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How Health Center Care Teams Can Address Health and Housing for Patients Involved With the Justice System

NATIONAL NURSE-LED CARE CONSORTIUM
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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

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Introduction

Health centers are on the front lines of providing care and resources to communities faced with one or more social determinants of health (SDOH), including housing security and involvement with the justice system. The effects of these determinants ripple outwards from the experiences of individual patients to their families, communities, and, potentially, the larger health center population. It is critical that health center staff thoroughly understand the justice and housing landscapes, including the ways in which those sectors interact with the healthcare system and affect clinical outcomes. This issue brief aims to provide an overview of both the civil and criminal justice systems in the United States. It also describes the cyclical relationship between those systems and housing insecurity (including homelessness). Based on this foundation, the brief outlines potential workflow considerations for health centers working to reduce health disparities for patients and families.

COVID-19

Public Health emergencies exacerbate the negative implications of SDOH, and COVID-19 is no exception. The current pandemic has revealed the true scale of inequities faced by communities made vulnerable by trauma, lack of access to resources, and discrimination. COVID-19 has thus necessitated flexibility from settings interfacing with justice-involved patients, including health centers, courts, law enforcement, correctional facilities and more. A pandemic-specific update has been included on **Page 15** to explore the impact of COVID-19 on vulnerable patients and how service providers have responded and adapted to this crisis.

Understanding the Complex Landscape of Justice-Involvement for Health Center Patients and Their Care Teams

An Overview of the Justice System

The legal system is complex, and justice-involved health center patients are often faced with a myriad of legal needs that threaten their health and well-being. Even after an individual has completed a sentence in the criminal justice system, they may face a number of civil collateral consequences resulting in barriers to social needs such as housing, employment, and access to health care. To help improve the health of justice-involved patients, health center care teams can begin by grounding themselves with a basic understanding of the landscape of legal systems that these individuals navigate. This section provides some general definitions that are particularly helpful in decision-making regarding care management or policymaking:

- Civil law and criminal law
- Federal courts and state courts
- Jails and prisons

Figure A: Civil and Criminal Law

Resolution of legal claims by one individual or group again another	Prosecution by the government of a person for an act that has been classified as a crime

In the United States, the legal system can be divided into two major categories: civil and criminal. (See Figure A.) The parties, penalties, roles, rights, and remedies may differ between each system, but there are some overlaps. An individual may have an interaction with the criminal justice system that results in not only a criminal sentence involving incarceration, but also civil penalties such as the payment of a money judgment for damages or the suspension of a driver's license. For justice-involved patients, these civil legal issues may long outlast an encounter with the criminal justice system and can pose recurring threats to one's ability to access needed health care.

There are also distinctions and overlaps between the federal and the state court systems as noted in Figure B. The primary distinction between the state and federal courts is jurisdiction over the types of cases the court may hear. Generally, federal courts hear cases involving federal law issues or cases involving the United States as a party, and state courts preside over matters involving state laws. However, there are instances of overlap, such as when a specific act is a crime under both federal and state laws.

Incarceration can occur in multiple settings, and most typically involves jails or prisons. As health centers consider ways to address the health needs of justice-involved populations, it may be helpful to keep in mind some general distinctions between jails and prisons. In general, jails are places of confinement for individuals awaiting trial or usually serving sentences for one year or less. **According to a 2018 report by the U.S. Department of Justice Bureau of Justice Statistics**, inmates spent an average of 25 days in jail. In contrast, prisons are typically used to house individuals convicted of more serious crimes that carry sentences of over a year.

