Transitions Home: A Health Needs Assessment for Individuals Leaving Boston-Area Jails

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Title: Transitions Home: A health needs assessment for individuals leaving Boston-area jails

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Abstract

Incarceration has profound impacts on health, particularly in the US, which continues to incarcerate more people than any country on earth. Incarceration may disrupt continuity of care and contribute to adverse social determinants of health, such as unstable housing and employment. The period immediately following release from prison or jail has been found to bear an extremely high mortality risk. Academic medical centers thus should have a natural interest in understanding the experience of transitioning home after incarceration. Local stakeholders in the Boston reentry landscape were identified and interviewed. A qualitative analysis of these interviews was conducted, resulting in this report on the reentry services landscape, with particular concern for: currently existing services; challenges to serving the reentry population; and, opportunities for academic medical centers, policy makers, and individual clinicians to innovate and provide better care for this marginalized population.

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Glossary of abbreviations

- MAT: Medication-assisted treatment
- CSS: Clinical Step-down service
- TSS: Transitional step-down service
- AMC: Academic medical center
- CBO: Community-based organization
- SUD: Substance use disorder
- CHW: Community health worker
- DOC: Department of Corrections
- BMC: Boston Medical Center
- MGH: Massachusetts General Hospital

SECTION 1: INTRODUCTION

People with a history of incarceration experience higher rates of chronic illness than the general population, including significantly higher rates of SUDs and serious mental illness.[1] 10% to 20% of jail inmates and 25% of prison inmates have a serious mental illness; the proportion of affected jail inmates is estimated to be three to six times that of the general population.[2] In terms of infectious disease, HIV prevalence among the incarcerated population has been reported as roughly five times that of the general population;[3] Hepatitis C prevalence estimates range from eight to 21 times that of the general population.[4] This population also has higher rates of dental disease than the general population.[5]

Incarceration in and of itself has been found to worsen a person's health status.[6] Additional health effects of incarceration are mediated through social determinants of health such as unemployment and unstable housing. Potential employers often screen out applicants with history of incarceration, creating major obstacles to securing employment.[7] Similarly, four out of five landlords use criminal background checks to screen out applicants.[8] As well, certain convictions confer restrictions on public housing. In one report, 79 percent of returning citizens reported being denied housing due to their criminal history.[9] The most acute form of incarceration's health hazard is experienced in the weeks after release, when rates of death from overdose catapult to 129 times the rate of peers -- and those data, from the early days of the opioid epidemic, likely underestimate risk.[10]

Six thousand individuals are incarcerated each year in Suffolk County's short-term jails. These individuals return to the community at a rate of twenty per day, often with no means to reconnect with their healthcare providers. Both of the Suffolk County short-term jails have discharge coordinators, but given the high volume, there exists limited capacity to link patients with clinical resources in the community.

With these issues in mind, the MGH Department of Medicine's Community Council sponsored a needs assessment and qualitative interviews to define the challenges and opportunities specific to reentry services in the Boston area. Nationwide, there is increasing recognition of the ways that incarceration adversely affects health.[11] However, the efforts to improve healthcare navigation post-release, both locally and nationally, are often piecemeal and focused on specific subpopulations.[12] For example, people with HIV and severe mental illness

are often provided more formal discharge planning to increase the likelihood of continuity of care as they transition between incarceration settings and the community.

Incarceration is in and of itself a factor in people's health, and so it is important to consider how to improve the health outcomes of all people affected by incarceration. The objective of this project was to conduct interviews and a qualitative analysis of the opportunities and challenges for academic health systems regarding patient navigation after release from incarceration. We hypothesized that formerly incarcerated population have unmet healthcare-related needs, which represent opportunities for better service coordination for this vulnerable population.

SECTION 2: STUDENT ROLE

Collaborating with another medical student, I developed the questionnaire for the project's interviews, recruited interviewees, conducted and transcribed the interviews, conducted qualitative analysis of the interview transcripts with NVIVO software, then prepared a report of the findings and presented these findings to the MGH Community Council, which sponsored the project.

