

Reaching In to Help Out

RELATIONSHIPS

BETWEEN

HCH PROJECTS

AND JAILS

by

Nan McBride

Policy Research Associates, Inc.

**NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL**

*Reaching In to Help Out:
Relationships between
HCH Projects and Jails*

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Policy Research Associates, Inc.

National Health Care for the
Homeless Council

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National Health Care for the Homeless Council, Inc.
P.O. Box 60427 • Nashville, TN 37206-0427
voice: 615/226-2292 • fax: 615/226-1656
e-mail: council@nhhc • website: www.nhhc.org

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EXECUTIVE SUMMARY

Jail inmates and detainees have a constitutional entitlement to shelter, regular meals and health care services while incarcerated. But once they are released, many individuals are without resources and unable to meet their basic needs. Those who were homeless may return to homelessness; others may become newly homeless. People who have no place to go when released from jail face many barriers accessing health care, substance abuse treatment, and mental health services.

Continuity of care—primary health care, mental health services, substance abuse treatment, housing, and entitlements—for individuals newly released from correctional facilities is a critical element in helping inmates successfully transition back into the community, thus breaking the cycle of recidivism. Transition—or discharge—planning acknowledges the need for effective post-release care and requires a commitment from community health providers as well as jail staff and administrators. The best transition planning is done through collaborative efforts, where community-based case managers and jail discharge planners work together to help link inmates to needed services.

Health Care for the Homeless (HCH) projects, supported by the Health Resources and Services Administration’s Bureau of Primary Health Care, annually provide comprehensive health care services to nearly 600,000 individuals throughout the country. Recognizing their favorable position for collaborations with local jails, many HCH grantees have found ways to help people transition from jail back into their communities. Frequently carried out with little or no additional resources, these collaborative efforts have evolved over time, both adapting to constraints and capitalizing on opportunities.

Working from interviews with nine HCH projects around the country, this report examines the issues surrounding individuals transitioning from jail to community health providers. Significant issues concern:

- Formal and informal partnerships
- Good communication
- Cross-training
- Attention to timing
- Access to records
- Service access pre- and post discharge
- Access to prescribed medications
- Key resource gaps
- Boundary spanning
- Transition planning

While not always the principal focus of the actual work, transition planning is inherent to the efforts at all nine programs. Even tasks as specific as HIV counseling or nutrition education provide opportunities to develop linkages. Health staff hand out brochures, locate clients, and identify needs as a natural consequence of their being at the jail. Contact with jail staff helps to foster awareness and working relationships with community providers. As different as their interventions are, community-based health agencies and local jails still share a common goal. To reduce the cycle of recidivism by supporting continuity of care, collaboration is best applied at the critical juncture of transition from jail to community.

INTRODUCTION

Jail inmates and detainees—more than 11 million adults in the U.S. each year¹—are entitled to shelter, regular meals and health care services while incarcerated. It's the law.² What happens upon their release is another story. Some have family and friends waiting for them. Others are referred to community treatment programs for substance abuse or to transitional housing. But far too many find themselves without resources and unable to meet their basic needs.

Without housing, they live in shelters, abandoned buildings, and on the street. In a recent study of persons staying in public shelters in New York City, 33 percent had entered a shelter within a week of being released from jail. For some, shelter stays alternate with incarceration resulting in prolonged periods of residential instability.³ All too often, homelessness increases the risk of incarceration and incarceration increases the risk of homelessness.

JAILS, HOMELESSNESS AND HEALTH CARE: WHAT'S THE CONNECTION?

People who have no place to go when released from jail also face barriers accessing health care, including access to medications, substance abuse treatment, and mental health services. Without proper treatment, they may become ill or pre-existing illnesses may be exacerbated. Some may have had their Medicaid benefits terminated while incarcerated—rather than suspended as Federal law allows—and must re-apply.⁴ The termination of Medicaid benefits can interrupt or delay access to medication and other health services for weeks or months, undoing any stabilization that may have occurred in jail and placing people at risk of hospitalization or return to the criminal justice system. Recently, the federal Centers for Medicare and Medicaid Services released a memorandum encouraging the suspension of Medicaid benefits, rather than termination, whenever possible.⁵ Others may have lacked access to health care prior to incarceration and must embark on a lengthy application process to obtain Medicaid benefits. Still others may not be eligible for Medicaid and have no means by which to afford health care.

Clearly, people newly released from jail need support to help them maintain their health while transitioning to life outside the jail. Continuity of care—primary care, mental health and substance abuse services—is critical for individuals whose lives are disrupted by incarceration. There are many benefits of ensuring continuity of care for people with health needs released from jail. Individuals

¹ Osher FC, Steadman HJ, Barr H. (2000). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*. Delmar, NY: Policy Research Associates, Inc.

² Vesey BM, Steadman HJ, Morrisey JP, Johnsen M. "In Search of the Missing Linkages: Continuity of Care in U.S. Jails." *Behavioral Sciences and the Law* 15:383-397, 1997.

³ Metreaux P, Culhane DP. (2004). "Recent Incarceration History among a Sheltered Homeless Population." In press. *Crime & Delinquency*

⁴ The National GAINS Center for People with Co-Occurring Disorders in the Justice System. *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders. Summer 1999*. Delmar, NY: The GAINS Center.

⁵ Memorandum from Centers for Medicare and Medicaid Services (May 25, 2004). *Ending Chronic Homelessness*. A copy of this memorandum is appended to this report.

receive services; recidivism is reduced; the costs for hospitalization, emergency room visits, and other services are reduced; and public safety is improved.

HEALTH CARE NEEDS OF PEOPLE IN JAIL

Of the two million people who are incarcerated on any given day in the U.S., the vast majority are held in city and county jails. It is estimated that as many as 700,000 adults entering jails each year have active symptoms of serious mental illness and three-quarters of these individuals meet criteria for a co-occurring addictive disorder.⁶ The prevalence of HIV/AIDS and other infectious diseases is much higher among inmates than the general U.S. population. Some chronic problems, such as asthma, are also more prevalent among jail populations.⁷ Finally, the high prevalence of health problems among people in jail is closely related to the over-representation of people of color in jails who come from communities with historically inadequate access to health care and insurance to pay for it.⁸

Jails are typically facilities with rapid processing and short stays. Jail stays can interrupt continuity of care when medication is missed upon admission to the jail, when routine screening fails to identify a health condition, or when a detainee is temporarily disconnected from a regular health care provider.