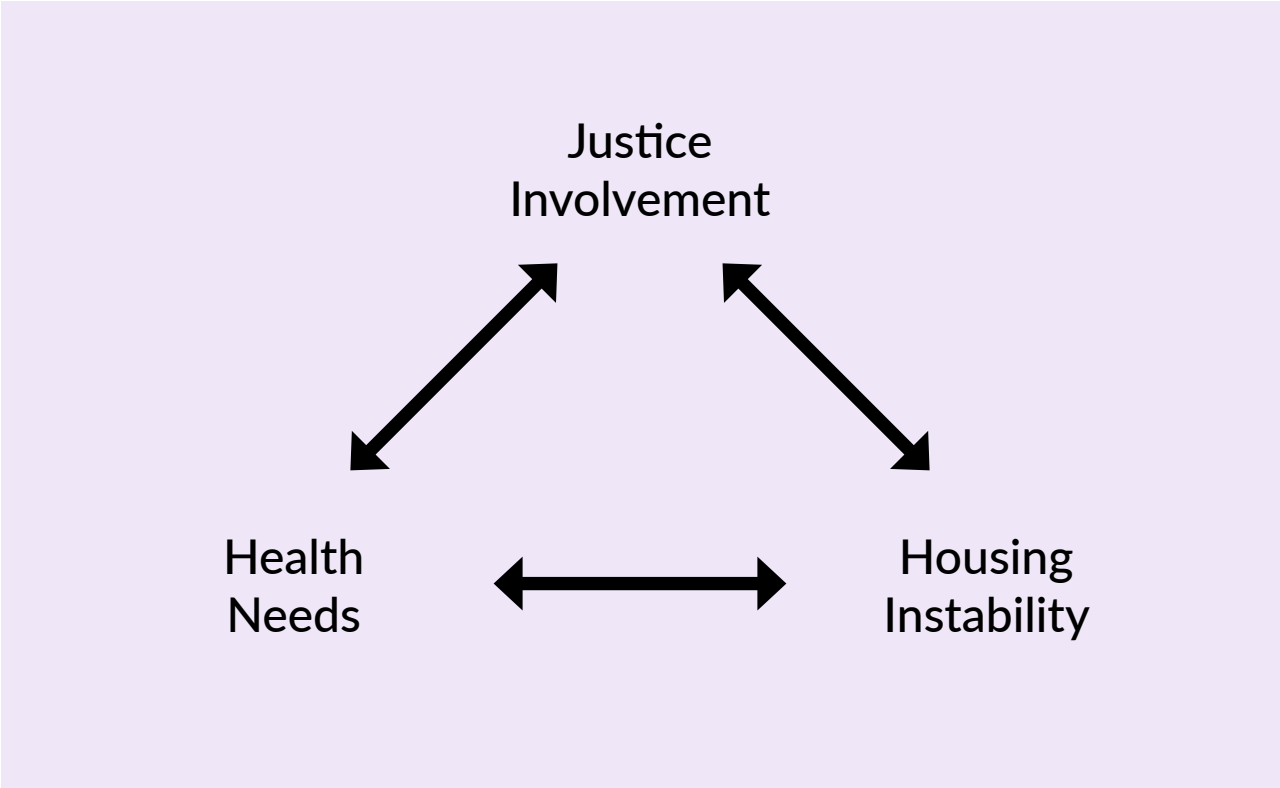
Access to health care in both settings is extremely limited and one's coverage for services, e.g. through Medicaid, may be terminated because of incarceration. In fact, federal law excludes Medicaid payment for services provided to inmates of public institutions, including pre-trial detainees. Exceptions are made for inpatients of a medical institution. In 2016, however, the **Centers for Medicare & Medicaid Services (CMS) issued a State Health Official Letter (#16-007)** clarifying that the inmate exclusion policy amounts to a general coverage exclusion. An inmate may be determined eligible for Medicaid and/or have their status suspended while incarcerated. Facilitating access to Medicaid services upon release is a critical step towards ensuring that individuals transitioning back into their communities have access to care needed to avoid reincarceration.

For health centers, a foundational understanding of the legal landscape can help care teams better identify risk factors, address capacity needs, and make informed decisions regarding how to improve care for patients involved with the justice system.

The Complex Needs of Justice-Involved Health Center Patients

With the help of funding streams made available through the HRSA health center program, Federally Qualified Health Centers (FQHCs or health centers) are uniquely poised to serve as access points for vulnerable individuals entering a system of care. Health centers with public or private funding to reach special and vulnerable populations have additional leverage to connect patients with resources that address the social determinants of health (e.g. enabling services, housing services, legal services). Data overwhelmingly supports the need for this type of service coordination. For example, individuals experiencing homelessness and housing instability have a significantly higher likelihood of interfacing with emergency services (emergency shelters, emergency rooms (ERs), and the justice system) than the general population.[1] [2]