SECTION 3: METHODS

This project has been approved by the Partners IRB. We first conducted seven informal, background interviews with national experts in work related to healthcare and reentry (see Table 1 for details). These discussants provided guidance on the state of reentry health in other large cities; suggestions of questions to ask and themes to explore in our questionnaire; and recommendations of specific local stakeholders to interview.

We then identified key stakeholders of local reentry efforts from pre-existing professional networks in the categories of government, CBOs, and academic medical centers (see Table 2 for stakeholder details). The co-authors have all worked in local jail-based healthcare, so the process of identifying stakeholders was facilitated by these professional networks. Some stakeholders were already known to the authors; others were unknown to the authors and recommended by professional network connections. The eligibility criterion was professional experience related to

the process of reentry. We recruited ten interviewees from among this pool of stakeholders. Our priorities in the recruitment process were: a balance between governmental, CBO, and AMC perspectives; and, within these categories, a diversity of perspectives about the reentry process. For example, within the governmental category, perspectives from the reentry support side were balanced with perspectives from the law enforcement (probation officer) side.

Background discussant	*City*	*Role(s)*
1	New York	Physician (SUDs specialist), Bronx reentry clinic
2	New York	Physician (SUDs specialist), clinical director of SUDS treatment program at Rikers Island Jail
3	New York	Director, Health Access Equity Unit, NYC Department of Health and Mental Hygiene
4	Philadelphia	Physician (Emergency Medicine) researching post-incarceration access to care
5	Los Angeles	Program Manager, Whole Person Reentry Program at LA County Jails
6	Los Angeles	Physician (Emergency Medicine), researching post-incarceration access to care
7	New Haven / San Francisco	Executive Director, Transitions Clinic Network; Program Manager, Transitions Clinic Network
Table 1: Background discussions		

Informant	*Stakeholder category*	*Role*
1	Governmental	Probation Officer, Sheriff's

		Department of Suffolk County
2	Governmental	Senior administrator, Sheriff's Department of Suffolk County
3	Governmental	Executive Director, Office of Returning Citizens
4	Governmental	Community Initiatives Coordinator, Boston Public Health Commission
5	Reentry-focused CBO	Job Readiness Manager
6	Reentry-focused CBO	Executive Director
7	Homelessness-focused CBO	Physician (primary care)
8	AMC	Physician (SUDs specialist)
9	AMC	Physician (primary care)
10	AMC	Community health worker
Table 2: Stakeholder categories and roles of informants		

The co-authors collaborated to develop the questionnaire, primarily based on themes and questions that emerged from the background interviews with national experts in the field. The questionnaire was organized around our objective of characterizing the state of local reentry healthcare work, and our focus on opportunities for AMCs specifically. As well, we included a question about other potential stakeholders that the interviewee felt we should interview. We included a range of open- and closed-ended questions and probes about services provided, challenges faced in this work, valued partners in the field, and informants' visions for future opportunities.

Interviews were conducted by an individual researcher, either at the informant's office or at a mutually agreed upon location. Informed consent was established to conduct the audio-recorded interview, with a duration of 30-45 minutes. The predetermined questionnaire was used to structure the interview. Interviews continued until we saturated our field of interest, which was the local reentry population's needs, the network of services currently available to meet these

needs, and barriers and opportunities in this work. The co-authors met at biweekly intervals during the interview phase to assess for saturation progress (i.e., whether or not interviews were continuing to glean new themes) and the need for further interviews.

Once interviews were completed, the two medical student co-authors transcribed them. These co-authors coded each interview in NVivo, then reconciled their respective coding schemes. There were also regular meetings with the more senior co-authors to get feedback on the coding tree and themes. Through this iterative process, the co-authors reached consensus on the coding and themes. The themes were grounded in the framing of the predetermined questionnaire: productive existing programs of providing reentry services, challenges faced in this work, and ideas for innovation.

SECTION 4: RESULTS

Existing Transitions Programs in Suffolk County

Several organizations in Suffolk County, including AMCs, provide resources to aid individuals transitioning from incarceration back to the community. Current programs include resource directories, job training programs, drug court, and housing assistance. Two AMCs in Boston provide a small pre-release care coordination program, medical clinics devoted to patients transitioning from correctional settings, and harm reduction programs for patients with SUDs.