While the short-term nature of jail stays can interrupt continuity of care, the jail setting nevertheless presents a unique opportunity for introducing services to underserved populations.⁹ With mandatory health screening upon booking, jails frequently become the first place a person receives a diagnosis of mental illness.¹⁰ For people with substance use disorders, incarceration may offer a window of opportunity to initiating treatment. If linkages to treatment and rehabilitation services in the community are established, treatment begun in jail can continue upon release.¹¹ Furthermore, individuals released from jails are likely to be under correctional supervision (68 percent on parole and 62 percent on probation), thus increasing opportunities for leverage of treatment compliance.¹²

⁶ Osher FC, Steadman HJ, Barr H. (2000). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*. Delmar, NY: Policy Research Associates, Inc.

⁷ Hammet TM, Roberts D, Kennedy S. "Health-Related Issues in Prisoner Reentry." *Crime and Delinquency* 47(3): 300-409, 2001.

⁸ Conklin T, Lincoln T, Tuthill R. (2000). "Self-Reported Health and Prior Health Behaviors of Newly Admitted Correctional Inmates." *American Journal of Public Health*, 90, 1939-1941.

⁹ Hammet T.M, Roberts D, Kennedy S. "Health-Related Issues in Prisoner Reentry." *Crime and Delinquency* 47(3): 300-409, 2001.

¹⁰ Hartwell SW, Orr K. "Release Planning and the Distinctions for Mentally Ill Offenders Returning to the Community from Jails Versus Prisons." *American Jails* (Nov/Dec) 9-12, 2000.

¹¹ McGuire J, Rosenheck RA, Kaspro WJ. Health Status, Service Use, and Costs Among Veterans Receiving Outreach Services in Jail or Community Settings. *Psychiatric Services* 54(2):201-207, 2003.

¹² Hartwell SW, Orr K. Release Planning and the Distinctions for Mentally Ill Offenders Returning to the Community from Jails Versus Prisons. *American Jails* (Nov/Dec) 9-12, 2000.

NEED FOR TRANSITION PLANNING

Transition planning acknowledges a realistic understanding about the lives of many individuals who have come in contact with the justice system.¹³ Inmates don't just *leave* jail; they transition to—and through—any number of institutions or systems of care. And without effective planning, far too many transition to homelessness and/or back to jail. Effective post-release care requires real connections and commitment from community-based providers and jail administrators. Likelihood of adherence to treatment can be increased if transition planning is done well.

The need for continuity of care upon release from incarceration was at least partially addressed by one federal circuit court, which required states to ensure that a released inmate who has been receiving medication while incarcerated leaves the facility with a short-term supply of that medication.¹⁴ Nine states have followed suit and made this decision law (California, Nevada, Arizona, Oregon, Washington, Montana, Idaho, Alaska, and Hawaii). New York has gone a step further, requiring local jurisdictions to provide adequate transition planning as a way to lessen the likelihood of re-arrest.¹⁵

Ensuring continuity of care for people with medical or mental health problems being released from jail involves paying attention to four key ingredients:

- Transition planning, including the establishment of community linkages
- Quick access to medications, Medicaid, HIV/AIDS drug assistance, and other benefits
- Special attention to the needs of dually- and triply-diagnosed individuals¹⁶
- Availability of appropriate transitional and permanent housing

The APIC Model is one approach to transition planning that, if implemented, is likely to improve outcomes for people with health or behavioral health issues being released from jails. These elements are:

- Assess the clinical and social needs and public safety risks of the inmate.
- Plan for the treatment and services required to address the inmate's needs.
- Identify community and correctional programs responsible for post-release services.
- Coordinate the transition plan to ensure implementation and avoid gaps in care.¹⁷

¹³ The American Association of Community Psychiatrists prefers the term, “transition planning,” because “transition” suggests bi-directional responsibilities and service collaboration. This approach promotes—and requires—a greater level of information sharing. “Discharge” and “transition” are used interchangeably in this report.

¹⁴ *Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999).

¹⁵ Bazelon Center for Mental Health Law (2001). *Finding the Key to Successful Transition from Jail to Community*. Washington, DC: Bazelon Center.

¹⁶ Hammet TM, Roberts D, Kennedy S. “Health-Related Issues in Prisoner Reentry.” *Crime and Delinquency* 47(3): 300-409, 2001.

¹⁷ Osher FC, Steadman HJ, Barr H. (2000). *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*. Delmar, NY: Policy Research Associates, Inc.

As can be seen in the next section and the case studies in the Appendix, some HCH programs have incorporated many of these elements of successful transition planning in their collaborations with local jails with varying degrees of success and comprehensiveness.

HEALTH CARE FOR THE HOMELESS PROGRAMS

Since 1987, the federal Health Care for the Homeless (HCH) program has provided critical health care services to thousands of homeless Americans. Supported by the Health Resources and Services Administration's Bureau of Primary Health Care, HCH projects are located in all 50 states, the District of Columbia, and Puerto Rico. These agencies provide primary health care, mental health services, and substance abuse treatment, as well as outreach, case management, and referrals to connect people to specialty services, entitlements, and housing. In 2003, federal assistance to HCH grantee reached \$130 million, and nearly 600,000 individuals were served. This paper explores the developing role HCH grantees have in improving continuity of care for individuals who are released from jails and at risk of becoming homeless.

HCH GRANTEES WORK WITH LOCAL JAILS

The activities required for successful transition planning are among the allowable services for federally-funded Health Care for the Homeless (HCH) programs.¹⁸ HCH projects across the country are in a key position to collaborate with local jails in the development of effective transition planning. Not all grantees have the resources or the cooperation from local correctional facilities to achieve this collaboration, but many HCH grantees have found ways to help people transition from jail back into their communities. We describe some of these approaches below.

To learn how HCH programs collaborate with local jails, we invited key staff at HCH programs across the country to share their experiences of successful collaboration with their local jails. Sixteen programs responded, and we selected nine programs for a follow-up telephone interview. The nine were selected to represent the range of different approaches including:

- Providing services within the jail,
- Offering services outside the jail for those who have been recently released,
- Assisting with transition planning, and
- Engaging inmates for later follow-up through jail "inreach."

It should be noted that much of what is reported in the case studies below owes its success to a "seat-of-the-pants" approach to problem solving, not to the deliberate adaptation of best practices models based on applied research. The achievement is most often the work of providers who recognize the need, nurture relationships with partners, and accomplish what they can in the midst of challenging circumstances.

¹⁸ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. *Requirements of Fiscal Year 2004 Funding Opportunity for Health Center New Access Point Applications*. Program Information Notice 2004-02, September 2003.

The HCH programs interviewed for this report are located in:

- Albuquerque, NM
- Atlanta, GA
- Baltimore, MD
- Cheyenne, WY
- Chicago, IL
- Manchester, NH
- Milwaukee, WI
- New York, NY
- Washington, DC

A detailed description of the approach taken by each site can be found in Case Studies section of this report.