Figure B: Now What



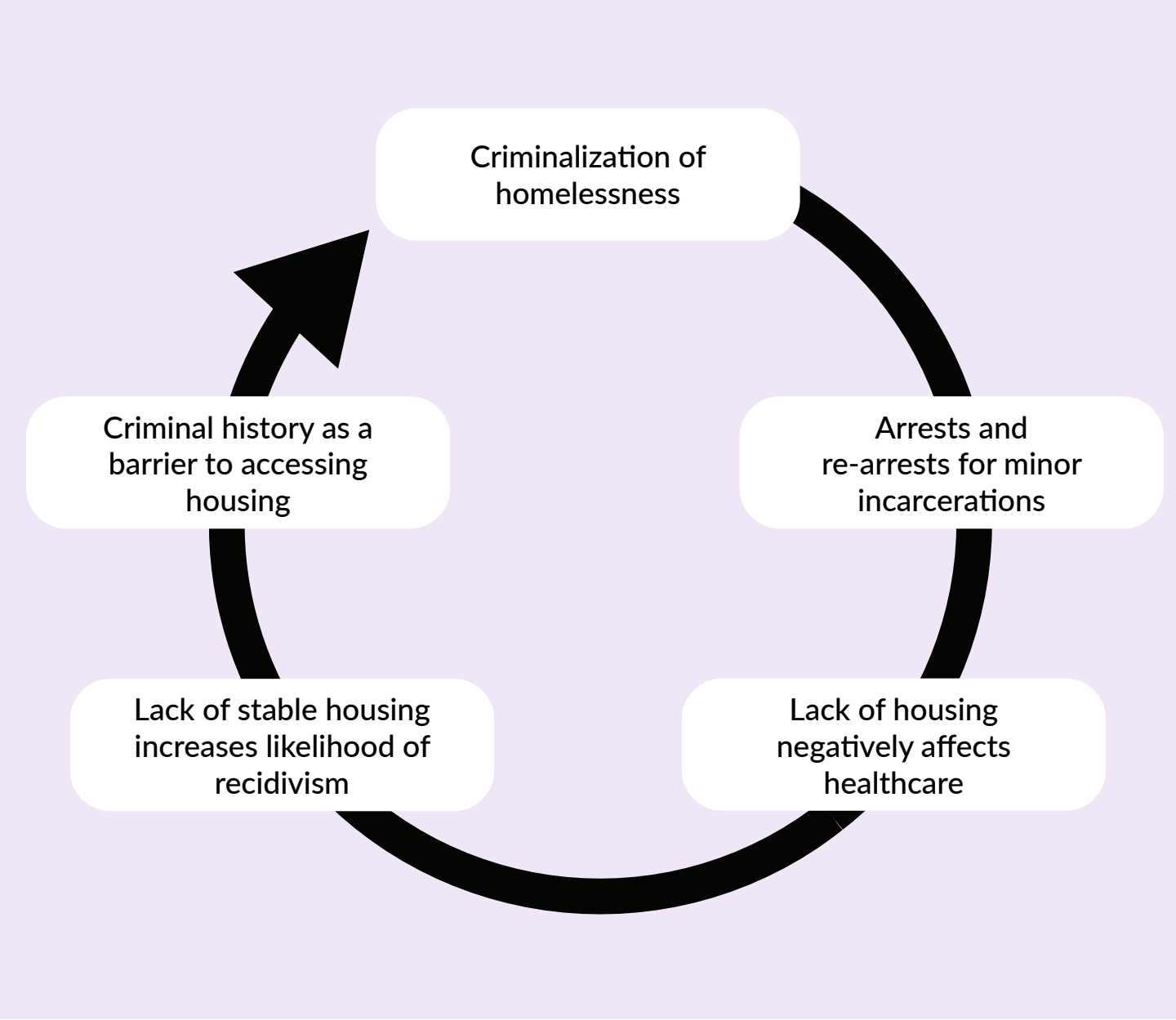
Justice involvement, housing instability, and complex health conditions overlap in the lives of many health center patients. In order to effectively serve those with these common challenges, it is necessary to first explore the health needs of justice-involved individuals and to learn how health centers have successfully employed strategies to meet these needs.

Numerous studies illustrate the disproportionate experience of chronic health conditions in justice-involved populations, such as hypertension, diabetes, and cancer. [3] [4] People with a history of incarceration are also more likely to have active communicable diseases like Hepatitis C (29% of all infections) and Tuberculosis (35% of all infections).[5] Behavioral health and substance use disorders also follow this trend, with justice-involved populations experiencing rates as high as 4 times that of the general population.[6]

	Justice-Involved Population Prevalence	Community Prevalence
Cancer	8.0% [4]	3.0 - 4.0% [4]
Cardiovascular Disease	38.0% [4]	18.0 - 20.0% [4]
Diabetes	Prisons: 9.0% [3], Jails: 7.3% [3]	6.5% [3]
	14.0% [4]	7.0 - 17.0% [4]
Hypertension	Prisons: 30.2% [3], Jails: 26.3% [3]	18.1% [3]
	39.0% [4]	27.0 - 42.0% [4]
Any Chronic Condition	Prisons: 43.9% [3], Jails: 44.7% [3]	31.0% [3]

Without adequate services during and after incarceration, individuals transitioning out of the justice system face countless barriers to health and housing. Individuals with justice involvement are 7-13 times more likely to experience homelessness, increasing with each instance of incarceration.[7] The combination of limited services, limited housing opportunities, and complex health challenges contribute to the cycle of re-incarceration, greatly costing the individual and the community at large.

