CARING FOR OUR CRIMINAL JUSTICE-INVOLVED PATIENTS
Example Case-based Discussion

Instructions: Please discuss the following case with your group. Explore parts 1 & 2, and make your way to part 3 if time permits. We will give you a heads up a few minutes before we plan to regroup and share with each other. At this time, please select a spokesperson to share 1) a brief summary of the case, 2) challenges your patient encountered, and 3) strategies for clinicians caring for patients at this stage in their criminal justice involvement. We will not cover every question with the large group, so please select aspects of the case that were most meaningful to you.

Case Objectives:

- Describe the health risks facing individuals as they re-enter the community after release from correctional settings.
- Navigate challenges of treating substance use disorders during the post-release period.
- Identify Medicaid policies impacting linkage to and continuity of care during the reentry process
- Discuss clinical and contextual factors contributing to retention in care after release and develop a framework through the Transitions Clinic model for improved primary care during the reentry process

Part 1: A risky reentry

Mr. H, a 52-year-old man with depression and opioid use disorder in remission, presents to establish care after being released from state prison five days ago. Before his 2.5-year incarceration period, his opioid use disorder was in remission on buprenorphine-naloxone (Suboxone®) at a total daily dose of 16-4 mg. During incarceration, buprenorphine-naloxone was discontinued, and he subsequently experienced opioid withdrawal, which was treated symptomatically. Before release, he was offered and subsequently received a naltrexone injection (Vivitrol®).

Discussion Questions:

1. What concerns do you have around the patient's opioid use disorder during the reentry period?
2. What other risks does the re-entry period pose?
3. What are your thoughts on a specific treatment being offered during the release process?

He opts to continue with the naltrexone injections. A few days before his third naltrexone injection is scheduled, his urine drug screen is positive for buprenorphine. He reveals that he was experiencing cravings between injections, so he started taking street buprenorphine.

Discussion Questions:

4. How would you handle this situation?

Key Points:

- Overdose risk: Drug overdose leads all other causes of death during the reentry period with a relative risk of death at 129 within the first 2 weeks of release compared to the non-incarcerated public.
- Post-release mortality spike: Reentry is a highly vulnerable period for our patients with a risk of death 3.5 times that of non-incarcerated public. This risk is greatest immediately after

release— with a risk of death during the first two weeks 12.7 times that of non-incarcerated public.

- Coercive treatment: Although intramuscular naltrexone is one option for the pharmacologic treatment of opioid use disorder, many drug courts and post-release supervision terms have adopted it as their sole pharmacologic option. While one study demonstrated a lower relapse rate in justice-involved patients receiving intramuscular naltrexone, its generalizability is severely limited due to its selection of patients not interested in agonist treatment and lack of effect on relapse rates beyond the treatment period. Lastly, when naltrexone is offered by correctional facilities and diversionary programs--often under the influence of drug company marketing, patients can feel forced into a judicially selected treatment as opposed to a clinically indicated one.

Part 2: A rocky post-release experience

You and he decide to discontinue naltrexone injections and start buprenorphine with home induction. For the next month, he is engaged regularly with the Office Based Addiction Treatment (OBAT) team. He is attending 4 hours of job training daily and NA meetings 3 times a week.

Two months later, the clinic receives a call from the patient requesting an appointment. Your office staff notices that his Medicaid is not active. Concerned that he may receive a bill, they advise him to speak to financial services before scheduling an appointment. After speaking with financial services, the patient is finally reconnected to care. He explains that he was re-incarcerated for a parole violation—switching from naltrexone to buprenorphine without informing his parole officer. To top that, his Medicaid was terminated during his re-incarceration.

Discussion Questions:

5. How would you change your management of his opioid use disorder after his re-incarceration?
6. What happens to patients' Medicaid when they are incarcerated and upon reentry?

Key Points:

- Medicaid Inmate Exclusion Policy (MEIP): Incarceration does not disqualify an individual's eligibility for Medicaid. However, under the MEIP, Medicaid does not cover care provided within correctional facilities and only covers care provided in an outside facility (i.e., hospital) if admitted for greater than 24 hours.
- Termination vs Suspension: As a result of this policy, states may either suspend or terminate an individual's Medicaid upon incarceration. Medicaid suspension (rather than termination) and facilitated enrollment prior to release expedites linkage to care for individuals re-entering the community.

Part 3: A smoother transition
Let's rewind the clock for our patient. After a 2.5-year sentence, he's only days away from going back home.

Discussion Questions:

7. How would you redesign your clinical practice and infrastructure to smooth his transition during the reentry period?

Key Points:

- Factors impacting retention in care: from a large cohort study of patients with HIV and prior criminal justice involvement, health insurance, intensive case management, and linkage to care within 14 days of release were positively associated with both sustained retention in care and viral suppression. However, re-entering patients without HIV but suffering from other chronic conditions, such as substance use disorders, hypertension, and diabetes mellitus, have lower retention in care-- perhaps due to a lack of the support services afforded to HIV-positive patients. For patients with opioid use disorder, several randomized control trials have demonstrated that pre-release methadone maintenance boosts post-release treatment entry and curbs post-release illicit opioid use.
- Transitions Clinics: while expedited linkage to primary care may improve retention within care, further bolstering of primary care infrastructure with criminal justice-adept providers and community health workers may offer a smoother re-entry experience for these patients.

Further reading:

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Hall W, Capps B, Carter A. The use of depot naltrexone under legal coercion: the case for caution. Addiction. 2008 Dec;103(12):1922-4. doi: 10.1111/j.1360-0443.2008.02370.x. PubMed PMID: 19469728.

Grabert BK, Gertner AK, Domino ME, Cuddeback GS, Morrissey JP. Expedited Medicaid Enrollment, Service Use, and Recidivism at 36 Months Among Released Prisoners With Severe Mental Illness. Psychiatr Serv. 2017 Oct 1;68(10):1079-1082. doi: 10.1176/appi.ps.201600482. Epub 2017 May 1. PubMed PMID: 28457211.

Loeliger KB, Meyer JP, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. *PLoS Med*. 2018;15(10):e1002667. Published 2018 Oct 9. doi:10.1371/journal.pmed.1002667

Fox AD, Anderson MR, Bartlett G, Valverde J, Starrels JL, Cunningham CO. Health outcomes and retention in care following release from prison for patients of an urban post-incarceration transitions clinic. J Healthcare Poor Underserved.2014;25(3):1139–1152. doi:10.1353/hpu.2014.0139

Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. Am J Public Health. 2012;102(9):e22-e29.