

P **UPDATED:** Innovation Profile:

Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism

Snapshot

Summary

The Michigan Prisoner Reentry Initiative, a statewide initiative through 18 regional sites that cover all 83 Michigan counties, helps newly released prisoners access services needed to facilitate successful reentry into the community. The Muskegon Community Health Project participates in the local implementation of the initiative by helping prisoners access health services; the health project has accomplished this through implementation of the Pathways model, a model that involves “pathways” of action steps implemented by community health workers who connect at-risk individuals to care. The health project's pathway links newly released prisoners to a medical home, helps them access needed medications and primary and specialty care, and ensures that they obtain their medical records on release from prison. The program appears to have been a contributing factor to a significant decline in recidivism rates in Muskegon. Without the program, more than 1,700 individuals (mostly men) who went through the pathway would have been returned to the community without access to medical support services.

See the Description of the Innovative Activity for new program components, Results for updated utilization data, and Resources Used and Skills Needed for updates on staffing and program cost (updated February 2011).

Evidence Rating [\(What is this?\)](#)

Suggestive: The evidence consists primarily of post-implementation data on program usage and pre- and post-implementation comparisons of recidivism rates (which may be partially attributable to the program).

Developing Organizations

Muskegon Community Health Project

Muskegon, MI

Date First Implemented

2007

February

Patient Population

Vulnerable Populations > Impoverished; Medically or socially complex; Medically uninsured; Prisoners

What They Did

Problem Addressed

Although most communities have publicly or privately funded agencies to assist newly released prisoners in reentering the community by helping them secure training, employment, transportation, and housing, few of these programs address health care needs. In fact, most prisoners are released with no medical insurance, plan for a medical home, health records, or knowledge of available community resources. As a result, these prisoners are more likely to be in poor health and to return to prison.

- **Poor access to health care:** Most parolees do not have medical insurance or access to stable sources of medical services.¹ In Muskegon County, those released from prison generally did not have insurance or a copy of their medical records; had only a 30-day supply of their medications; did not have a medical home; and had not been screened to determine eligibility for medical coverage through public programs.
- **Leading to poor health:** Prisoners' illnesses often go undiagnosed and untreated by prison physicians. As a result, when released, they tend to be in poorer health than the general population.² Infectious diseases carried by ex-prisoners are particularly concerning. For example, compared with the general population in Los Angeles County, newly released prisoners experience a 4 times higher rate of active tuberculosis, a 9 to 10 times higher rate of hepatitis C, and a 5 times higher rate of acquired immunodeficiency syndrome (AIDS).¹
- **Contributing to high rates of recidivism:** Recidivism rates of paroled or newly released prisoners remain very high; one study found that two-thirds of released prisoners were rearrested within 3 years.³ Poor physical and mental health contribute to these high rates, as ex-prisoners seek the "security" of the life they knew in prison.

Description of the Innovative Activity

The Muskegon Community Health Project developed a pathway that uses medical navigators to help newly released or paroled prisoners obtain their medical records, find a medical home, and access needed primary care and specialty services. The health navigation program began in Muskegon County and currently serves 12 counties representing two Michigan Prisoner Reentry Initiative regional hubs. Key elements of the pathway include the following:

- **Identification of soon-to-be-released prisoners:** The Michigan Department of Corrections sends the health project a listing and case review of each individual to be released within 6 months.
- **Prison "in-reach" sessions:** Approximately twice a week, an initiative in-reach team goes into one of the three Muskegon County prisons to educate prisoners nearing release about the services they can expect when they reenter the community. The team includes four individuals: one medical navigator and three community health workers with specific expertise in housing, job training/employment, and transportation services. The team talks to the prisoners as a group to present the scope of services in each of these four areas. Over the course of the 6 months before release, the team meets with prisoners periodically to prepare them for the services they can expect after release.
- **Health screening:** The medical navigator meets one on one with each prisoner to conduct a personal health assessment to determine the presence of chronic diseases, infectious conditions, and other health needs. The medical navigator also assesses whether the prisoner may be eligible for certain entitlement programs and determines what medications the prisoner is or should be taking.
- **Facilitating access to health services:** Some of the health-oriented services arranged by the medical navigator and provided by the program during the year after release include the following:
 - **Access to medical record:** The medical navigator arranges for a copy of the prisoner's medical record to be released with the prisoner upon reentry into the community.
 - **Access to medical home:** The medical navigator sets up a primary care medical appointment for the prisoner, scheduled within 2 weeks of prison release. For parolees, keeping the medical appointment is a condition of parole. The medical navigator follows up with released prisoners to ensure that they attend their primary care visit and to address other health services needs.
 - **Arrangement for prescription drug coverage:** The medical navigator prompts another community health worker who manages a pharmaceutical systems program to identify free and low-cost medication programs for which the prisoner might be eligible. This pharmaceutical health worker assists the ex-prisoner in applying for appropriate programs. The program covers the cost of medications while released prisoners wait for their applications to be approved, which generally takes 45 to 60 days, thus ensuring access to drugs until other assistance programs begin. As of February 2011, pharmacy assistance has been offered to nearly 600 parolees, valued at \$660,000 (retail cost of the drugs).
 - **Link to needed medical services:** The medical navigator links prisoners with chronic diseases to chronic disease management programs; some are triaged into the Stanford Chronic Disease Self-Management Program, run by health workers on staff at the health project. Medical navigators also arrange for community screenings and access to other community resources, such as AIDS clinic care, specialty care, and surgical

procedures.

- **Assistance with copayments, initial visit:** The program pays released prisoners' copayments at federal health centers and other community clinics. The program will also pay for an initial office visit to a private physician, up to \$125 (updated February 2011).
- **More intensive pathway for medically fragile individuals:** Prisoners who are medically fragile—typically those who have been in prison for many years and have severe chronic conditions—require more intensive services. Accordingly, the health project created a second pathway, currently being piloted with state funding across Michigan, to address the needs of this population. This pathway outlines a similar pattern of service provision as the original but also arranges for an appropriate long-term medical home, such as a hospice, nursing home, or home-based health care. The medical navigator works with a social worker, medical providers, and parole agents to arrange needed services and cultivate an understanding of the special needs and adaptive behaviors that the medically fragile individual has developed over time.

References/Related Articles

More information on this program can be found at <http://www.mchp.org>.

Contact the Innovator

Peter J. Sartorius

Development & Planning Manager
Muskegon Community Health Project/Mercy Health Partners
565 W. Western Avenue
Muskegon, MI 49440
(231) 672-3201 (Office)
(231) 672-3204 (Direct)
Fax (231) 672-8404
E-mail: sartorip@mchp.org
Web site: <http://www.mercy-healthpartners.org>

Vondie Woodbury

Director, Community Benefit
Mercy Health Partners Executive Director, Muskegon Community Health Project
565 W. Western Avenue
Muskegon, MI 49440
(231) 672-3201 (Office)
E-mail: woodburv@mchp.org
Web site: <http://www.mchp.org>

Did It Work?

Results

The program appears to have been a contributing factor to a significant decline in recidivism. Without the program, more than 1,700 individuals (mostly men) who went through the pathway would have been returned to the community without access to medical services. The program also appears to have generated a positive return on investment.

- **Undetermined changes in health status:** No data on the health status of parolees and newly released prisoners are available (either before or after implementation of the initiative). However, health project staff believe that linking more than 1,700 individuals to medical homes has improved the health of at least some of these individuals, compared with what it would have been without this linkage (updated February 2011).
- **Contributing factor to a significant decline in recidivism:** Since the program began, the overall recidivism rate for parolees has fallen by more than half, from 46 percent to 20 percent (updated February 2011). Although there is no way to determine what portion of this decline is due to the health project's medical services pathway, staff members believe that the program has made an important contribution to stabilizing these individuals in the

community. The local department of corrections began a comprehensive evaluation of the program in August 2009 that will ultimately produce a 10-year trend analysis.