Many resources exist in Suffolk County to assist patients transitioning from incarceration, but often patients and providers struggle to access the appropriate resources at the right time. The city created a free website called the Coming Home Directory, which lists the 1,700 programs and social service agencies in the greater Boston area that assist transitioning individuals.

For the past several years, the Boston Mayor's office has run recovery panels within the Suffolk County jails. Described by one provider as similar to a job fair, CBOs and healthcare providers come to the jail to present to individuals nearing release about the organizations and resources available to them upon release. Many providers feel that by streamlining this process, this program has increased follow-up rates because patients are likelier to show up to seek services when they have already met providers face-to-face.

At BMC, two physicians have dedicated a weekly half-session in their outpatient addiction treatment clinic to see patients with SUDs recently released from jail. Referrals come from the local jail, the state prison, their own pre-release assessments conducted in the jail, halfway houses, and elsewhere.

> *"One kind of cool story. We have another provider…he is also in primary care and focuses on addiction...one of the very few providers who works on Friday afternoon. He saw one of our patients for whom we had done a prerelease assessment [in his Friday afternoon clinic]. They met and talked and the patient said that had it not been for us and getting linked to care, he probably would have relapsed and potentially overdosed that weekend. We were able to get him a [Suboxone] script that day."*

MGH has set up a "low-threshold, immediate access transitional addiction program for all patients." They provide same-day access to MAT for patients with opioid use disorder in order to reduce the risk of overdose for patients who are at increased risk upon release from incarceration. They also provide teaching about harm reduction for patients injecting drugs, naloxone training, housing assistance, and clothing for patients.

One organization in Boston, Access To Recovery (ATR) is specifically dedicated to providing support and resources to individuals with a SUD transitioning from incarceration. ATR coordinators work with clients to create an individualized recovery plan and devote resources (approximately $900 per person) to help each individual achieve their goals within a 6-month period. These funds support material items such as driver's licenses, T passes, clothing, and cell phones, as well as tuition and an hourly wage to attend job-training programs. They also refer individuals to resources as necessary, such as recovery coaches and housing assistance (though they do not have sufficient budget to provide substantial housing assistance). A 7-year analysis of the program demonstrated an increase in abstinence from substance use, a doubling in employment rates, 85% completion rate in job-training programs, a doubling in housing stability rates, decreased recidivism, and a <1% risk of opioid overdose among participants.

Drug courts are an increasingly mainstream alternative to incarceration for patients with SUDs. MGH funds an employee to serve on the Charlestown drug court treatment team. This employee serves as a liaison between the drug court team and the providers at the Charlestown

community health center to determine and meet the needs of the drug court participants. This employee described her role in this way:

> *"If somebody needs help getting into detox, I can help them get into detox. If somebody needs help getting into an IOP, I can help them get into an IOP…I'll help people do resumes. It's a lot of stuff, but these are all the things that play into a successful recovery. They need housing, they need a job, they need a doctor."*

Suffolk County has at least two dozen job training programs in fields such as food service, hospitality, construction, and technology. These programs provide skill-based training, assistance in the job search with resumé writing and interview skills workshops, access to work clothes, and connections to housing resources. They also provide structure and support during the challenging transition period after individuals are released, which one training program highlighted:

> *"Honest care. I care about them, our chef instructor cares about them, our staff cares about them. There are photos all around the building of our students right now. Being in a setting where they are acknowledged and everyone knows their name and people smile and ask them how their day is is really significant, especially for people who have been incarcerated. I think that really changes people."*

Challenges for Transitions in Suffolk County

Though Boston-based AMCs and CBOs have created several successful partnerships with jails, many challenges remain. Communication barriers persist between correctional and community settings. Scheduling appointments continues to be a challenge, particularly for patients with a SUD. Many providers have not been trained or do not understand how best to support patients with a history of incarceration. As one interviewee said, "For many providers, if they just get people [from jail] without any heads up, it's overwhelming."

<u>Communication Barriers Between In and Outside of Jail</u>

Many providers find the transition from the medical clinic in the jail to their clinic in the community particularly challenging. One provider said, "Often, patients arrive with no information from the jail on what was done medically and with many medical issues that need to

be addressed." Another provider said that it would be useful if there were "some sort of connection for people who are receiving them to know what's been done so it's not kind of figuring it all out." This interviewee conceptualized it as similar to a "discharge summary" that patients are given when they are released from the hospital.