Figure C: Cycle of Incarceration



Thousands of individuals are released from jails and prisons each year without care coordination or access to crucial resources. Because of their unique services and funding streams, community health centers are well positioned to suit the needs of individuals transitioning out of the prison system across the country. Health centers around the country are employing creative strategies to make an impact. The following case studies are examples of health centers leveraging their expertise, partnerships, and funding streams to address the needs of justice-involved patients.

Albuquerque Health Care for the Homeless

Albuquerque Health Care for the Homeless (AHCH) is a health center that has provided services to patients experiencing homelessness and housing instability since 1985. AHCH serves nearly 7,000 people without homes every year, providing comprehensive health and integrated supportive services while maintaining a leading voice in their community on issues of homelessness.

AHCH has long been a central 'first stop' for individuals released from jails and prisons, as a well-known resource for obtaining medications and health services. By integrating behavioral health services, substance use services, physical health care, and resource coordination that is low barrier and requirement free, AHCH has found success in improving health outcomes for justice-involved patients.

AHCH's unique intervention strategies that have been successful in engaging justice-involved patients include:

Harm Reduction

AHCH's Harm Reduction Outreach Program provides services through certified harm reduction specialists located on-site and at various outreach hubs. Services are made available to individuals experiencing homelessness, substance use disorders, or looking for connection to services.

ArtStreet Studio

ArtStreet is a community-based studio open for clients interested in therapeutic art activities, opportunities to socialize, and to find respite from the heat and cold.

Resource Center

AHCH's resource center is open for access to showers and to have immediate, basic needs met without requirements.

These interventions have been successful methods of building relationships with justice-involved individuals and connecting them with services. AHCH leadership attributes the success of each program to the lack of restrictions accessing resources, stating: "All we want is to build relationships while navigating and linking people to care… this is a very effective strategy for working with justice-involved populations."

Promising practices in approaches to systems change: Building on their programmatic success, AHCH has formed strong relationships across sectors to change systems affecting those experiencing homelessness and justice-involvement. By collaborating with local and regional partners, AHCH has addressed the gaps and barriers existing in the criminal justice system. Those outreach opportunities and partnerships include:

Criminal Justice Coordinating Council

Through participation in a local Coordinating Council, AHCH is attempting to disentangle law enforcement from behavioral health crises and to explore alternatives to punitive measures for those experiencing behavioral health issues. Through long standing partnerships, AHCH is beginning to see success in bridging behavioral health and criminal justice systems (improving data sharing between systems, reducing the number of individuals with behavioral health conditions in jail, and reducing the length of stay for individuals with behavioral health challenges).

Outreach Court

AHCH has partnered with local officials to redefine avenues of clearing citations and tickets. Rather than requiring community service or employment, establishing services at AHCH can now be a way of erasing charges. Through this outreach court partnership, AHCH has helped shift perspectives from traditional punitive measures toward emphasizing health services.

Promising practices in policy reform: AHCH participates in various other committees and coalitions that inform local and state policies that have real impact on their clients:

Law Enforcement Reform

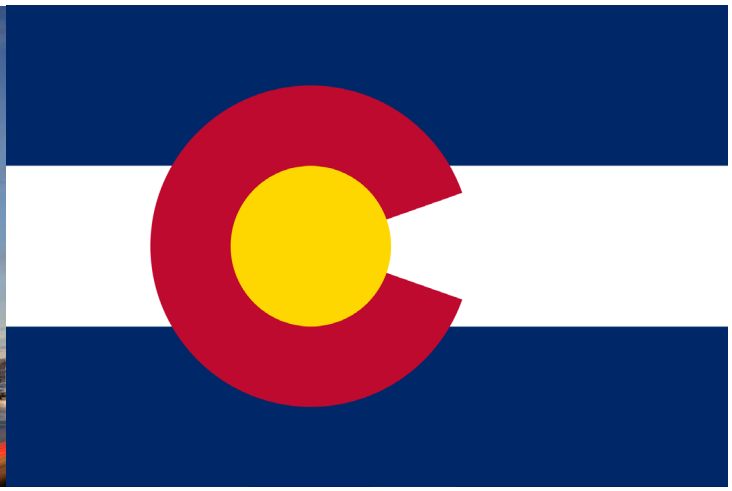
Since 2014, AHCH has sat at the table of Albuquerque's law enforcement reform coalition, which holds the local police department accountable in cases of excessive force. Participation in this coalition enables AHCH to work for the decriminalization of homelessness and limit instances of adverse experiences with law enforcement.