COMMON THREADS AMONG HCH/JAIL COLLABORATIONS

The HCH programs interviewed for this report reveal the wide range of relationships that HCH programs and/or their sponsors have with local jails. These examples are neither exhaustive nor suggestive of any single best way to develop linkages. State and local regulations, funding supports (or lack thereof), political climate, cultural attitudes, and even stakeholder personalities all leave their marks. While it is difficult to compare these collaborations because their approaches are so varied, it is useful to look at the common threads that run through these nine projects for what they have to say about what makes these collaborations work and what could work better.

Partnerships are both formal and informal

Collaborations between programs and jails are as formal as contractual agreements or as casual as community providers and correctional facility staff simply knowing they have clients in common. Collaborations, such as that described in Manchester, NH, are forged by informal relationships in a setting where institutional boundaries are somewhat blurred and goals are shared. Without additional resources, Manchester has found a way to make something work better. Other examples, such as Unity Health Care (Washington, DC), involve multiple service systems, formal partnerships, and municipal support. With the right timing—and adequate resources—Unity Health Care has created a facility with the single purpose of helping to break the cycle of recidivism.

Good communication is essential

Correctional systems and health care systems face many challenges because their institutional cultures are so different. This makes day-to-day communication with jail staff very important. Most programs have recurring interchange with jail clinic staff, from occasional phone calls to formal weekly meetings. For many agencies, some exchange of medical records is common. Regular communication with jail administration is also important. Staff from Unity Health Care

(Washington, DC) and St. Joseph's Mercy Care Services (Atlanta, GA) has regular monthly meetings with key jail administration staff.

Cross-training

Cross-training was identified by staff at several sites as an effective way to bridge the institutional gap. In Atlanta, GA, staff from both organizations participated in a one-day training where information was shared about their programs, including staff roles, relationships with inmates/clients, and how they might work together to improve mental health and substance abuse outreach. In Chicago, Heartland Health Outreach conducted a training on cultural competence for staff at Cook County Jail.

Timing is everything

Throughout a person's incarceration, timing is critical. It is important to act quickly to identify people who may benefit from transition planning before they are released. In New York City, for example, people are jailed and released so quickly that staff is often unable to conduct health screening or attempt to engage people once they are processed. Moreover, inmates are often unexpectedly released in the middle of the night or following court appearances. These indeterminate releases (reported by seven of the nine programs interviewed) offer little assurance that inmates will be linked to community-based services. Two agencies report that being apprised of court dates was the best means of staying connected to inmates. People released following court appearances can be immediately offered transportation to shelters, clinic sites, or other treatment services. Most programs suggest that making connections with individuals *in jail*—before trial or release—is the best way to ensure follow-up when they are out of jail.

Access to records

All agree that being able to review records increases the chances of locating clients in need of services. Community provider access to inmate records, however, varies greatly by site. Some jail clinics conduct an initial filtering of inmate records before providing inreach staff with records of a segment of the population (Washington, DC). For others, records are shared—in both directions—upon request (Manchester, NH). Access to records in Chicago's Cook County Jail is facilitated by an on-line information system that can identify inmates who are also served by the state mental health system. For others, meeting clients at their court hearings is the only way of obtaining records, simply because that is where the papers are (Atlanta, GA).

Access to jails and access to services

Jail access is a continual problem for community providers. For security reasons, lockdowns (where all inmates must remain in their cells) prevent routine activities from occurring. Classes are cancelled and appointments may be rescheduled. Even inreach workers with authorization and proper identification, who have been through the jail's gates many times, are occasionally denied access for unspecified reasons.

Another kind of access problem is the inmates' access to services that are brought into the jail by community providers. Two sites reported that inmates sometimes make requests for services, such as attending a class or seeing a social worker, and without explanation, the necessary forms are not completed and their requests are denied.

Obstacles to access, such as those mentioned above, suggest a larger problem that was identified by several HCH program staff interviewed. There is a perception on the part of community-based providers that jail staff and/or administration at several sites are not pleased with the efforts to bring services into the jail. Whether a consequence of excessive work load, turf issues, institutional protocols, and/or deeply entrenched attitudes, this resistance was identified as a major obstacle to effective collaboration.

Access to prescribed medications

Taking medication as prescribed is critical to maintaining good health in the best of circumstances. For people released from jails, the circumstances are not generally good. Staff at the reporting sites noted many obstacles to accessing medication beyond the jail's door. At some sites, medication is only mandated for inmates with mental illness (New York, NY); at other sites, pregnant women (Milwaukee, WI) or HIV patients (Atlanta, GA, Baltimore, MD) stand a better chance of maintaining their treatment regimen because they are the target population for a specific health care/jail collaboration. At other sites, efforts are focused on prescription assistance programs (Cheyenne, WY) or entitlements (Washington, DC) to bridge the medication gap. But at far too many sites, inmates are being released without adequate supplies or access to needed medications.

Key resource gaps

Resource gaps at the nine sites fall into three areas: dedicated funding, staff, and medications. Most projects noted they did not have sufficient resources to provide adequate transition assistance. Several sites currently seeking additional funding report having a broad vision for jail inreach but report that they are limited by financial constraints. Lack of adequate resources on the jail's part was also noted at several sites. The jail health system, particularly in the area of transition planning, is seen as contributing to poor health outcomes and, ultimately, to recidivism.

Boundary spanning

When staff is able to span the boundaries of both the correctional facility and the health care agency to function, in some capacity, on both sides of the jail's gate, they become a key element for effective interaction between these two organizations.¹⁹ At two sites, HCH staff persons are employed to provide health services in jail (Cheyenne, WY; Milwaukee, WI). For someone, such as clinic director Connie Miller (Cheyenne, WY), who is also employed as a health provider in the local jail, the ability to work across system boundaries helps her clients make better transitions from one system to another. While not part of their job description, boundary spanners often

¹⁹ Steadman HJ. "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems." *Law and Human Behavior* 216(1): 75-87, 1992.

manage the interaction between the two organizations. Through regular interaction with personnel at both sites, they develop a set of skills that bridge the culture (often competing) of both organizations. In Manchester, NH, two HCH staff persons are former nursing staff at the local jail. Hiring staff with real life experience within the other system is another way to create a boundary spanner who can effectively speak the language of both systems.

Transition planning

Effective linkage to community services is part of the efforts at all nine programs, no matter what the focus of the actual work is. For some, transition planning is the purpose; for others, it is a welcome side effect of other work. Providing specialty care, such as prenatal services, HIV education and prevention, and stress reduction, to inmates presents an opportunity to build relationships—with both inmates *and* jail staff. These in-jail connections help people make the link to community-based services when they are released. Health agency staff share information about services, hand out brochures, recognize clients, and identify needs as a natural consequence of their being at the jail. Personal contact with jail staff helps to foster awareness and working relationships with community providers. Many collaborations are carried out without formal arrangements or dedicated resources. But even for those whose work is contractual, supported by a grant, or in response to a legal mandate, it is clear that the results of these linkages extend far beyond the original intent.