Moreover, there is rarely oversight from jail providers to ensure that patients with medical issues follow-up with their physicians upon release. This becomes particularly important for patients with mental health diagnoses and SUDs. One provider said, "I know they say they do that, but I don't know what that really translates to and how long that goes."

Lack of continuity for individuals between inside and outside of jail is challenging for CBOs as well, not just healthcare providers. One interviewee said, "I just feel so confused about why there are the people on the inside and the people on the outside and there doesn't seem to be [communication]...These staff work with inmates and then the person is released and [they're] no longer allowed to have contact."

Another challenge for coordination is the short stays in jail and unpredictable discharge dates. Seventy-five to eighty percent of a jail's pre-trial population are released within 24 hours of entry. The churn of individuals in and out of the jail is very challenging. One DOC employee said, "[You] could be here today and [I'm] working with [you], and then you could be gone in three hours." Approximately one-third of men and women incarcerated in Suffolk County have a sentence of 90 days or less. This short time period poses a challenge for caseworkers in the jail and CBOs to connected these individuals with resources.

Providers' Lack of Understanding of Incarceration

There is a lack of understanding among healthcare providers about how to best help patients with a history of incarceration. Thus, many patients with a history of incarceration do not trust their physicians. This lack of trust lowers the probability that they seek follow-up care, and may hamper the quality of care they receive when they do seek care. One interviewee said: many people "say, 'I have a doctor' but they haven't seen them and the doctor doesn't really understand incarceration as a social determinant of health or all of the other issues." Physicians are not the only medical providers that lack an understanding of incarceration, and nurses, medical assistants, and front desk staff also play an important role in patients' experiences. One physician interviewed said that the physicians in their transitions-like clinic were attuned to the

issues of incarceration, however front desk staff were not. In some settings, anti-stigma training may be limited to physicians, neglecting the fact that all staff contribute to how welcomed or stigmatized patients may feel in a given clinical setting.

Interviewees also acknowledged that caring for patients involved in the criminal justice system may involve tasks that are outside of usual clinical duties, and which may be more complicated or challenging. For example, patients in drug court must undergo routine drug testing to ensure they are maintaining their sobriety. Patients' physicians have the opportunity to advocate for their patients with the probation officer if the patient is struggling in order to keep the patient in drug court, in treatment, or out of jail. One provider said, "If someone is struggling and they're worried that they're going to test positive [for opioids] and they're going to be violated, then it's always helpful if I make a call…a lot of physicians don't want to do that. They have to pick up the phone to do that. But it really makes a huge difference." Providers could call probation officers when appropriate to advocate for their patients, but several barriers exist to such patient advocacy: providers may not want to, may not have time, may be nervous to engage with probation officers, may not be aware that this is possible, or may not know the proper channels for doing so.

Stigma

There is also a range of opinions on how and to what extent to ask patients about their histories of incarceration. One interviewee felt that the way to address the stigma of incarceration was to talk about it more rather than less, and that professionalism means minimizing biases rather than not obtaining certain information.

> *I know a lot of providers try to minimize or try to prevent obtaining information about patients' incarceration. You know, like, what got them into jail. But I feel like in order to get to know the person, you have to know what's going on. I understand that there are potentially things that individuals can do that could potentially bias someone in regards to their care. But if we're trained as professionals, then we should be able to try to minimize any biases. Especially if they're out of jail, they've hopefully been rehabilitated and maybe this could be a way of trying to address whatever that issue was. Whether it was violence, whether it was drug use, or what not. It opens up that door that maybe they can reach out to me or I can reach back to them and give them a way – or any options of addressing those issues.*

On the other hand, some experts have suggested that it is critical to leave disclosure about decisions up to the patient. "Over time, clinicians can create and nurture a longitudinal relationship in which the patient feels comfortable disclosing past events or life experiences…[a patient] might not want to talk about his incarceration history today, but he might feel more comfortable at the next visit." [13]

Navigating the Healthcare System

Several interviewees raised the issue that individuals with a history of incarceration often have limited experience navigating the complex healthcare system. For example, one interviewee spoke about what people expect from healthcare, and how expectations of what is "normal" derive from past experience. Speaking about why many of her employees with a history of incarceration seek care at Emergency Departments, as opposed to preventive care with their primary care doctor, she said, "A lot of people I work with are totally comfortable sitting in a waiting room all day. That's just normal to them. But making an appointment is not normal, so it makes sense that [the ED] is the type of place that they would choose to get care."

