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A description of an urban transitions clinic serving formerly incarcerated persons

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Background

The United States has the world's highest rate of incarceration (937 per 100,000 adults). As of 2011, seven million Americans were under correctional supervision, including 2.2 million held in jail or prison.¹ Incarceration disproportionately impacts persons of color thereby destabilizing communities that already suffer disparities in health care access and health outcomes.^{2,3} Chronic health conditions, including infectious diseases, substance use disorders, mental illness, and non-infectious chronic diseases are overrepresented among inmates⁴ and may go untreated during incarceration. For example, 65% of prisoners have drug or alcohol dependence, but few receive treatment during incarceration, and up to 95% relapse following release.^{5–8} After release (hereafter referred to as community reentry), chronic health conditions, such as HIV, often worsen in part due to poor health care access; up to two-thirds of released inmates fall out of medical care.^{9–13} Systems-level barriers like provider availability or costs, may limit access to care,^{10,14–16} while provider-level barriers like stigma or an uncaring demeanor, may limit engagement in care.¹⁵ During the 2-week period following release, former prisoners are at 12 times higher risk of death than the general population;¹⁷ therefore, timely linkage to care and preventive services is urgently needed. In this article, we describe the collaboration between a community-based organization and an academic medical center in developing a transitions clinic to provide rapid access to care for formerly incarcerated persons.

The Transitions Clinic Model

Transitions clinics provide a medical home to formerly incarcerated persons during community reentry.¹⁸ Typically, transitions clinics are staffed by physicians with experience caring for this population, offer patient navigation, and are closely aligned with Community Supervision (parole) or a community-based organization (CBO) that provide pre-release discharge planning and facilitate access to housing, employment, and other social services. Ideally, inmates have appointments at the transitions clinic upon release. Models of care where physicians split time between correctional facilities and the community have been shown to improve continuity of care,^{19,20} but these models are not feasible in large states where prisons may be distant from inmates' homes and communities. The Bronx Transitions Clinic (BTC), which is located in an area severely affected by incarceration and capitalizes on the expertise of a CBO that provides reentry services, can be a model for other health centers seeking to serve formerly incarcerated persons.

Program Overview

Montefiore's Comprehensive Health Care Center and the Osborne Association (OA) collaborated to develop the BTC. Both organizations serve predominately working-class minority communities in the Bronx, NY. The OA provides grant-funded discharge planning at New York State prisons. Medical services are paid for by health insurance. The BTC provides comprehensive treatment including primary care, HIV, substance use, and mental health treatment.

Collaborators and sites

Montefiore Medical Center, the University hospital of the Albert Einstein College of Medicine, is an integrated health system with four hospitals, over 30 ambulatory clinics, and seven federal qualified health centers (FQHCs). The *Comprehensive Health Care Center*, Montefiore's largest FQHC, serves Highbridge and Morrisania sections of the South Bronx, which have a high prevalence of HIV infection, substance use disorders, and incarceration.²¹ Over 65% of patients have public insurance. Those without health insurance pay a sliding scale fee. Services provided include: primary care, obstetrics and gynecology, psychiatry, dermatology, podiatry, dental, pharmacy, social work, HIV case management, substance abuse treatment (including buprenorphine²²), and Hepatitis C treatment.

The *Osborne Association (OA)* provides many reentry services to formerly incarcerated persons. Inside 13 New York State correctional facilities, OA staff members provide health education, screen inmates for chronic health conditions, and initiate case management. At three community sites, the OA provides ongoing case management, non-pharmacologic treatment of substance use disorders, cognitive behavioral interventions tailored to formerly incarcerated persons (e.g. anger management), and workforce preparation programs.

Program Development and Evolution

We developed the Bronx Transitions Clinic (BTC) to meet community needs. In our pilot study of FQHC's patients, 18% reported a history of incarceration, 51% had a family member who had been incarcerated, and many believed that incarceration directly impacted

their health.²³ Subsequently, we met with key stake holders in the Bronx and physicians with experience developing transitions clinics. The OA was selected as a community partner because of its prominence in the community and expertise in providing reentry services. Starting in 2009, attending physicians volunteered their time to see BTC patients at the FQHC one half-day per week. Initially, parole officers referred most patients to the clinic, but because patients had few chronic health conditions, they had limited interest in medical care. In 2010, OA hired a grant-funded community health worker to recruit formerly incarcerated persons with chronic health conditions.

Program Description

The BTC is fully integrated into the FQHC's normal work flow. Currently, the BTC provides care two half-days per week with a voluntary physician, including one open access session. Following initial visits, patients are integrated into the physicians' primary care panel, and they may schedule follow-up visits during regular FQHC hours or return to the open access session on Saturday mornings. By providing access to primary care within 2 weeks of release from correctional facilities and retaining patients in ongoing medical care, the BTC ultimately seeks to improve health outcomes for formerly incarcerated persons.

Prison Referrals—Most new patients are referred from a release facility within the state prison system. OA staff perform pre-release health screenings on all inmates and inform the *community health worker (CHW)* about those with chronic health conditions. Following release, the CHW transports former inmates to their homes or residential facilities, and begins the referral process (completing clinic registration forms, confirming Medicaid application, building rapport, etc.). The CHW calls former inmates with reminders about BTC appointments. At release, a medical summary is available to former inmates, but accessing more complete medical records has been a challenge.

Community Health Worker—Our CHWs come from the same communities as BTC patients, were formerly incarcerated, and speak English and Spanish. They were hired because of their strong communications skills and commitment to this population. Linkage interventions often use nurses or social workers as patient navigators, but the life experience of CHWs may be better suited to motivate formerly incarcerated persons to seek medical care. The OA trains CHWs in health education, evidence-based recidivism prevention, and communication skills. By demonstrating caring attitudes (e.g. checking in with patients several times a week about unmet needs), CHWs become trusted advocates for BTC patients; this reduces fear of stigma or mistreatment during medical visits.