Criminal Justice Reform

AHCH, through their involvement in various coalitions, has been involved in statewide criminal justice reform. In 2019, New Mexico passed legislation regarding expungement for misdemeanors and certain felonies. AHCH also participated in efforts to promote Ban the Box legislation, which was passed for public employers in 2019.

Client Leadership Committee

AHCH's standing Consumer Advisory Committee provides essential feedback that informs services, amplifies patient experience, and guides quality improvement. The Client Leadership Committee also informs policy priorities—including issues related to the criminal justice system and civil rights. With their expertise in civil rights, this committee organizes a forum with the ACLU of New Mexico every year to train individuals experiencing homelessness on what their rights are when interacting with law enforcement.



Colorado Coalition for the Homeless

Colorado Coalition for the Homeless (CCH) is a Denver-based organization providing health services, service coordination, and housing to individuals and families in Colorado. CCH operates 19 permanent supportive housing and affordable housing properties and, with additional wrap-around supportive services, provides assistance to over 18,000 families and individuals each year. CCH's Stout Street Clinic is a health center providing integrated health care services to clients experiencing homelessness and housing instability on site and at various satellite clinic locations.

Through a unique "Pay for Success" grant opportunity, CCH prioritizes housing and wrap around services to clients with a history of justice involvement and emergency service utilization. Funding for this project comes from CCH's involvement in a Social Impact Bond (SIB), which is a collaboration between:

- CCH
- The City of Denver
- Mental Health Center of Denver
- Denver Police Department
- Various Private Investors

This SIB project, which began in 2016, prioritizes housing and supportive services for 250 individuals experiencing chronic homelessness that have also been identified as the 'highest utilizers' of Denver's emergency services—police, jails, detox centers, and emergency rooms. The goal of the SIB is to evaluate how housing and supportive services reduce jail bed days, emergency room stays, and how investment in these interventions can save costs to the community.

Promising models for intervention:

Housing First and Harm Reduction

CCH operates within a housing first and harm reduction frameworks, which ensure their services are low barrier and accessible to patients regardless of background. The SIB project creates low barrier housing opportunities for individuals with a history of chronic homelessness and justice system involvement. Considering the success of the housing first model, CCH expects ER and jail stays will decrease dramatically, saving the community up to $18,000 per resident, per year.

Assertive Community Treatment (ACT)

The SIB project also funds two Assertive Community Treatment (ACT) teams focused on this high utilization group to connect individuals with services that prevent homelessness, emergency room stays, and interaction with law enforcement. ACT teams are interdisciplinary teams of professionals providing case management, assessment, medical care, psychiatric treatment, substance treatment services, and more to ensure all needs are met once an individual is in housing. These ACT teams also work from a harm reduction framework and work to reduce negative consequences associated with substance use.

Though complete results from the SIB project are not yet available, preliminary data indicates that this intervention is promising in its ability to reduce jail stays and prevent returns to homelessness. Early outcomes support the claim that permanent housing with harm reduction and comprehensive wrap-around services are effective approaches to serving patients with a history of justice-involvement and other systems of emergency services.[8]