Patients with a history of incarceration also often do not choose to switch primary care doctors, even when they do not like the doctor they have. Another interviewee said, "I can't really stress enough that empowerment piece. Just knowing – I've always been surprised when inmates are like, 'Well this is where I go but you know, I don't really like it.' I'm like, 'Ok, so why are you still going there, right?' Or, 'So you're not going to the doctor anymore?'"

Hiring Employees with a History of Incarceration

Several AMCs have explored the CHW and recovery coach models to help care for patients with a history of incarceration and/or a SUD. The CHW or recovery coach in this model are individuals with lived experience that enables them to better relate to the patients they are working with. Some interviewees expressed skepticism about this role. "People are excited and talk about how you're also giving people a job. But how good is that job, really? Is it a job with dignity where you're getting paid enough to live or is it more like a stipend?" These models also force AMCs and other organizations to confront the barriers to employment faced by people with

a history of incarceration. A team in the MGH Department of Medicine is currently working with the Partners Human Resources Department to consider adjustments to the hiring process.

> *"The dialogue thus far has been that there is a host of impediments that will prevent an individual from working at a location, such as [this AMC]. But those different infractions should be – and I'm challenging them to be – re-examined in terms of what the past was…Shoplifting is something that can bar you from working at a location. However, the reason that I was caught for shoplifting was because I didn't have any money to feed my family. Now, how do you weigh that? Now, if you gave someone an opportunity that had a record for that, and you gave them an opportunity to actually work and feed their family, I doubt very much if you would see a repeat performer."*

Challenges of Insurance Barriers

One major barrier for individuals released from incarceration is access to health insurance. Upon entering prison or jail, individuals' Masshealth is suspended and cannot be re-started until within 30 days of someone's release. Release dates for pre-trial detainees are difficult to predict, so as one DOC employee described, "That doesn't help our largest population, which is pre-trial...So, there are a lot of stumbling blocks for the population that most needs Masshealth." Due to these difficulties, many individuals leave jail without health insurance coverage.

> *"It's a lot on the health centers we're sending people to if we were unable to get them signed up for Masshealth. You know, you have some places who will say, 'Well you don't have insurance, so we can't really do anything.' … If someone has to go and sit there and the person is like, 'It's going to take four hours,' they're not going to stay. I wouldn't stay."*

One city-funded organization helps sign individuals up for Masshealth, but awareness about and follow-up to the program continues to be a challenge.

Challenges for Individuals with a SUD

A significant proportion of incarcerated individuals have drug-related charges and many of those individuals struggle with a SUD. Certain challenges of reentry may become especially high risk in the setting of SUD, particularly OUD.

Continuity of Care

Patients with a SUD are frequently on multiple medications, so continuity of care from inside to outside jail is a significant challenge. One interviewee described, "Most of my students are on various mental health medicines or medicines related to recovery, like Suboxone. So it's stuff they desperately need and they can't have a lapse in. It creates tremendous anxiety for them."

Scheduling poses a challenge both when people are sent to jail and when they are released. Providers are seldom notified when their patients are incarcerated, which could lead to missed appointments being interpreted as a "non-adherent" patient rather than a patient whose life has been disrupted by incarceration. On the post-incarceration side, many primary care physicians do not have open appointments for weeks. Patients are often left without medications if they are unable to schedule a prompt appointment after release. This problem is particularly worrisome for people with SUDs, for whom medication lapses translate to increased risk of relapse.

> *"[Typical office scheduling] misses the mark. People have addiction every day of the week. If I only have that [MAT] slot on Monday and they're coming out [of jail] on Thursday, that's a miss."*

Additional Challenges for Transitions

Recovering from incarceration itself

Many individuals who transition back to the community have significant barriers to finding stable housing and employment, such as low literacy levels, medical conditions, or a trauma history. Additionally, one interviewee said that the experience of incarceration may in and of itself be a source of trauma that makes it difficult to transition home.