CONCLUSION

For many, jail is a temporary way station in a cycle that too often includes shelters and the streets, as well as time in apartments, with family, or in treatment centers. Understanding that detainees are community members is crucial to effective partnerships between correction facilities and community-based health care providers. Only by acting on this understanding can these two systems find common ground for collaboration and shared responsibility for care.

Correctional institutions and health care agencies operate from very different models of oversight and care. Their differences are as particular as institutional policies and procedures and as far reaching as political and societal biases. But for all they do not share, their collaborative efforts offer a unique opportunity to work toward a common goal—return and reintegration of an individual to the community.

By collaborating to support continuity of care—primary care, mental health and substance abuse services—as people move from jail to the community, jails and community-based health care providers can help reduce the likelihood of recidivism. Collaborating, communicating effectively, sharing records, ensuring access to medication, and providing needed treatment do far more than enhance a single system of care. New ways of working together emerge that benefit providers in both systems and individuals in need of health care.

CASE STUDIES

Albuquerque, NM Albuquerque Health Care for the Homeless, Inc.

Albuquerque Health Care for the Homeless (AHCH) provides services at five facilities as well as extensive outreach. It operates a free-standing medical clinic, dental clinic, three residential programs, drop-in centers, and case management/counseling and social work for people with substance use, chronic and/or serious mental illness, and co-occurring disorders. Through these programs, AHCH provides a continuum of homeless recovery services. A motel voucher program provides lodging for people in need of respite care.

Linkage with jails

AHCH has worked for over two years with Albuquerque's advocacy organizations, local service providers, and city and county administrators to establish formal mechanisms for conducting inreach to jail detainees.

Transition planning. AHCH outreach workers go into the local jail, Metropolitan Detention Center (MDC)—Albuquerque/Bernalillo County, to conduct transition planning for current clients who become incarcerated. This collaboration, now in its ninth year, was initiated by AHCH case managers who recognized the needs of their incarcerated clients to maintain continuity of care. Work with HCH clients in jail begins when AHCH staff schedules an appointment to see an inmate. Because there is no formal protocol governing provider access to detainees, inreach workers encounter mixed receptions from jail staff who places greater restrictions on chronic offenders and inmates convicted of serious crimes. While jail staff is generally receptive to AHCH's work, the corrections system's priorities (e.g., safety and security) create tensions that are mediated by the establishment of strong relationships between jail staff and inreach workers. On some occasions, jail staff will contact AHCH staff, referring an inmate to them.

Mental health case management. For patients with mental health needs, the University Hospital Mental Health Center operates an intervention and case management system in the jail and makes referrals to AHCH. In addition, a HRSA/SAMHSA collaborative grant between the two organizations better coordinates street to jail to release for persons who have chronic and/or serious mental illness.

Obstacles and opportunities

Insufficient funding, communication mishaps, and inadequate transition planning are some of the obstacles that this collaboration faces. AHCH funds support this inreach undertaking. Frequently, AHCH staff is not informed in advance of inmate release dates or times. It is not unusual for inmates to be released from the jail (which is 20 minutes outside the city) late at night or very early in the morning with no transportation. Further, there is no mechanism in place to ensure that

people at risk of homelessness being released from jail will be connected to community services. While information about community resources is supposed to be included in every discharge plan, it is not always.

There are no policies in place for gaining access to inmates. While jail staff is receptive to AHCH's inreach, security issues make transition planning a low priority for jail administrators. This underscores the importance of building relationships to nurture cooperation and to identify common goals. With the new policy of the Centers for Medicaid and Medicare Services (CMS) which encourages suspension of benefits—not termination—while persons are incarcerated, discharge planning is all the more critical.

For the past two years, AHCH, along with advocacy organizations and other service providers, have met with county administrators to discuss developing formal mechanisms for more effective inreach. Through this ongoing effort, AHCH—and others—hope to build relationships, trust, and good communication that will make for greater cooperation in the future.

Services following release

Due to AHCH's contact with inmates, releasees are able to receive their benefits in a relatively timely fashion. Ex-offenders sometimes bring new treatment issues to AHCH, such as bronchial infections that are acquired while in jail. Staff also recognizes and addresses other issues, such as high levels of frustration among people who become newly homeless upon release.

For more information, contact Sigrid Olson, Executive Director, Albuquerque Health Care for the Homeless, at (505) 767-1172 or email: sigridolson@abqhch.org

Atlanta, GA
Saint Joseph's Mercy Care Services, Inc.

St. Joseph's Mercy Care Services (SJMCS), through paid and volunteer staff, provides comprehensive health care services at more than 40 clinics monthly, located at two fixed clinic sites and eight additional locations, including a mobile clinic. Services are also provided at numerous host sites, including shelters, soup kitchens, churches, and apartment complexes.

Linkage with jails

For the past 10 years, SJMCS has collaborated with two local jails, the Atlanta Department of Corrections–Pretrial and the Atlanta City Community Court. Beginning with a single focus of HIV prevention, services have evolved and expanded to meet a broader range of needs.

Transition planning. Case managers from SJMCS go into the jail to identify the medical and housing needs of inmates who will be released. Efforts are made to see inmates before they go before the judge because, once a disposition has been made, the inmate is either moved to another facility or released to the streets. In many instances, arrangements are made for one of SJMCS's vans to pick up inmates at the jail's door and transport them to shelters, clinic sites, and other treatment services. Due to diminishing funds for mental health services, including treatment residences and in-patient hospitalizations, community court judges recognize the need for continuity of care to reduce the "revolving door" experience of many inmates. SJMCS's work is a help to both inmates and the overburdened criminal justice system.

About six years ago, SJMCS conducted a focus group with inmates to learn about the major issues they faced upon release. Inmates reported that they often didn't have anywhere to go and that finding employment was very difficult. The focus group also revealed that substance abuse was a major barrier to gaining employment and/or housing. In response to these issues, SJMCS provides help with obtaining photo IDs, housing, and employment. Also, case manager transition planners link inmates to community substance abuse services prior to release.

HIV outreach program. Approximately nine years ago, SJMCS initiated talks with jail administration on providing HIV education to inmates. Since then, through a memorandum of agreement, SJMCS's outreach program has expanded to include a broader range of services, including HIV testing, TB testing, syphilis screening, and a women's HIV discussion series. Funds from the U.S. Centers for Disease Control and Prevention support these services.

Obstacles and opportunities

SJMCS is welcomed by the jail administration. With proper ID, the outreach team can move about freely. The outreach team has weekly meetings with jail staff, where all parties recognize that timing is crucial for connecting with inmates just prior to their pre-trial hearing.

