Spotlight on the Safety Net

A Community Collaboration

Connecting People Released from Incarceration to Essential Health Services: The North Carolina Formerly Incarcerated Transition (FIT) Program

In 2018, 25,888 people were released from state prisons in North Carolina [1]. Likely one-third of these individuals have chronic medical conditions which require close medical follow-up. With the exception of a small number of people with serious mental illness (SMI) and substance use disorder (SUD), most people released from prisons and jails have no medical follow-up arranged prior to release. People released with chronic medical conditions like diabetes and hypertension may be given 30 days of medication upon release but rarely receive medical discharge planning. Studies of post-release health care utilization reveal that only 15%-25% see a physician outside of the emergency department (ED) in the first year. Estimates suggest that 35%-45% of the prison population is uninsured.

Lack of care coordination and timely access to care contributes to excess morbidity and mortality in this population. The risk of death upon release from prison is 12 times higher than the general population for adults of similar age during the first two weeks after release [2]. A recent study of people released from North Carolina prisons showed a 74-times and 40-times higher risk of death from heroin overdose and any opioid overdose respectively in the first two weeks post-release compared with the general population [3].

North Carolina is not unique; virtually every state has insufficient resources to assist people leaving incarceration in accessing needed health services. Additionally, as North Carolina did not expand Medicaid coverage, many people exiting prisons and jails are uninsured and too poor to qualify for insurance through the Affordable Care Act. For those with Medicaid as a result of disability (often SMI or SUD), it is terminated upon incarceration in prison and not automatically reinstated upon release. When individuals do not have access to routine primary care services, overall health outcomes are worse. As a result, individuals overuse emergency services and face preventable hospitalizations from chronic disease, mental illness, and SUD. This gap in our safety net comes at a high cost to these individuals, the health care system, and our society.

To bridge this gap of care in North Carolina, we looked nationally for evidence-based interventions to inform the design of a program to serve our population returning to the community from incarceration. We found the Transitions Clinic Network (TCN), which developed a model using community health workers (CHWs) with a personal history of incarceration to act as peer navigators linking people to essential health services and assisting with reentry. TCN programs collaborate with community health centers as primary care medical homes and assist clients with addressing reentry barriers. These barriers include poverty, housing and food insecurity, unemployment, lack of transportation, low educational attainment and health literacy, lack of identification and driver's license, and strict post-release parole/probation conditions. The CHWs are highly effective, using their shared lived experience to develop rapport and trust with people exiting incarceration. Peer-reviewed literature has shown outcomes of TCN programs to include increased use of preventive and primary care services, decreased ED utilization, and reduction in number of days incarcerated if re-arrested [4].

To assist people released from our prisons and jails who are suffering from chronic disease,

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Address correspondence to Evan A. Ashkin, MD, UNC Department of Family Medicine, 590 Manning Dr., Chapel Hill, NC 27599 (ashkin@med.unc.edu).

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mental illness, and/or SUD, we created the North Carolina Formerly Incarcerated Transition (NC FIT) Program. We adopted and modified the TCN model and became part of their national network. The NC FIT Program was designed to leverage substantial investments previously made by governmental and community-based reentry organizations and the Department of Public Safety (DPS), which administers the state's prison system.

For the last decade, DPS has enacted a two-pronged approach to improve reentry through creation of local reentry councils (LRCs) and reentry-focused prisons. The role of the LRC is to bring together community organizations, governmental agencies, and programs working with people in the criminal justice system to facilitate collaboration. LRC members may include programs that assist with housing, education, legal services, vocational training, job placement, mental health and SUD treatment, and issues involving law enforcement, parole, probation, and the court system. DPS created reentry-focused prisons where in anticipation of release, individuals can be transferred close to where they plan to live, enabling them to reconnect with their community and begin working with members of the LRC to assist with a more coordinated and successful reentry.

The NC FIT Program was designed to employ CHWs in the TCN model and place them at the intersection of community reentry, essential health care, and the criminal justice system. Our pilot FIT program was developed in Durham County in 2017 with seed funding from the North Carolina Department of Public Health. The CHW was hired by the Durham County Health Department and the medical home for our clients is the Lincoln Community Health Center (CHC). Durham's existing strong local reentry council run by its Criminal Justice Resource Center allowed our CHW to easily connect clients to needed reentry services [5]. We worked with DPS to enable our FIT program to work with reentry-focused prisons in Wake and Orange counties for in-reach into those facilities, identifying eligible clients prior to release. Due to Medicaid non-expansion, 74% of our clients are uninsured and cannot afford the costs of medical care or medications, even at federally qualified health centers like Lincoln CHC. To overcome this barrier, we raised private funds to assist our clients with these expenses.

Clients are referred to FIT CHWs from sources including LRC members, parole and probation officers, jail and prison staff, word of mouth among individuals within the criminal justice system, and directly from DPS. In-reach into prisons and jails has been effective in engaging people in the FIT program upon release. During enrollment, clients identify their barriers to successful reentry and we help them define short- and long-term goals. FIT CHWs develop a comprehensive reentry plan with clients and assist with all aspects of that plan. FIT CHW duties include scheduling appointments, accompanying clients to clinic visits, ensuring they obtain medications, providing assistance with court appearances, and obtaining identification, cell phones, and transportation vouchers. They also help with applications for housing, insurance coverage, and public assistance programs, and support clients with vocational training, employment, and obtaining clothing for job interviews.

After our initial seed funding, we received a three-year grant from the Duke Endowment, allowing us to continue our program in Durham and expand to Orange County. These programs are now self-sustaining as both health departments have made FIT CHWs regularly funded positions. We created FIT programs in both Wake and Mecklenburg counties through a contract with DPS and will expand to Guilford County in the fall of 2019. Unfortunately, we are only able to serve a small fraction of the population returning from incarceration in our state as a CHW's full caseload is between 40 and 50 clients.

We expect the FIT programs to increase engagement in primary care, mental health, and SUD treatment. Collaborating with TCN, we will measure ED visits, preventable hospitalizations, recidivism, and death from opioid overdose among other outcomes.

Future directions of the NC FIT program include expansion of existing sites and new programs in underserved areas of the state. Additionally, we are assisting in the creation of jail- and prison-based medication assisted treatment programs and continuing treatment upon release, which has been demonstrated to radically reduce post-release opioid overdose death in this highly vulnerable population. NCMJ

Erin E Clark, MPH fourth-year medical student, Campbell University School of Osteopathic Medicine, Buies Creek, North Carolina.
Evan Ashkin, MD professor of family medicine, University of North Carolina Department of Family Medicine, Chapel Hill, North Carolina.

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