> *"Sometimes individuals are just not read to go to work. Sometimes they need to deal with the trauma they've experienced first, of being incarcerated, maybe solitary confinement, being treated in a particular manner, maybe being sexually assaulted. They have to deal with that first. And because the system and our society is such that...as soon as a person gets out...they've got to hit the ground running, in doing so, they hit the ground with a deficit."*

Funding

Many CBOs struggle to find adequate funding sources to support their work on transitions. Some organizations raise the concern that funding goes to intermediaries doing transitions work, instead of individuals with a history of incarceration who are working in this realm. “There are other people from organizations that aren’t led by formerly incarcerated people who funders trust more than they trust us.”

Opportunities for Innovation: AMCs

Many interviewees recommended that AMCs could increase provision of healthcare and social services, in particular with respect to SUDs, across the treatment continuum. These included improving pre-release coordination, improving navigation, increasing access to dental care, engaging in more advocacy and providing more employment opportunities

Increased healthcare and social services across the treatment continuum

Many interviewees recommended that AMCs could help address the shortage of detox beds, as well as CSS, TSS, and halfway houses either through increased provision of these services directly or advocacy to encourage government or other organizations to increase and improve provision of these services. One probation officer said that at each transition along the path to recovery, patients with SUDs have an increased risk of relapse when they are unable to access housing or services.

Another opportunity for AMCs is to provide dedicated appointments for patients transitioning from incarceration back to the community. Patients with medical and behavioral health needs need medication refills, usually within 30 days of discharge from jail. Many clinics do not have openings in that time frame, so patients may have lapses in their medications. As one physician said, “We work it out, but it would be smoother if it was dedicated [transitions care]. On our side, I feel like we could do better.”

Many of the needs interviewers cited were barriers to accessing healthcare. Transportation was raised as a major barrier that AMCs could help to address. Another was mechanism by which people could get mail, a phone number, and a way to check email.

> *"I just see those as barriers to follow-up, to making sure you maintain your health insurance benefits, because there's a piece of the puzzle that's like, people are falling off, they're in crisis and want to see a doctor but they're like, "Oh I don't have health insurance right now. It's been terminated because I didn't get the notice that told me what services I need to get."*

Improved pre- and post-release coordination and navigation

Many interviewees felt that it was important to set people up resources prior to release. The recovery panels offered at the jail and the pre-release assessments that one Boston AMC are already doing are two examples of how to address this issue. Many more such opportunities exist. Many of the interviewees discussed the importance of improved navigation for patients with a history of incarceration after they leave jail as well. One person who runs a training program for formerly incarcerated individuals said:

> *"We've actually had people miss a ton of class because they get booted off Medicaid or they need a new prescription. That is something that feels to me so basic…That to me feels like a huge gap that is a time suck that ultimately takes away from their ability to get ahead…I'm like an educated employed person and I don't know where to go. How are my students supposed to know where to go? They don't use computers, they're not going to make phone calls and ask these questions. They don't have time, they don't have cell phones. But when you catch someone in person and you can actually do with them what it is they're motivated to do and ready to do and help them get that all set up so they can take care of themselves, why do we not have systems that do that?"*

Another physician said, "I remember thinking my [physician] services were good, the behavioral health services were good, but the most valuable services were the navigator, the peer, the coach, whatever you want to call him. everything falls apart without him…His role was the linchpin."

Several programs in Boston provide care coordinators to assist patients with a SUD find programs, housing, clothes, and employment. Several interviewees, such as the one quoted above, wanted to see a similar program enacted for patients with a history of incarceration that essentially provided them with a "life navigator," to help with accessing healthcare and other social services. One interviewee said: "I wish there were people who could be outside the door the day people are released…Look over their psych-social or a basic form of who this person is and what their needs are and get those things they need to them. I know it sounds so simple, but it's so complicated at the same time."