Recently, a full-day training session was held for staff from both agencies to share information and ideas for more effective collaboration. Both partners provided an overview of their programs, their purpose and goals, and representatives from each section of the jail reported on its work and relationship to inmates. As part of the training, both groups discussed the challenges that had arisen in the course of their work together.

Services following release

SJMCS has a strong intra-company referral process to make sure all the organization's resources are accessed across disciplines and funding streams. While a client's prior contact with the criminal justice system may be elicited during intake, no specific question is asked to obtain this information. Client records are not regularly exchanged between SJMCS and the jail, but personnel from both institutions have regular meetings to exchange information and support their collaboration.

In the fall of 2004, SJMCS expects to begin a new partnership with the Gateway Project, a 24/7 comprehensive services center to provide health care services, mental health screening, shelter, and recuperative care, to homeless men and women, including newly released inmates. Located adjacent to the jail, this project is an outgrowth of the mayor's new Commission on Homelessness. The Gateway initiative also will partner with other local homeless service providers.

For more information, contact Tom Andrews, Executive Director, Saint Joseph's Mercy Care Services, at (404) 880-3693 or email: tandrews@sjha.org

Baltimore, MD
Health Care for the Homeless, Inc.

Health Care for the Homeless, Inc. (HCH) provides primary medical care, mental health treatment, social work, and addiction services, along with education and advocacy to reduce the incidence and burdens of homelessness. HCH Baltimore is affiliated with more than 50 community coalitions.

Linkage with jails

In 2000, the City of Baltimore began several initiatives to link the criminal justice system, HCH services, and other community-based programs. Representatives from HCH were invited to participate in a Task Force on the Needs of Ex-Offenders, which was started by the Baltimore City Health Department and the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration. At about the same time, a number of programs began that created opportunities for HCH staff to serve individuals in Baltimore's jails.

HIV services. In 2000, HCH staff began meeting with social workers within jails to inform them of HCH services and to offer to work with them to create smooth transitions for inmates upon release. Following this, Baltimore City Jail invited HCH to come in and talk about HIV education. With HUD funding, the jail expanded HCH's role at the jail. HCH staff worked with men who had HIV, hepatitis C, mental illness, and/or substance use disorders. The Connect Project offered weekly education to teach men about taking responsibility for their illness and to provide smooth transition to community-based services. Through this effort, inmates and HCH staff began to realize that the inmates were not getting the care that they needed. Inmates began to be more proactive in their HIV treatment needs, inquiring about their health status and requesting better and more timely services. In fall 2003, HCH's involvement in this project ended.

The Community Health Outreach Team (CHOT) provides HIV related services to women in Baltimore City Women's Detention Center. CHOT staff goes into the jail biweekly for presentations, health education, art groups, and individual sessions with women who have HIV. During these sessions, CHOT staff talks about HCH services, builds relationships with the women, and links them to services when they are released.

Women's pilot program. In 2002, CHOT, with HCH staff participation, began a pilot program at the Baltimore City Women's Detention Center to instruct women in stress reduction and meditation. Parenting classes, HIV art group, guided imagery sessions, and health education are also offered. Funded through the Ryan White Program, this five-week program follows HCH's model of engagement. About 30 women go through this program every four to five weeks. Upon completing the program, women are given an incentive award (including phone cards, coupons, gym bags, and hygiene items) that can be picked up at the HCH clinic following release from jail. This tool is effective in bringing women to the clinic, where they then access health care.

Working with other organizations. HCH Baltimore has a number of relationships with other organizations that work inside the local jail. The Medicaid Education and Outreach project is operated by a private company under contract to the state. Twice each month, an HCH staff person goes to the jail to provide education and technical assistance regarding the availability of public benefits to people who will be released in the near future. On one day, a formal presentation is conducted where inmates learn about accessing public benefits. On the other day, HCH staff participates in a fair, attended by 50–100 inmates, where they learn about community-based resources. As a result of these contacts, many people who exit the jail come to the Baltimore HCH program upon release. Baltimore also has an HIV prevention grant, through the Maryland State AIDS Administration. While not a jail-specific grant, Baltimore staff is able to conduct groups and some individual sessions at the Women’s Detention Center.

Obstacles and opportunities

HCH relies on jail staff to announce upcoming programs open to the general jail population. Because the program announcements and authorization to attend depend on the willingness and availability of jail staff, it is difficult to ensure that inmates are aware of or able to attend sessions. HCH staff also report that even with necessary badges and documents, it is sometimes difficult to gain access to the jail for planned events. Further, the resources to support the sessions are minimal. Promised equipment may be missing or not in working order and there are no offices or meeting spaces designated for inreach staff.

There is little transition planning. The jail generally does not make an attempt to connect releasees with community-based services nor does it notify community providers in advance of inmate release. A 3:00 a.m. release is not unusual. With no formal mechanism in place to track clients, HCH staff relies on word of mouth, HCH brochures, or their own contact with inmates to help in their transition. For women in the pilot program, who convey information about their court dates to HCH staff, there is some opportunity for follow-up.

Inmates are not always supplied with three days of medication upon release as mandated by the Department of Corrections.

Services following release

HCH Baltimore’s ability to engage inmates and subsequently provide post-release services is, at best, very informal. A client may arrive at the reception desk and ask for the person he or she had met in the jail. Clients who are incarcerated may write to their social worker, doctor, or substance abuse counselor, and the provider typically responds with instructions on how to re-engage with HCH upon release.

For more information, contact Jeff Singer, President & CEO, Health Care for the Homeless, at (410) 837-5533 or email: jsinger@hchmd.org

Cheyenne, WY
Cheyenne Crossroads Clinic

Cheyenne Crossroads Clinic (CCC) provides onsite primary care, along with referrals and transportation to community providers for dental, mental health, substance abuse, and radiology care. CCC also works with the Coalition of Agencies Serving the Homeless to meet social service needs.

Linkage with jails

In addition to her work at CCC, Clinic Director Connie Miller visits the Laramie County Detention Center one afternoon a week as an independent contractor to Correctional Healthcare Management, a private health agency that provides services to inmates.

Spanning boundaries. Connie Miller, is a boundary spanner, the key link across two organizations whose common thread is clients needing health services both in and out of jail. Through this weekly contact, Connie meets with inmates who are about to be released and gives them information about services at CCC. In Wyoming, where there is no entitlement to health care services except for pregnant women, connecting to programs like CCC is the best assurance of continuity of care for underserved populations. Connie also provides information to jail staff about CCC clients who are in jail. Connie works with the Southeast Wyoming Mental Health Outreach Team, which provides mental health services to inmates, sharing information and making referrals. Approximately 100 inmates per year are contacted through this linkage effort.

Prescription assistance programs. At CCC, a staff person is dedicated half-time to helping clients and other community members apply for prescription assistance programs. Connie identifies inmates who will need medications upon release and links them to CCC's prescription assistance program.