- **Assumed positive return on investment:** The cost for health navigation services averages \$139 per parolee. Consequently, the program appears to be highly cost-effective, considering that each ex-prisoner who does not return to prison saves the state \$31,000 a year. Additionally, the total cost of the program since inception (roughly \$260,000) is far less than the value of services, which includes \$660,000 in pharmaceutical assistance plus other benefits (e.g., food assistance, health coverage programs, vision and dental services) to date.

Evidence Rating (*What is this?*)

Suggestive: The evidence consists primarily of post-implementation data on program usage and pre- and post-implementation comparisons of recidivism rates (which may be partially attributable to the program).

How They Did It

Context of the Innovation

The Muskegon County Health Project, located in Muskegon, MI, is a community health collaborative focused on ensuring that all county residents have appropriate access to care by linking residents to a medical home and addressing disparities in care. The county, which has a population of approximately 175,000 (roughly 10 percent of whom are uninsured), has three prisons releasing roughly 230 parolees annually. In 2005, the state of Michigan initiated the Michigan Prisoner Reentry Initiative program to provide services to individuals being paroled (approximately 430 parolees annually across 10 counties). The initiative, a community-based effort instituted statewide, helps newly released prisoners access services related to housing, employment, and transportation to facilitate their reentry into the community. The local coordinator of the initiative in Muskegon County realized that health care was missing from the array of services needed for stable reentry. The coordinator approached the health project director for help in listing the medical assets available for Muskegon parolees and newly released prisoners. The director quickly realized that the health project could enhance the initiative's effort by incorporating services for parolees into the project's mission. The health project currently covers 12 counties in western Michigan; the medically fragile prisoner pilot is administered statewide.

Planning and Development Process

Key steps included the following:

- **Joining local coalition:** Health project representatives joined the 40-person coalition charged with implementing the local reentry initiative in Muskegon County. The health project highlighted for the coalition the interrelationships between health and other initiative goals (access to housing, employment, and transportation). The local coalition agreed to incorporate health-related services—overseen by the health project—into its mission.
- **Securing funding:** The health project received “carve-out” funding from the local initiative coalition to address health issues.
- **Conducting medical needs assessment:** The health project convened a small group of individuals—including representatives from hospitals, the county health department, and other agencies that address medical issues for low-income populations—to clarify the issues these organizations faced when serving newly released prisoners. Problems identified during the assessment process included:
 - **Lack of medical home and preventive care:** Newly released prisoners had no primary care physician. As a result, no mechanism existed for ex-prisoners to receive preventive care. Rather, parolees only sought care in response to an acute episode, typically from the health department, an emergency department, or the state-operated indigent care program.
 - **No medical history:** Newly released prisoners did not receive their medical records, which often documented years of care.
 - **No plan for infectious disease care:** Infectious diseases—such as tuberculosis and HIV/AIDS—were not being adequately tracked or addressed. Health department staff did not know of all parolees with infectious diseases. In addition, newly released prisoners often did not know how to locate organizations, such as the local human immunodeficiency virus (HIV)/AIDS clinic, that provide infectious disease care.
- **Researching strategies:** After identifying problems and related issues, health project staff interviewed experts about prisoner and men's health to identify models for addressing the health needs of this population. The research

revealed that prisoners may not have had appropriate care before incarceration and may not have had their health needs fully addressed while in prison. Optimal strategies involved taking advantage of the incarceration to stabilize the health of prisoners, monitoring prisoner health status, and ensuring a continuum of care, including transition of the medical record, once prisoners are released.

- **Hiring and training:** The health project hired and provided in-house training to one full-time and one half-time medical navigator from the community. The health project already had community health workers on staff to provide services (e.g., applying for food stamps or Medicaid) to needy populations.
- **Developing pharmaceutical assistance program:** A staff member was charged with identifying and tracking pharmaceutical programs offering free and reduced-cost medications, and then filing applications with appropriate programs on behalf of released prisoners. The staff member developed an electronic system for tracking the programs and applications.