Another interviewee recommended not only someone waiting outside once people leave, but instead advocated for patient navigators who worked with patients both before they left and after they were released. One DOC employee said, "For years, we've known based on best practices that if someone has met with them before they leave, they are so much more likely to go meet with them."

Increased access to dental care

Dental care was raised as a major barrier for patients with a history of incarceration that AMCs could help address. For example, one student in an employee training program had to miss class because she had three molars crumbling. She sought care at the local community health center dental services, but they did not have an appointment for a month so she had to go to the Emergency Department.

Recovery coaches and other employment opportunities

Employment for individuals with a history of incarceration is an area where AMCs can take a leading role. Some AMCs have begun hiring recovery coaches and CHWs with lived experience of incarceration. As one interviewee said, "I think if we're really going to get serious about improving transitions, improving outcomes for individuals with SUD, then we're going to start utilizing…recovery coaches." Several barriers to employment at AMCs exist, such as challenges with HR departments discussed above.

More advocacy and educational opportunities

AMCs also have the opportunity to leverage their power in the Suffolk County community to educate the community about incarceration and SUDs, as well as to advocate for policies to improve care for their patients. One physician talked about how the criminal justice system is out of step with the model of SUD as a chronic disease, and recommended that AMCs "need to start educating…to minimize stigma and educate [criminal justice system administrators] on what it means to be in treatment." AMCs also have the opportunity to train the next generation of physicians about these issues. One AMC in Boston is offering an elective for medical students on transitions care, another AMC offers a residency elective. Not only do AMCs have the responsibility to educate physicians on these issues, but they also can help

advocate for changes in policies. One interviewee said, "[AMCs] have to get more engaged to use their power and voice for things like safe injection sites. They just have to."

Additional Opportunities for Innovation

Coordination among organizations

Boston has many organizations focused on transitions, but there is a limited amount of coordination among them. "Boston is definitely blessed to be resource-rich. But we don't have collective data from all the different [departments and outside organizations] to tell the tale...If we can pool all that information to say, 'This is what the picture looks like,' to have a common language...then we could be a powerful resource." Increased coordination among the government and CBOs focused on transitions would enable better data collection and more efficient and effective use of resources.

Transitional Housing

Housing is a major barrier for individuals transitioning from incarceration and many end up homeless. One interviewee said:

> *"Nobody that is coming out of prison should be homeless. There should be some kind of transitional housing that would be the default if they didn't have another plan. Right now, the default is the homeless shelter. I don't know how you would do that...I just know how disruptive it is to come out of prison and have everything all over the place. Housing seems pretty fundamental."*

Advocacy and community organizing

One organization in Boston is teaching individuals transitioning from incarceration how to become more active in advocacy and policy-making. "We have this thing called, "Bringing the people to the policy." That's what we call it. We get [them] to tell their stories...and say, 'Hey, where's the policy in the story that you just told?' Or, 'What out of your life experience would you change and how can we turn that into something different?' Whether it's drafting a bill or changing policy." Empowering individuals with lived experience of incarceration to tell their stories and advocate for policy change would enable drafting of more effective policies to provide maximal benefit to those the policies are intended to help.

SECTION 5: DISCUSSION

This was a health needs assessment for individuals leaving Boston-area jails. We specifically focused on how AMCs currently play a role in this work, and what opportunities exist for AMCs to better serve this marginalized population. The current landscape of resources was described, as well as the challenges that remain. These challenges include: communication barriers between inside and outside prisons/jails; healthcare providers' limited training and understanding around incarceration; the stigma of incarceration; healthcare system navigation; employment discrimination based on histories of incarceration; insurance barriers; funding; and, continuity of care.

This report also presented stakeholders' ideas for innovation opportunities. The ideas included: policy and program level interventions, such as improved pre- and post-release coordination and transitional housing; health systems recommendations, such as increased access to dental care and better appointment availability and scheduling flexibility, especially for patients with SUDs; health sector employment interventions, such as recovery coaches and other mechanisms to employ people with histories of incarceration; and, more advocacy, community organizing and educational activities around incarceration.

Concerning predominant themes, there was a large degree of convergence both in the informal background interviews and in the structured interviews. As a result, saturation of our field of interest occurred early in the interview process and we did not find a need to increase the number of interviews beyond the original plan.