Obstacles and opportunities

Jail nursing staff is very receptive to Connie's work. Good communication, exchange of information, and common goals are credited for effective collaboration. The contractual agreement for these services contributes to its success, including the timely release of information (in both directions), adequate resources, and access to inmates.

Services following release

Releasees find services at CCC primarily via word of mouth or information that has been distributed at local agencies. Those who are in a shelter are required to go to CCC for TB testing. Frequently Connie recognizes new clients who she has seen earlier in jail. It is estimated that CCC staff serves 6 to 12 individuals each month who have recently been released from jail.

For more information, contact Connie Miller, Cheyenne Crossroads Clinic, at (307) 632-8064 or email: conmill@aol.com

Chicago, IL
Heartland Health Outreach

Heartland Health Outreach (HHO), a partner of Heartland Alliance for Human Needs & Human Rights, provides a continuum of services to individuals who are homeless and have serious mental illness and/or substance abuse problems and refugees who have experienced war and displacement. Heartland's Mental Health and Addiction Services (MHAS) operates a drop-in center, a day treatment program, residential programs, and comprehensive outpatient services.

Linkage with jails

Staff at HHO and Cook County Jail recognized that they serve many of the same individuals. At any given time, Cook County Jail, a jail of 10,500 beds, houses 1,000 individuals with serious mental illness, 60 percent of whom are estimated to be chronically homeless. Heartland provides services to many of these individuals, both before and after their incarceration.

Continuity of mental health services. In 2002, representatives from HHO approached the mental health staff at Cook County Jail to discuss developing a joint project that would link inmates with serious mental illness to services upon their release. While seeking funding to support this initiative, Heartland provides linkage services on a voluntary basis. An outreach worker goes into Cook County Jail biweekly to engage Heartland clients and to identify others who may be in need of their services. At the same time, the social worker at the jail identifies individuals who were homeless upon entry to the jail and informs the outreach worker.

Information exchange. The steps leading up to this collaboration involved nearly three years of networking. An amendment to the Illinois Confidentiality Act now allows the Illinois Division of Mental Health and county jails to share information about detainees without a signed release. This amendment became the impetus for another initiative that identifies incarcerated persons with mental illness who have been served at state-funded mental health agencies. Now, mental health staff at Cook County Jail can immediately talk to a state mental health provider to discuss continuity of care planning for the inmate/patient they both provide services to. This electronic identification system has begun to play an integral part in Illinois criminal courts as 1,000 mentally ill detainees daily are identified and cared for by mental health staff at Cook County Jail.

Cultural competence training. HHO has conducted cultural competence trainings at the jail.

Transportation. HHO provides transportation on week days, as able, for new releasees who have been referred to their mental health and addiction services.

Obstacles and opportunities

There are several barriers to providing effective linkages for releasees. HHO staff does not always receive advance notice of court hearings or release dates and thus often has no opportunity to provide transportation to inmates who are released quickly. Inmates are often released late at night when transportation services are not available. In addition, inmates are often released with little or no medication, which poses a significant problem for persons who are not yet enrolled in one of Heartland's programs. Illinois has drafted legislation that would require releasing inmates with medications, but it has not yet become law.

Financial resources and dedicated staff are critical for Heartland to continue its work at the jail. Illinois is undergoing a series of changes in the funding system for mental health services. Unless HHO receives funding, it is highly doubtful that these first steps toward transition planning will be able to continue.

Services following release

HHO's outreach workers meet potential program participants at shelters. Because there is often a waiting list for many of Heartland's programs, staff focus their efforts on the individuals currently engaged in services who cycle through the jail system.

For more information, contact Karen Batia, Director of Mental Health/Substance Abuse Services, Heartland Health Outreach, at (773) 506-2379 or email: kbatia@heartlandalliance.org

Manchester, NH
City of Manchester Public Health Department

The Mobile Community Health Team Project (MCHTP), sponsored by the Manchester Public Health Department, is an HCH team of health providers who bring medical care and substance abuse counseling individuals who are homeless in Manchester. Clinic services are offered daily at New Hampshire's largest shelter and its largest transitional housing program for families. Care is available to anyone who is homeless, including people who are connected to other programs, including substance abuse treatment facilities, runaway youth projects, and vocational programs. MCHTP/HCH works closely with hospitals, mental health centers, and other systems of care to provide outreach, psychiatric services, diagnostic services, specialty care, and more.

Linkage with jails

For the last 10 years, HCH staff has built a relationship with staff at the Correctional Medical Clinic at Hillsborough County Department of Corrections. HCH staff and the correctional nursing staff exchange medical information, with clients consent, to gather history and coordinate the health needs of inmates. Largely conducted on an informal basis, this sharing of information was born from staff's awareness that shelter clients and jail detainees were very often one and the same. Strengthening this collaboration, two HCH nurses, prior to their employment at HCH, were nursing staff at the correctional facility.

The HCH program is sponsored by—and located at—Manchester's Department of Public Health. Public health staff go into the jail for communicable disease testing surveillance (tracking TB, HIV, and Hepatitis), which creates regular opportunities to identify patients and make referrals to HCH staff. Because both clients and staff have shared experience in three linked systems, there is a fundamental understanding of the homeless/prison/public health population and their needs.

Obstacles and opportunities

Because there are no funding resources to support HCH's work in the county jail, HCH direct services to inmates within the jail are limited to informational and educational sessions. Several times a year, however, an HCH substance abuse counselor conducts group sessions on health education and addiction topics and talk to inmates about services in the community. The well-established collegiality among staff from these two systems contributes to the easy and timely sharing of medical records.

Less successful is the jail administration's mechanism for discharge that leaves inmates ill-prepared for release and without medications. Because the Correctional Medical Clinic staff and community service providers are not notified in advance of inmate release times, they are unable to meet newly released inmates and direct—or transport—them to services. According to one HCH provider, "once they are released, they are gone."

Services following release

Following release, ex-offenders usually encounter the HCH program in Manchester through informal connections, including the shelter/soup kitchen, where HCH conducts outreach and clinics. Word-of-mouth and HCH flyers are other common means of information sharing. Parole officers regularly connect parolees directly to HCH by setting up appointments.

During intake appointments at the HCH clinic, all persons are asked if they have been in jail and, if so, how recently. Of the 874 users of Manchester's HCH services last year, 82 (9%) had been in jail within the last month and 29 percent within the past year prior to HCH program intake.

For more information, contact Marianne Savarese, HCH Coordinator, City of Manchester Public Health Department, at (603) 663-8716 or email: msavarese@cmc-nh.org

Milwaukee, WI
Health Care for the Homeless of Milwaukee, Inc.

