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SIGN OF THE TIMES: PART II

# From Justice to Health: The High Cost of Poor Transitions

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Improving medical care during the transition from inpatient to outpatient services has been a focus of broad efforts for many years. The transition from larger systems such as justice to health, however, has been ignored at considerable cost to individuals and health systems alike.

Of the 10 million individuals released from prison or jail each year, the majority will be uninsured as they return to the community.[1,2] This population is aging and increasingly burdened by chronic medical conditions such as cardiac disease, diabetes, chronic obstructive pulmonary disease, and malignancy.[3-7] After release, justice-involved individuals die more frequently[8-12] and use inpatient services for ambulatory conditions more frequently than their peers.[12,13] Access to care for mental health and addiction disorders has improved, but chronic medical conditions have received less attention.

There are many immediate needs after release from incarceration that take precedence over establishing care with a primary care physician. These include obtaining safe housing, food, and income as well as avoiding old enemies, reengaging with family, and maintaining sobriety. As a consequence, the most frequent portal into health systems is the emergency room or urgent care clinic—our most expensive sources of health care. Alternatively, chronic conditions may remain untreated, resulting in hospital admission or death. Historically, hospitals and health care systems have been reluctant to address the needs of released prisoners as new patients because they rarely have health insurance and are often non-paying patients.

Anyone released from a correctional facility will face barriers to accessing health care, but there are predictable differences between transitions from jail and transitions from prison.

Jails are responsible for those recently arrested or awaiting sentencing. Their jurisdiction can be as short as a few hours or may last many years. Acute health issues in jailed individuals are often untreated and may influence the circumstances prompting arrest. Substance use, addiction, and undertreated psychiatric disorders are prevalent. With rapid turnover of inmates, chronic conditions may not be fully addressed before charges are dropped and the individual leaves the facility.

Prisons hold people who have been convicted and sentenced; prison stays may range anywhere from one year to life. During imprisonment, health care is institutionalized, structured, and managed within a single system. At the moment of release or parole, the prison no longer has any obligation to provide health care for these individuals. People frequently leave prison with only a few weeks of medication (or less) and no plan for health care follow-up.

In both prisons and jails, cessation of care at the time of release is abrupt, and resumption of prior health insurance benefits is not guaranteed. Inmates are not eligible for social security payments while incarcerated. The Social Security Administration offers a $400 incentive payment for each inmate reported within 30 days of arrest.[14] In many states, this reporting is linked to the Centers for Medicare and Medicaid Services (CMS), which suspends or cancels their insurance. Therefore, prisons and jails are paid to suspend benefits but have no incentive to reinstate them upon release. The patient you enroll in Medicaid during a visit to your emergency room or clinic can be arrested and released only to be uninsured again by the time of the next clinic visit a week later. Thus begins the revolving door of insurance, incarceration, cancellation, and release. There must be solutions to these problems. If we act together, efforts to develop partnerships between the health care and justice systems can improve outcomes for patients while reducing costs.

The Affordable Care Act (ACA) has dramatically changed eligibility for criminal-justice populations. This is most notable in states that have accepted Medicaid expansion. By including those with income below 133% of the federal poverty level and eliminating the need for disability or dependent family members, the majority of current inmates are now eligible for Medicaid coverage once released. Seeking out criminal-justice populations is no longer a financially risky proposition for health systems.

Financial incentives for justice facilities that enroll or screen their populations for Medicaid also exist. Under the ACA, the federal government pays for inpatient admission to hospitals and offers meaningful use payments to justice facilities if they institute an electronic health record (EHR). These incentives are successfully leading prisons and jails to screen and enroll their populations in health care in many states.

The financial "carrot" of payments may, however, soon be followed by a federal "stick." Just as hospitals dread readmissions, justice facilities loathe recidivism. It is conceivable that future payments will depend on good transitions. To re-

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ceive the full Medicaid payment, a facility may need to demonstrate plans that avoid return to prison or avert an inpatient admission soon after release. Cooperation across disciplines is therefore necessary.

Transition clinics offer a bridge from justice to health. They can be implemented in a variety of ways. One model imbeds specialized transition clinics within the justice facility. Medical teams can be incorporated into probation offices, and justice staff can be encouraged to collaborate with community clinics. A patient navigator for health care can be included in release planning teams for those with chronic medical conditions. Responsible health systems can fund the first month of medications and initiate the first outpatient appointment rather than bear the cost of an emergency visit or inpatient admission.

We can share our medical knowledge of patients. Compatible EHRs will shorten length of stay, improve the quality of justice intake screening, and maintain uninterrupted specialty services from the correctional setting to the community.

Some of the most challenging patients are often those affected by the criminal justice system. Those most vulnerable patients—the emergency department "frequent flyers"—may be well known to the local jail as well. Incarceration may provide a period of opportunity for health interventions for these patients. Management of conditions such as hepatitis C, drug addiction, mental illness, and diabetes can be facilitated by institutional collaboration. By ensuring continuity or preventing disruption of treatment, costs and duration of expensive care plans can be appropriately managed.

The delivery of health care and justice are political but bipartisan. Solutions require local and national effort. Partnerships between prisons and health care systems can form a strong voice for change. We can lobby state governments to suspend Medicaid rather than terminate it upon incarceration. We can add our voice to sentencing reform and compassionate release for elderly patients with high health care needs.

The cost of a poor transition from justice to health is high, but the potential for benefit is significant. There are solutions to these problems. We can combine our expertise to affect change for the sake of our patients and the welfare of our communities.

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