To achieve rapid access, all new patients are accommodated at the open access session. To optimize retention, the CHW provides positive social support and contacts patients who have disruptions in their care. Additionally, BTC physicians are self-selected, experienced with medical care for formerly incarcerated persons, and visit the correctional facilities on an annual basis; this likely reduces stigmatizing attitudes that could compromise retention in care. To improve health outcomes, the BTC physicians provide evidence-based care and work closely with case managers from the OA to ensure that competing needs (i.e. housing, employment, etc.) are addressed. Patients with high needs are discussed in weekly case

conferences, and there is an ongoing quality improvement initiative to assess health outcomes.

Program Participants

We conducted a retrospective cross-sectional study reviewing all 266 patients' electronic medical records from July 2009 to January 2013. Mean age was 41.0 and patients were mostly male, racial/ethnic minorities, and had Medicaid [see table 1]. Most patients had at least one chronic health condition (77%), most commonly HIV-infection, opioid dependence, or chronic hepatitis C. All patients had criminal justice involvement, and 62% were released from prison within 4 months. Others had more distant incarceration or were referred from court-mandated drug treatment programs, but had not been incarcerated.

For 164 patients with recent incarceration, median time from release to the initial visit was 10 days and 54% were seen within two weeks. Six-month retention in care was 39%; however, after hiring the CHW and placing more emphasis on retaining those with chronic health conditions, retention improved to 52%. Among 124 patients with chronic health conditions, 72% had at least one additional visit to the BTC.

Lessons Learned

Barriers to care, such as cost and provider availability were mostly overcome, and fear of stigma did not seem to impact clinical care. We learned three key lessons: (1) Even with prison discharge planning, 30% of patients lacked health insurance. Locating the clinic at an FQHC allowed us to see uninsured patients, provide medications at low or no cost, and assist with Medicaid enrollment. In the future, we will examine whether health insurance is associated with retention in care. (2) Formerly incarcerated persons are often stigmatized in medical settings, but having CHWs build trust before medical encounters seemed to reduce fear of stigma and patients were willing to disclose clinically relevant information about their past incarceration. In the future, we will collect data on patient experience and rigorously assess stigma and perceived discrimination. (3) CHWs identified patients with chronic health conditions better than parole officers, and patients who received support from the CHWs were more likely to be retained in care. Therefore, we are committed to using CHWs and will evaluate how they impact retention.

Challenges

Providing transportation, mental health services, and physician coverage have been challenges. (1) Transportation is a barrier to medical care for formerly incarcerated persons. Anecdotally, patients reported missing appointments because they could not afford public transportation. Previously, when possible the CHW would transport new patients to the BTC using a vehicle provided by the OA; however, now we have acquired grant funding to provide transit passes. (2) The demand for mental health services has exceeded the capacity of the FQHC. Several patients without chronic physical conditions were referred seeking parole-mandated psychiatric evaluation. These patients received a routine physical and referral to a mental health provider; however, the need for a second visit caused unnecessary delays and many of these patients were lost to follow-up. While generalist physicians manage some mental health conditions, a future goal is to provide comprehensive

psychiatric care at the first visit. For now, we will be collaborating with a community mental health provider who will accommodate BTC patients within one week. (3) Open access scheduling allowed us to see new patients soon after release from correctional facilities, but it also led to inconsistent patient volume, which stressed clinic staff during some sessions. (4) Our physicians have mostly participated in the Transitions Clinic on a voluntary basis, which could lead to burn out. For example, of the six original physicians only two continue to serve as BTC providers. However, because nearly all patients qualify for Medicaid, we hope to hire a part-time physician or mid-level provider to assume some of the clinical duties.

Next Steps

In addition to addressing the challenges above, two future goals are to continue quality improvement and expand our collaboration to include additional correctional facilities. For quality improvement, we are collecting data on the number of referrals from correctional facilities, the clinic show rate, and retention and health outcomes. To expand, the OA already has staff in additional correctional facilities, and the CHW will meet with discharge planners at these facilities.

Conclusions

Despite a high prevalence of HIV-infection, substance use disorders, and mental illness, formerly incarcerated persons face many barriers to obtaining medical care. Our partnership capitalizes upon several components – specialized community health workers, efforts to reduce stigma, flexible scheduling, and a federally qualified health center – which are likely available in other communities and allowed us to reach our goals of rapid access and retention in care. Building upon available resources with minimal additional grant funding, the Bronx Transitions Clinic has delivered patient-centered care to over 250 formerly incarcerated persons and serves as a medical home for many with chronic health conditions.

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Table 1

Sociodemographic and health characteristics among the 266 Transitions Clinic patients

Patient Characteristic	N (%)
Age (years $\pm$ SD)	41.0 $\pm$ 10.8
Male	239 (90)
Race/Ethnicity	
Hispanic	134 (50)
Non-Hispanic Black	113 (42)
Non-Hispanic Other	19 (7)
Insurance	
Medicaid	185 (70)
Uninsured	78 (29)
Other	3 (1)
Chronic Health Conditions *	
Medical	
HIV	48 (18)
Chronic Hepatitis C	60 (23)
Diabetes Mellitus	22 (8)
Hypertension	56 (21)
Asthma	44 (17)
Substance Use Disorders	
Tobacco Dependence	174 (65)
Opioid Dependence	49 (18)
Other	26 (10)
Mental Illness	
Depression	47 (18)
Other	30 (11)
1 chronic condition	206 (77)

* Data incomplete for 1 participant