Health Care for the Homeless of Milwaukee (HCHM) provides comprehensive primary care, behavioral health services, housing, assertive community-based case management, HIV services, and outreach at 13 locations throughout Milwaukee's metropolitan area, including five HCHM supported clinics. This model of care includes service coordination and access to pharmacies, laboratories, radiology, and specialists. In 2003, the number of HCH project users was nearly 8,000 individuals.

Linkage with jails

For over two years, HCHM Director N. Lee Carroll has served as Vice President on the Board of Wisconsin Community Services, a private subcontractor to the Department of Corrections and the court system that works with ex-offenders. HCHM is involved in collaborative projects with two local jails, the Milwaukee County Jail and the Milwaukee County House of Correction.

Entitlement assistance. Through a grant from Social Security Administration's Homeless Outreach Projects and Evaluation (HOPE) program, HCHM provides case management services at both local jails to assist with securing entitlements prior to an inmate's release from jail. This initiative was awarded in May, 2004, with services beginning in the fall of 2004. In collaboration with jail administration, HCHM staff identifies eligible chronically homeless inmates and helps them apply for Supplemental Security Income (SSI) and Social Security disability benefits.

Prenatal care. HCHM contracts with the Black Health Coalition to provide prenatal outreach, case management, and health education. Begun in 2000, services are limited to women at both jails. HCHM staff uses this access point as a way to identify women who are soon to be released from jail and in need of services upon release. Jail medical staff makes referrals to the HCHM outreach team whose office is located at the jail and open 40 hours per week. HCHM staffing at the jail comprises two outreach workers, a case manager, and health educator who are all under supervision of the director of social services. Financial resources for this initiative are provided entirely through the Black Health Coalition.

Obstacles and opportunities

Although HCHM has a physical presence at the jail, HCHM's interaction with jail administration is minimal as substantive issues are discussed and implemented through the Black Health Coalition. HCHM staff is continually working to obtain advance notice of an inmate's pending release. By virtue of their contract with Black Health Coalition, their efforts on behalf of pregnant women are most successful. Women are assigned to a case manager who then works on linking them to services in the community. Entitlement assistance is also provided, with the HCHM clinic

providing a safety net for those who were not identified in advance of their release. Consumer satisfaction surveys and weekly meetings help monitor the effectiveness of the prenatal program.

Services following release

Intake staff at HCHM completes Service Initiation Forms for all new clients, at which time clients are asked about events precipitating homelessness. Through this, staff may learn of a recent incarceration. The only other mechanism for tracking jail/HCHM follow-up is through the prenatal care services in jail for the few women (average case load is 20) who continue with HCHM upon release.

For more information, contact Lee Carroll, Director, Health Care for the Homeless of Milwaukee, at (414) 374-2400 or email: lee@hchm.com

New York, NY
Bowery Residents Committee

The Bowery Residents Committee (BRC) is a network of 25 different programs, encompassing parts of New York City's five boroughs. BRC operates three HCH projects in lower Manhattan: Project Rescue, an outreach team; Chemical Dependency Crisis Center (CDCC), a residential detox program; and Delancey Street Homeless Services Senior Center, which works with seniors in the lower East Side. BRC has linkages with more than 400 service providers.

Linkage with jails

The Bowery Residents Committee has linkages with two programs whose work is focused on connecting ex-offenders with community-based services. These collaborations are part of a natural evolution of jail programs and HCH programs serving the same cohort of individuals. It is estimated that nearly all of the clients seen through Project Rescue or CDCC have at one time been in jail.

Transition planning. In 2003, BRC entered into a contract with the City of New York to provide services as part of the SPAN initiative (Service Planning and Assistance Network) in an effort to prevent inmates with mental illness from being discharged without support services in place. SPAN stems from a settlement agreement in the class-action lawsuit *Brad H. v. City of New York* that was filed against the City for releasing inmates with serious mental illness without needed services. All people who have received mental health treatment while in jail or who have taken medication for a mental health condition while in jail are eligible to receive transition planning services. A SPAN office is strategically located adjacent to the courthouse in each of the five boroughs. SPAN connects inmates with mental illness to treatment services upon their release. SPAN also provides a range of other services, including medications, housing, public benefits, and transportation.

Through SPAN, BRC refers ex-offenders to the CDCC and the drop-in center at Project Rescue. Both these projects have onsite medical clinics, operated by BRC. BRC also helps clients obtain medication grant cards ("emergency Medicaid") and conducts short-term case management that links releasees to other needed services.

Alternatives to Incarceration Program. Since 1998, BRC has collaborated with various alternatives to incarceration (ATI) programs for clients who are mandated to treatment programs as an alternative to serving jail sentences. Many of these clients have been detained in jail for two or three months before their court dates. They may have been arrested for a probation violation and taken to Rikers Island until their court hearing. When staff from the ATIs go to court to meet these clients, they have an opportunity to access their medical histories and other records from the jail caseworker. Because these inmates have spent a substantial amount of time in jail, they are more apt to have received services and to have records that can be transferred to the next treatment provider.

Recognizing the number of inmates with serious mental illness (approximately 40%), ATI programs assist persons in need of a high level of services and who are more likely to have more serious physical health problems. BRC's HCH project has begun to educate the ATI case managers on the integral part health care plays in treatment services. Sixty percent of BRC clients have serious and/or chronic medical problems.

Obstacles and opportunities

BRC staff has no opportunity to communicate with jail staff at Rikers Island. Due to the generally rapid turnover (stays are usually less than 72 hours), there is little time to identify clients—either BRC's existing clients or potential clients. Efforts to phone jail administration are complicated by lack of a centralized phone system. Also, exchange of records presents a challenge. Only if there is contact prior to an inmate's release (e.g., through an alternative to incarceration program), might records be accessible.

Services following release

It is estimated that nearly all of BRC's Homeless Services clients have had contact with the criminal justice system at one time. At intake, during the bio-psychosocial assessment, BRC's staff asks clients if they have ever been in jail. It is estimated that for any given month, 17 percent of clients have recently been in jail and 1 percent are on parole or probation. BRC staff does not receive records from Rikers Island administration.

For more information, contact Karen Roach, Program Director, Bowery Residents Committee Chemical Dependency Crisis Center, at (212) 533-3281 or email kroach@bowrescom.org

Washington, DC
Unity Health Care, Inc.

Unity Health Care (UHC) is a private, nonprofit organization that provides comprehensive health services to underserved individuals in Washington, DC. Through a network of 28 clinics that operate in shelters, community agencies, and outreach sites, UHC has developed a coordinated system of care that addresses patients' needs along a continuum of care. In 2003, with a staff of more than 180 persons, UHC served 10,092 individuals.