Next Steps and Promising Practices: Workflows

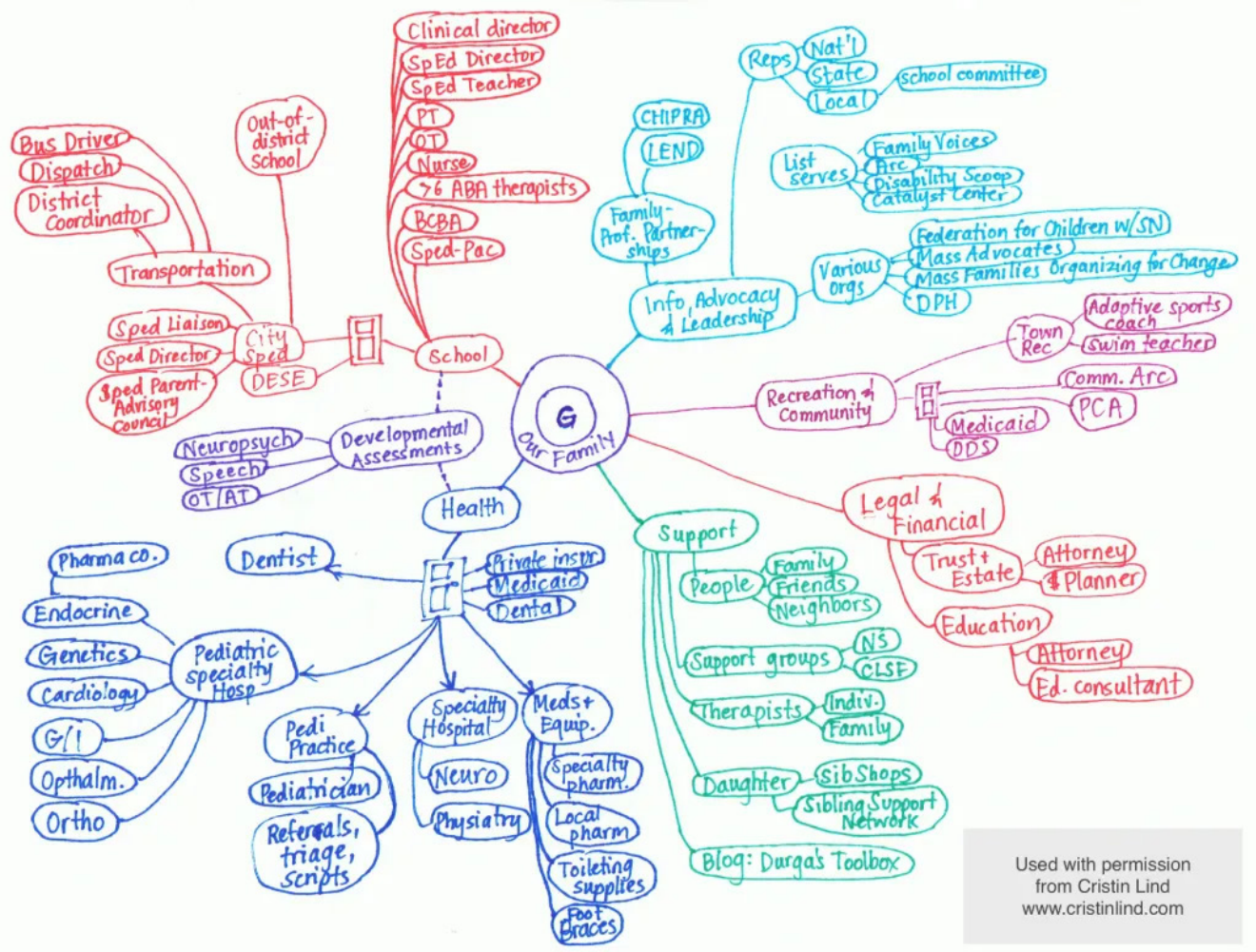
Health centers can address the implications of housing insecurity and justice involvement by initiating a clear, sustainable workflow designed to coordinate care for patients. Like any quality improvement initiative, the implementation of this workflow must account for current staffing capacity. Without adequate time, resources, or staffing, health centers run the risk of stalling potential progress. Quality improvement efforts are not implemented in isolation from other health center initiatives. When possible, health centers should align improvement efforts across the organization, including those driven by external forces like funders and payers. The below workflow should be adapted to meet the needs of each health center's infrastructure.

Housing and Justice-Involvement Linkage Workflow

Screening →	Registry →	Outreach →	Ongoing Follow-up
• Staffing • Timing • Methodology • Tool	• Registry tool • Payer considerations	• Schedule visits • Recommend interventions and resources	• Regular check-ins with defined timeline • Tap into medical neighborhood partners

Before piloting this workflow, health center's must (1) identify staff responsibilities and roles, and (2) map their medical neighborhood. The former will involve creating an inventory of current staff responsibilities, and may require the help of volunteers (like interns or **AmeriCorps VISTA** members) to fill in any gaps. Once each staff member's capacity to support the project has been assessed, health centers can use tools like a **RACI matrix** to assign tasks and accountability. Health centers must also determine which members of their "**medical neighborhood**" should be included in operationalizing this workflow. Medical neighbors for this project may include legal advocacy organizations, city or state departments of justice, housing authorities, and/or behavioral health specialists. A medical neighborhood map could take the form of a circular diagram of organizations, a virtual or physical map of the community with pushpins, or a spreadsheet with columns that list a partner's location, contact information, and other necessary details. No matter how the medical neighborhood is depicted, the key community partners identified within it should be included in the health center's objectives and goals. If and when appropriate, community partners should be referenced as part of the health center's workflow.