There are several strengths to the study that support its truth value.[14] Also, audio recorded interviews enabled us to revisit the data to check emerging themes throughout our iterative theming process (i.e., two co-authors coding and then reconciling respective codes for each transcription). The research team included members with qualitative research experience; discussing emerging themes with them allowed for assumptions to be challenged and consensus reached. In reporting the findings, we used rich and thick verbatim passages of data, enabling the reader to judge fidelity between the final themes and participants' accounts. Finally, we plan to invite the informants to comment on the research findings and themes prior to submitting for publication (respondent validation).

There are several limitations to the study. One potential limitation of the study was the authors' reliance on a pre-existing professional network to recruit interviewees. This strategy did enable access to key stakeholders. However, to the extent that people in the same professional network are like-minded, this may have skewed the informant pool towards more homogeneity and more convergence with the authors' own views and biases. Peer debriefing was helpful in identifying this potential source of bias. To account for this potential source of bias, informants were explicitly recruited to include people outside of the authors' professional networks. Also, our questionnaire included a question about other stakeholders we should interview; everyone recommended by our interviewees was someone we were already in touch with, either directly or via a close colleague of theirs. This suggested that our interviewee pool was adequately representative of the stakeholders of interest.

Another limitation in our methods relates to the iterative process of achieving consensus on themes. Although the iterative process did help to ensure consistency and neutrality, meeting notes were not kept for all of the coding reconciliation discussions. More record keeping would have been helpful in more clearly demonstrating the decision trail regarding our interpretation of data.

Finally, a key limitation of this study is that it does not center the perspective of people most directly affected by incarceration. An ongoing aspect of this project is collaboration with a community-based advocacy organization, Families for Justice as Healing, to strategize about the best approach to ensure that this project and the recommendations we produce are aligned with the perspectives of people who have themselves experience incarceration. Further work is needed to ensure that this perspective is appropriately centered; as is often said in the movement to end mass incarceration, "Nothing about us without us."

SECTION 6: ACKNOWLEDGMENTS

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APPENDIX

Reentry Needs Assessment: Questionnaire

We are going to ask you a series of questions regarding your and/or your organization's experience working with individuals transitioning from correctional settings to the community. We are seeking to learn about the existing services for individuals after release with the goal of understanding how academic health systems can support formerly incarcerated individuals in accessing health care resources and improving their health outcomes. We understand that health is impacted by many factors. As such, we are also interested in the social and structural factors that affect this population's health, such as housing, employment, and efforts to reduce recidivism. We encourage you to bring up these issues when they are relevant to the questions.

You are not required to answer any of the questions; please feel free to notify us that you would prefer to skip a question. You also may pause or end the interview at any time. Thank you for agreeing to participate!

1. What are your organization's goals related to community reentry from prison/jail?
2. Does your organization offer any specific services to support clients' transitions from prison or jail?

a. *If yes,* please describe those services.

b. *If yes,* what challenges or lessons learned led you to develop your current services?

c. *If yes,* what groups do you collaborate with regarding post-release transitions to the community?

i. Do you have any suggestions for whom we might interview in those groups?

d. *If no,* can you describe any programs run by other organizations that are specifically dedicated to clients undergoing post-release transitions?

3. Can you describe any programs (yours or other organizations') that you believe are most valuable or highly utilized by clients transitioning from the correctional setting?
4. What data do you track specific to clients experiencing community transitions? Are you aware of any other organizations that track transitions-related data?

5. Does your organization employ or train formerly incarcerated peers / community health workers / patient navigators? If so, what have been the successes and challenges of these efforts?

6. What characteristics do you perceive place individuals at higher risk of having poor health outcomes after release?

7. What specific systems do you have in place to identify / capture individuals who may have a high risk of poor health outcomes upon transition?

a. Please describe that system in detail.

8. What opportunities do you see in the future to support the reentry population?

a. Are there any programs that you would like to implement, but that you have not had the time or resources yet to do so?

(Prompts: healthcare barriers; social services; state/local legislation; other resources/funding; organizations that you perceived use best practices.)

9. How do you think large teaching hospitals and their affiliated community health centers might best contribute to post-release transitions?