trained and waivered to prescribe buprenorphine (also referred to as x-waivered) as permitted through the Drug Addiction Treatment Act (DATA 2000). This is beneficial because it allows a patient to receive help from a provider with whom they have built trust. Providers can also be patient-centered by offering options that fit with each individual's goals around substance use. The options can range from harm reduction education, supplies to reduce risks of infections or overdose (e.g., syringes or naloxone), and medications for substance use treatment such as buprenorphine and naltrexone. Patient care is further improved when behavioral and physical health providers are co-located and coordinate care.

Team-based care is also patient-centered. In a team-based approach, a dedicated team provides specialized services for a specific group or "panel" of patients with complex needs. The composition of the care team may vary depending on the specific patient population and setting, but generally includes a medical provider, a medical assistant, staff members responsible for care coordination (e.g., CHW and care coordinator), a nurse, and other clinical staff such as behavioral health providers. For primary care teams serving patients returning from incarceration, a community health worker (CHW) with a history of incarceration should be a central member.

Clinic schedules should be adapted to meet the needs of returning community members. The amount of time allotted for an initial visit with a primary care provider needs to account for the additional time it takes to begin establishing trust and fully understand a patient's medical history and health priorities. It is also important that providers are able to see returning community members within a few weeks of their release from incarceration. Clinics often find they need to set aside appointment slots or utilize flexible scheduling templates (such as open access) that more easily accommodate patients who are just released and may need to be seen within a few days.

Clinics also benefit from identifying and rewriting policies that may be experienced as punitive, such as turning away patients from the clinic if they are more than 15 minutes late for their visit. As an alternative, front desk staff can attempt to accommodate the patient, or if they cannot be seen, ask a nurse or the CHW to triage the patient to identify urgent needs such as medication refills or assistance with the social determinants of health (e.g., helping patient access an on-site food pantry).

Community health systems can also systematically screen new and existing patients for recent incarceration and refer these individuals to receive additional services. The PRAPARE tool is one example of a screening tool for the social determinants of health that is widely used in primary care settings (National Association of Community Health Centers, n.d.) and includes a question about experiences of incarceration. While returning community members benefit significantly from a tailored model of care, these individuals should not be segregated from other patients or treated differently. Instead, our experience has shown that these individuals benefit from being integrated in the same clinic that their family members and other community members are seen in.

The biases and stigma of health providers and clinic staff can directly limit access to the clinic and negatively affect the patient experience (Fahmy et al., 2018). People with histories of incarceration have experienced discrimination in the healthcare system both in carceral and community settings

(Frank et al., 2014). Successful clinics provide opportunities for staff to identify their own biases and question stereotypes about returning community members. Formal training for all clinic staff is critical to ensure that people with histories of incarceration feel welcome and respected in all interactions with clinic staff. Including CHWs with histories of incarceration as part of the clinical team also increases the likelihood in culturally responsive interactions between team members and the patient over time.

Community Health Workers with Histories of Incarceration

CHWs with personal histories of incarceration are critical members of a primary care team that serves returning community members. Using their lived experience, CHWs are able to establish trust with patients and serve as cultural interpreters between the patient and the rest of the team. CHWs work with patients to address social determinants by connecting them with social services agencies, reentry organizations, potential employers, and with other resources that promote well-being, such as community groups and places of worship. As individuals with shared lived experience, they also serve as mentors and sources of social support.

CHWs are most effective when fully integrated into the primary care team (Centers for Disease Control and Prevention, 2014). Integrated CHWs participate in care team huddles and meetings and have a workspace within the clinic. At the same time, it is equally important that CHWs spend about half of their time in the community building relationships and meeting patients in the field, as illustrated by the roles outlined below.

Clinic-Based CHW Roles

- Health system navigation (e.g., teaching patients how to refill prescriptions and make appointments).
- Cultural interpretation (e.g., providing context to a provider so that they can fully address the patients' needs).
- Using patient-centered practices to establish individualized goals.
- Communicating with primary care team about patients' needs and strengths.
- Health education about chronic conditions and self-management support.
- Contributing to planning and evaluation of clinical programs for returning community members.
- Advocating for clinic policies that support returning community members.

Community-Based CHW Roles

- Relationship-building across systems (including parole, probation, community-based organizations).
- Community outreach (e.g., going to transitional homes to visit or recruit patients).
- In-reach into incarcerated settings (e.g., speaking to groups in prison, meeting with individuals prior to their release, or corresponding with incarcerated people).
- Social services navigation (e.g., accompanying a patient to activate public assistance or connecting a patient to a staff person at a job training program).
- Emotional support and mentoring.
- Individual patient advocacy (e.g., advocating on patient's behalf to parole).
- Policy advocacy (e.g., speaking on behalf of community members to a policy maker).