Resources Used and Skills Needed

- **Staffing:** Program staff include the following:
 - **Medical navigators:** As noted, the program employs one full-time and one half-time medical navigator.
 - **Pharmaceutical community health worker:** The program requires approximately 15 percent time from a pharmaceutical health worker (updated February 2011).
 - **Other community health workers:** The health project also employs three trained health workers who spend some of their time supporting the medical navigator by managing other aspects of cases, such as applying for food stamps, Medicaid, and Social Security.
- **Costs:** As previously mentioned, the cost to serve over 1,700 ex-prisoners since the program's inception has been a little over \$260,000, or roughly \$139 per individual (updated February 2011).

Funding Sources

State of Michigan

The initiative coalition allocated \$44,300 in State funding to the health project to provide health-oriented services in 2007; these funds pay the medical navigators. The coalition allocated additional funding of \$10,263 for the pharmaceutical program. A 1-year AMERICORP scholarship initially funded the pharmaceutical health worker; this individual is now employed as a regular health project staff member, with 15 percent of salary funded by the initiative.

The state continues to fund the program through two fiduciaries in west Michigan. The health project supplements this funding through Mercy Health Partner's community benefit program, principally to cover the remaining salary of the pharmaceutical health worker, administrative costs, and indirect expenses (updated February 2011).

Adoption Considerations

Getting Started with This Innovation

- **Start slow:** Start with a small number of clients to ensure that staff can execute the process outlined by the pathway.
- **Acknowledge, address public perceptions by articulating program benefits:** The public may view the prison population as one that does not deserve help. The health project's experience, however, suggests that newly released prisoners want to stabilize their lives, improve their health, and become productive members of society. To help the public understand the potential benefits, program developers should emphasize (1) the moral imperative of the program ("this is the right thing to do"); (2) the fact that the program can generate a positive return on community investment (lowering taxpayer costs via reduced recidivism); and (3) that many newly released prisoners have infectious diseases, creating a significant health risk in the community if left unaddressed. Health care and prisons represent the two largest line items in most state budgets. This type of program can help states cut their budgets by reducing recidivism and improving community health.
- **Obtain funding:** Other communities can call attention to Michigan's success to encourage their State governments to fund this type of program. Grant funding may also be solicited from foundations that partnered with the Michigan Department of Corrections. Would-be adopters should consider keeping foundations in their "comfort zone" by

requesting seed money rather than ongoing funding.

- **Hire the right staff:** Hire people who are indigenous to the community, have strong interpersonal skills, and are truly interested in helping this population.

Sustaining This Innovation

- **Triage parolees based on needs:** Prioritize the arrangement of medical services to focus on individuals with the greatest need.
- **Follow up with existing clients:** Ensuring that ex-prisoners have access to the services they need on an ongoing basis can help reduce recidivism rates.

¹ American Public Health Association. Public health and returning offenders in Los Angeles County. Summer 2006 Newsletter. Available at:

http://www.apha.org/membersgroups/newsletters/sectionnewsletters/public_edu/summer06/2708.htm.

² Confronting Confinement. Commission on safety and abuse in America's prisons. June 2006. Available at:

<http://www.prisoncommission.org/report.asp>.

³ Bureau of Justice Statistics. Re-entry trends in the US. October 25, 2002. Available at:

<http://bjs.ojp.usdoj.gov/content/reentry/recidivism.cfm>.

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Innovation Profile Classification

Patient Population:

Impoverished
Medically or socially complex
Medically uninsured
Prisoners

Stage of Care:

Primary care

Setting of Care:

Community social setting
Physician office
Public health clinic

Patient Care Process:

Coordination of care
Disparities reduction
Epidemic control
Follow-up care
Improving access to care
Infection control
Medication: ordering, transcription, administration, dispensing
Outreach to patients
Primary care
Primary prevention
Provider-patient communication
Transitions between settings

IOM Domains of Quality:

Effectiveness
Equity

State:

Michigan

Quality Improvement Goals and Mechanisms:

[Medical home](#)

Organizational Processes:

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[Staffing](#)

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Developer:

[Muskegon Community Health Project](#)

Funding Sources:

[State of Michigan](#)



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Agency for Healthcare Research and Quality • 540 Gaither Road Rockville, MD 20850 • Telephone: (301) 427-1364