Linkage with jails

In December 2003, UHC entered into a relationship with the DC Department of Corrections, the DC Health Care Safety Net Administration, and Court Services Offenders Supervision Administration (CSOSA), which supports continuity of services for inmates transitioning to the community. This began out of concern for inmates who had no real ties with community-based organizations. The only established linkage had been for inmates with HIV. UHC staff saw clients at outreach and shelter sites and recognized the need for service coordination. One incident served as a catalyst for change. An inmate with severe mental illness was released from jail during the winter with no support services. In his confusion, he walked around the jail's parking lot for two days until his feet were frostbitten. It was this incident that prompted UHC to initiate contacts with DC Department of Corrections.

After years of incarcerating inmates for minor infractions, the political climate in DC had begun to change. DC had been spending approximately \$30,000 a year per inmate. The District of Columbia developed a re-entry initiative that mandated each agency in the District spend one percent of their total budget on re-entry programs. Creating a network of support upon release from jail was identified as the key element to bringing about change.

Transition planning. UHC provides transition planning services for inmates at the two correctional facilities in the city, Correctional Treatment Facility and Central Intake Facility.

As part of this initiative, UHC supports one staff person—a nurse case manager/discharge planner—who has an office inside the jail. This person receives information about all inmates who are receiving any kind of medical treatment. The medical vendor inside the jail provides a list of inmates who are soon to be released. It is UHC's goal to have contact with every individual who is about to be released, but limited resources cause staff to prioritize inmates with the greatest medical needs. The nurse case manager interviews inmates prior to their release date and develops a comprehensive treatment plan. The nurse case manager also begins inmates' enrollment into the DC Health Care Alliance, which is available to most clients.

Information and records flow in two directions. UHC's case manager provides the medical vendor inside the jail with information on any of its clients who are incarcerated. The exchange of paperwork is overseen by the DC Department of Health.

Integrated Care Center. UHC operates the Integrated Care Center (ICC), the entry point for releasees transitioning from jail. It was developed as a more effective means to break the cycle of recidivism and reduce financial overload. The ICC is supported by a reallocation of UHC's existing funds while additional resources are sought. Discharge plans are transferred to the ICC. The inmates are referred to the ICC, which is located directly across the street from the jail. Regular monthly meetings with ICC staff and jail administration keep both agencies informed of activities and current issues.

While the majority of health services are contracted to two private agencies (CHPPS and Greater Southeast Community Hospital), some inmates are occasionally transported to the ICC for treatment of Hepatitis C.

Obstacles and opportunities

With its own office inside the jail, the UHC nurse case manager accesses medical records, interviews inmates, makes assessments, prioritizes needs, and assists in transferring releasees to ICC. Frequently, UHC staff relies on jail staff to provide lists of names of individuals who can receive assistance. Currently, the UHC case manager serves approximately 30 inmates per week, which is only 5 to 10 percent of potential cases.

Of the 50 to 60 inmates per month who are referred to the ICC by the nurse case manager, less than half end up reporting to the ICC upon release. UHC is looking into implementing an incentive system to improve follow-up to the ICC.

Services following release

The nurse case manager/discharge planner relays information to the social services staff at the ICC about inmates who may be in need of housing, treatment services, and/or entitlements. If the ex-offender meets the criteria for DC Health Care Alliance—and most do—the city has agreed to provide 30 days of coverage, which helps to bridge the gap before other entitlements, such as Medicaid, are secured. ICC staff helps with the application process. If a releasee needs housing, ICC staff contacts a social worker at the Health Care for the Homeless Program who then helps to locate shelter. The HCH social worker also helps connect releasees with other community-based agencies that provide assistance with securing benefits and obtaining photo IDs and other documents.

For more information, contact Rodney Scales, Director of Clinical Support, Unity Health Care, at (202) 518-6401 or email: rscales@unityhealthcare.org

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

TO: State Medicaid Directors
CMS Associate Regional Administrators for Medicaid

CC: Charlene Brown, CMSO Deputy Director

FROM: Glenn Stanton
Acting Director
Disabled and Elderly Health Programs Group (DEHPG)

SUBJ: Ending Chronic Homelessness

DATE: May 25, 2004

The United States Interagency Council on Homelessness, recently chaired by HHS Secretary Thompson, is working to develop and implement a comprehensive national approach to end chronic homelessness in the United States through interagency, intergovernmental, and intercommunity collaborations. CMS has been supporting the efforts of the council in several ways. First, we worked with our federal partners to release a new tool on our website entitled *First Step on the Path to Benefits for People who are Homeless*. The *FirstStep* product is an easy-to-use, interactive tool designed to assist case managers and outreach workers in helping people who are homeless to gain access to mainstream programs. The tool may be found on the CMS website at <http://www.cms.hhs.gov/medicaid/homeless/firststep/index.html>.

Second, I am pleased to announce that we have posted a report on our website that is entitled *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*. This report focuses on practices that have increased Medicaid access for people experiencing chronic homelessness, including assisting people leaving psychiatric facilities and correctional facilities to obtain Medicaid quickly. We hope this report will provide useful information about state efforts as you address chronic homelessness issues in your state. The report may be found on CMS's website at <http://www.cms.hhs.gov/promisingpractices/> or at <http://www.cms.hhs.gov/medicaid/homeless/>.

Finally, CMS is encouraging states with this letter to "suspend" and not "terminate" Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD). Persons

released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.

As a reminder, the payment exclusion under Medicaid that relates to individuals residing in a public institution or an IMD does not affect the *eligibility* of an individual for the Medicaid program. Individuals who meet the requirements for eligibility for Medicaid may be enrolled in the program before, during, and after the time in which they are held involuntarily in secure custody of a public institution or as a resident of an IMD. The statutory federal financial participation (FFP) exclusion applying to inmates of public institutions and residents of IMDs affects only the availability of federal funds under Medicaid for health services provided to that individual while he or she is an inmate of a public institution or a resident of an IMD.

Thus, states should not terminate eligibility for individuals who are inmates of public institutions or residents of IMDs based solely on their status as inmates or residents. Instead, states should establish a process under which an eligible inmate or resident is placed in a suspended status so that the state does not claim FFP for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements). Once discharge from the facility is anticipated, the state should take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility. If an individual is not already eligible for Medicaid prior to discharge from the facility, but has filed an application for Medicaid, the state should take whatever steps are necessary to ensure that the application is processed in a timely manner so that the individual can receive Medicaid-covered services upon discharge from the facility.

Given the high incidence of substance abuse, mental illness, and physical illness among those who have been incarcerated or otherwise held in involuntary custody, I encourage states to coordinate prison health services and other health care services provided during involuntary confinement with Medicaid services. By working with parole officers and other social services professionals who deal with inmates and residents of IMDs who are to be released, State Medicaid programs can assure that eligible persons are enrolled in Medicaid prior to release and can create an ongoing continuum of care for these individuals, regardless of the source of funding for such care.

In closing, I want to thank you for your ongoing efforts to improve access to Medicaid for all persons, and particularly for those who are homeless.