Relationships with Community Organizations and Criminal Legal System Entities

Health systems are best able to address the social determinants of health when they have strong relationships with community-based organizations and social services agencies that help returning community members access housing, foods, jobs, education, social support, and other basic needs. These organizations can identify clients that could benefit from the clinic's services and provide mutual referrals. Clinics can also reach returning community members by building relationships with other parts of the health system that work with these patients, including emergency departments and substance use treatment programs. CHWs often spend a substantial portion of their time establishing and maintaining relationships with these organizations and systems.

Community health systems also need to build relationships with carceral facilities who can refer returning community members to these clinics immediately after release. It is particularly valuable when CHWs are able to enter these facilities to connect with returning community members before they are released. One clinic found that their show rates for primary care appointments more than doubled to 70% after CHWs with histories of incarceration began meeting with returning community members prior to their release. Other CHWs have shared that even a phone call prior to a person's release increases the chance that they will reconnect with the CHW after coming home.

Relationships with parole and probation also provide a pathway for referrals and for clinic staff to advocate on behalf of their patients. For example, if a patient has relapsed, healthcare staff can work with the patient to engage them in substance use treatment and potentially avert a parole or probation violation. While relationships with criminal legal entities are valuable, clinics need to avoid inadvertently becoming an extension of a punitive system. For example, even when well-intended, providing information such as results of a urine test, a patient's progress toward meeting their treatment goals, or where a patient is living could be all used to revoke parole or probation or apprehend an individual. As more clinic systems move toward contracting with probation and administering court-mandated treatment, the danger of fundamentally changing the role of the healthcare system increases. However, health systems can work with criminal legal systems while still putting their patients' needs first. For instance, a TCN program in North Carolina agreed to accept funding from the state prison system but buffered themselves by using a state university as a fiscal intermediary and developing strict agreements to protect the confidentiality of patients.

Advocacy Beyond the Clinic

In addition to caring for individual returning community members, healthcare providers also can play an important role in changing the deleterious policies of mass incarceration or addressing the impact of collateral consequences on the social determinants of health. Working with patients often reveals patterns of injustice that healthcare providers are uniquely positioned to change locally or more broadly. A patient might share that she was denied services at a certain institution or that she is unable to find housing because of her conviction.

If providers ask questions and identify the root causes of these experiences, they may find that an individual parole officer, a local ordinance, or a state legislation is responsible. They can then address the issue at its source, potentially improving conditions not only for the patient who brought it to their attention, but others who may be suffering under the same decision or policy. Health workers are generally well respected and considered credible by lawmakers, government officials, and others who have power to make change, which provides them an opportunity to use the power of their voices to lift up the issues affecting the communities they serve.

Provider Advocacy: An Example

Problem: A patient shared with a CHW that he was being denied mental health care at county clinic based on an outdated policy that prohibited people on parole from getting state-funded mental health services.

Solution: The CHW raised the issue at the local county run reentry council meeting attended by the director of the county mental health department.

The result: Department-wide education of county mental health staff about inclusion of people on parole in county mental health services.

In addition to addressing issues that affect patients after their release, health workers have advocated for changes that address mass incarceration or improve the conditions inside. For example, CHWs and other clinic staff have advocated against the imposition of extreme sentences such as life without parole and for eliminating co-pays for medical care during incarceration. Some of the concrete actions these individuals have taken include meeting with individual lawmakers, speaking at legislative hearings, and participating in rallies and other mass mobilizations.

Summary

Due the expansion of Medicaid coverage via the ACA, community-based health systems have a growing opportunity to care for returning community members, a majority of which have chronic conditions that can be treated in a primary care setting. Unfortunately, long-standing structural barriers to primary care in communities most impacted by mass incarceration and the quality of healthcare services and denial of individual autonomy during incarceration have lasting impacts that decrease the likelihood these individuals will seek or utilize primary care after release. These factors and others contribute to shockingly high rates of death, hospitalizations, and use of the emergency department among this population.

Because of these challenges, CHWs with lived experiences of incarceration are uniquely positioned to engage returning community members in care. One evidence-based model of care is to embed CHWs in primary care teams to work with patients to set individualized goals, address social determinants of health, teach skills in navigating the medical system, and facilitate communication between patients and the medical team.

Health systems must transform existing services to meet the health and social needs of returning community members, including by building partnerships with social services agencies and community-based organizations. Community health systems can work with correctional systems to ensure timely referrals. While doing so, community health systems have a responsibility to ensure they prioritize the health and welfare of their patients and avoid becoming an extension of a punitive system. Health systems can also be more responsive to the needs of those recently released by offering behavioral health services and adapting policies and practices that could otherwise create barriers for this population.

Ultimately, it is our responsibility as providers and public health professionals to address the broad health needs and wellness of returning community members in a way that centers their individual needs and goals. To achieve this, we must work alongside leaders and community members with histories of incarceration to recognize, name, and work with the intention to dismantle correctional and community-level structural barriers to health, often entrenched in racism.

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