Map example:



Screening

According to the **2019 Uniform Data System (UDS) report**, nearly 71% of health centers "collect data on individual patients' social risk factors, outside of the data reportable in the UDS." This indicates that the majority of health centers are well positioned to enact the first step of the Housing and Justice-Involvement Linkage Workflow. By screening for the social determinants of health (SDOH), health centers can identify patients' relevant non-medical needs, including their access to stable housing and past or present involvement in the justice system. **Tools like PRAPARE** already include questions related to housing and justice involvement, but can be adapted to include additional questions around these issues. Once a tool has either been selected or modified, health centers must determine:

- Whether patients are self-screening, or being walked through the screener by staff
- Which staff are conducting screenings, and when
- How screening results are being communicated to the other members of the care team
- How screening results are recorded and tracked.

Routine SDOH screening can identify patients who may benefit from inclusion in a targeted patient registry.

Registry

Patient registries are traditionally used to track and measure outcomes for patients with a particular chronic condition, but health centers can utilize registries to monitor outcomes for patients with positive screenings for housing instability, justice involvement, or any number of social determinants of health. Some health centers participate in **alternative payment models (APMs)** with either private insurers or state-based Medicaid programs, which may provide pre-populated registries of high-risk or high-cost patients. In this case, health center staff can determine whether patients on these existing registries have needs around justice involvement or housing. If a health center opts to create a registry themselves, there are several options:

- Determine the capability of your electronic health record (EHR) to automate registry assignment based on screening results
- Manually assign patients to a registry within the EHR
- Creating a spreadsheet of patients with columns to track screening information and outcomes

Patient registries should answer a key question about the health center's patient population: are there outcomes disparities between those with and without justice involvement? What interventions are most helpful for patients experiencing housing insecurity? How can we best serve residents of public housing?

Registries are living documents - they should be regularly reviewed to update a patient's status, add additional patients, or modify outcomes or measures. Health centers building registries for the first time should focus on small pilot projects (like the Housing and Justice-Involvement Linkage Workflow) before creating registries for every clinical priority. Once a patient is assigned to a registry, members of the health center care team can conduct outreach and recommend interventions based on their needs.

Outreach

Many health centers participate in quality improvement initiatives like the **National Committee for Quality Assurance's (NCQA's) Patient-Centered Medical Home Model**, which encourages the adoption of team-based care and care coordination. Some health centers may divide care coordination responsibilities between several staff members, while others have a dedicated Care Coordinator (typically a member of the nursing staff) to oversee the process for particular populations or initiatives. Regardless of how tasks are assigned, care coordination responsibilities in the Housing and Justice-Involvement Linkage Workflow should flow sequentially from the time a patient is added to the registry.

- Step 1: Conduct patient outreach either during or after the visit when the patient was added.
- Step 2: Schedule patient for a follow-up care coordination visit with relevant staff, which may include a nurse, a social worker, and/or a behavioral health consultant.
- Step 3: During the care coordination visit, create a **shared plan of care** with the patient's input.
- Step 4: Link patient with resources from the medical neighborhood (including resource databases like **findhelp.org**) and/or recommend an evidence-based intervention.
- Step 5: Create a plan to follow up.
- Step 6: Reassess patient progress at regular intervals.

Primary care providers should be informed and consulted about their patient's participation in care coordination activities, and should **regularly huddle with all members of the care team** to ensure continuity of care.

Ongoing Follow-up

Without ongoing follow-up, patients may experience worsening conditions, miss or skip referrals to services, or be lost to care. It is critical that care coordinators work closely with specialists and community partners to close referral loops and bolster patient compliance by engaging in evidence-based strategies like motivational interviewing and goal setting. Follow-up procedures and timelines can be maintained in the EHR via alerts, notes, or in the patient's shared plan of care.

COVID-19: The Impact on Vulnerable Patients and Health Center Response

COVID-19 necessitated a seismic shift in healthcare delivery, and continues to affect the way health centers operate. Notably, health centers quickly ramped up telehealth efforts to continue seeing patients during phase one of stay-at-home orders. Telehealth can be a powerful tool for patients with transportation issues, and **may reduce stigma** for patients seeking behavioral healthcare. For justice-involved patients and/or patients experiencing housing instability, ongoing access to telehealth may promote continuity of care and encourage the utilization of behavioral health and other services.

> *"Homeless patients are 2 times more likely to experience serious psychological distress and 57 percent more likely to report being in fair/poor health than community health center patients."*
>
> ***HRSA 2019-2020 Health Equity Report: Special Feature on Housing and Health Inequalities*** *(October 2020)*

The COVID-19 pandemic has caused increased rates of unemployment and housing insecurity, which are particularly harmful to the health and well-being of justice-involved patients. In recognizing the important **link between health and housing**, health centers across the country continue to adapt their practices to better serve vulnerable populations, such as people experiencing homelessness who may not have access to protective measures during the pandemic. In practice, this looks like:

Albuquerque Health Care for the Homeless (AHCH)		Colorado Coalition for the Homeless (CCH)
AHCH shut down indoor programs that posed a concern for COVID-19 spread. However, recognizing the importance of engaging clients in services, leadership developed plans to adapt programming.	Flexibility	To curb the spread of COVID-19, they began operating at a limited capacity, closing several locations and limiting hours. However, CCH has remained flexible and adopted new approaches to service delivery.
The ArtStreet community space transitioned to ArtStreet To Go, a virtual program that allows access to the arts and focuses on supporting individuals with anxiety and stress, especially for people in shelter, supportive housing, or quarantining due to COVID-19 exposure.	Telehealth & Virtual Programming	CCH has expanded telephonic care significantly since March of 2020. Thanks to already existing telehealth infrastructure and statewide policies allowing for reimbursement of telehealth, this quickly became the primary mode of reaching patients.
AHCH has also ramped up their street outreach. AHCH initially limited clinical services resulting in less connection with patients. Attempts to stay connected and reach medically fragile patients has been central to their COVID-19 response.	Combatting Isolation & Increasing Outreach	
	Building & Strengthening Community Partnerships	CCH is a member of the Denver Joint Task Force, which leads Denver's planning and response to COVID-19 in the city's unsheltered population. This task force published strategies on supporting the shelter system, installing isolation and quarantine sites, alternative care sites, and protection for medically fragile individuals in congregate shelter settings.
For many, the expiration of 2020 federal protections for rental relief means a return to homelessness and possible interactions with the legal system. AHCH has issued an exhaustive list of state and federal resources for protecting patients from eviction and securing additional financial support in the winter of 2020/21.	Resource Provision & Filling Gaps	Residents of CCH's supportive housing sites, some of whom are prioritized within the SIB project, have a particular need for ongoing wrap-around services in this challenging time. In order to facilitate connection with residents of the greatest need, CCH purchased cellphones and distributed them to those identified as highest risk.

In an effort to slow the spread of the virus, the justice system (courts, law enforcement, correctional facilities, etc.) has also taken steps to ensure the safety of staff, justice-involved individuals, and local communities. Rather than making arrests, law enforcement authorities have opted to issue citations. Courts have suspended in-person proceedings. Correctional facilities have released inmates as early as possible or may waive the costs incurred for care or communications. Counties and policymakers are also seeking longer term solutions for justice-involved individuals, such as the better integration and sharing of health systems data or changes to Section 1905(a)(A) of the Social Security Act to limit applicability to only post-adjudicated individuals. Finally, states and the CDC have issued a variety of eviction moratorium policies, but researchers and policy experts have noted that rental assistance is still needed to help **tens of millions of individuals avoid homelessness.**

3 WAYS TO HELP PATIENTS WITH EVICTIONS & FORECLOSURES DURING THE COVID-19 PANDEMIC

As health care providers and staff, here are three ways you can help patients facing a possible eviction or foreclosure by working with legal aid attorneys in your community:

1. Talk to an attorney about free housing legal services available for your patients.
2. Review the COVID-19 Housing Policy Scorecard to find out what protection measures are in place in your state so that you can better inform patients of their housing rights.
3. Advocate for stronger housing protections in your state.

For more detailed information on how to help patients facing health-harming legal needs, see the **National Center for Medical-Legal Partnership's Tip sheet**: three ways to help patients with evictions & foreclosures during the COVID-19 pandemic.

Conclusion

With over **10 million arrests in 2019**, the highest number of which were for drug abuse violations, millions of Americans have an encounter with the justice system that may result in new barriers to health care and housing. The COVID-19 pandemic only exacerbates the economic, social, and mental health needs of already vulnerable patients, such as justice-involved individuals or those experiencing housing instability. When equipped with a clearer understanding of the justice system, the complexity of social needs, and strong examples of promising practices from the field, health centers can take concrete steps to improve the care and health of vulnerable patients and communities.

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