



RESEARCH REPORT

Expanding Medicaid Access to Halfway House Residents

Early Qualitative Findings from Connecticut's Experience

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Expanding Medicaid Access to Halfway House Residents

Until a Medicaid policy change in 2016, many people living in Connecticut halfway houses had to return to jails and prisons to receive health care. Once Medicaid became available to them, halfway house residents, staff, and correctional personnel found community-based care a substantial improvement over the previous system, which deterred people from seeking care, entailed logistical and security challenges, and burdened staff and residents alike. Residents thought care quality and access were superior in the community, while staff perceived less burden and no additional risk. Yet, programmatic- and individual-level obstacles remain, and we suggest ways to better link people with needed community-based services. Future research will examine whether Medicaid access affected rates of health care usage and criminal reoffending.

About Halfway Houses and Medicaid

This report describes the early effects of a 2016 policy change in Connecticut to expand Medicaid coverage to all people living in halfway houses after serving time in prison. Halfway houses are a unique part of the transition from prison to the community; as the name implies, they are community-based residential programs that bridge incarceration and living independently. However, many halfway house residents were legally defined as “inmates,” which prohibited them from using Medicaid benefits and services in the community until the federal Centers for Medicare & Medicaid Services issued a clarification about halfway house eligibility. Until then, the majority of Connecticut halfway house residents had to return to prison or jail to use the correctional facility’s medical unit for virtually all their health care needs, ranging from preventive health maintenance to acute medical or mental health problems. (Residents were taken to local emergency rooms for urgent problems but had to visit a Department of Correction medical unit immediately afterward for follow-up care.)

Approximately 10 percent of the people who serve time in Connecticut prisons—1,000 men and women a year—are subsequently placed in halfway houses in communities across the state (OPM 2015). Approval of a halfway house placement is based primarily on a person’s good conduct during incarceration and the time remaining on his or her sentence. Most are placed in work-release halfway

house programs contracted by the state Department of Correction's Division of Parole and Community Services; these houses accommodate between 10 and 75 people each, providing housing, meals, and other transitional assistance (Semple and Haggan 2016).¹

While living in a halfway house, people have the freedom to come and go daily for work-related, educational, and other prosocial activities. But, because halfway houses are accountable for residents' whereabouts, people must get a pass from staff before leaving and provide documentation upon their return.² Similarly, residents are generally not allowed to drive or get rides from friends and family,³ so they usually walk or use public transportation to get to work and other approved activities. People typically stay in Connecticut halfway houses for three to four months before leaving to live independently in the community.⁴ Some remain in the community surrounding the halfway house, while others move to another geographic area.⁵

People with different legal statuses could be placed in a Connecticut halfway house but, until the 2016 policy change, a person's specific legal status determined whether he or she was eligible to receive Medicaid-funded health services in the community. In Connecticut, halfway house residents can be under the legal custody of either the Board of Pardons and Paroles or the Department of Correction (DOC). Both types of residents are supervised similarly, as described above, but the legal distinction mattered with respect to Medicaid access:

- Residents on parole supervision have historically qualified for Medicaid. Legally, they were no longer "inmates" because they had been released from prison by the parole board. However, some "parolees" are placed in halfway houses because they lack an appropriate sponsor or housing in the community. As a result, "parolees" living in halfway houses have long enrolled in Medicaid and received health services from local, community-based providers.
- By contrast, halfway house residents under DOC legal custody historically did not receive Medicaid coverage because federal rules prohibit "inmates of a public institution" from receiving most Medicaid-funded services. Though no longer incarcerated, these halfway house residents were considered analogous to "inmates" under DOC physical custody because, technically, they had been transferred from prison to a halfway house. As a result, people considered "inmates" under DOC legal custody had to go back to designated prisons and jails to receive any nonemergency care from the facility's medical unit.

Yet, regardless of legal status, access to health care is important for formerly incarcerated people. As in other states, most incarcerated people in Connecticut have chronic physical and behavioral health conditions of varying severity, such as asthma, diabetes, HIV, depression, other mental illnesses, and

substance use disorders (Mallik-Kane and Visser 2008).⁶ Left untreated, these conditions can interfere with successful reintegration into the community—for example, by making it more difficult to maintain steady employment. Before placing someone in a work-release halfway house, Connecticut DOC medical personnel must attest that the person is well enough to use public transportation, maintain employment, and manage his or her health conditions independently. Having Medicaid coverage after incarceration promotes health care usage (Mallik-Kane et al. 2016), though connecting this population to nonacute preventive health services remains challenging (Shavit et al. 2017).

In April 2016, the federal Centers for Medicare & Medicaid Services clarified their guidelines on when halfway house residents could qualify for Medicaid services. Upon determination that all Connecticut halfway house residents met federal criteria, the state’s Department of Social Services (DSS) partnered with the DOC to enroll all halfway house residents into Medicaid in September 2016. DOC health services and parole officials anticipated that access to community-based Medicaid services would facilitate better self-management of health needs, in keeping with the reentry preparation goals of halfway house placement.

About This Study

The “Evaluating Medicaid Access for Halfway House Residents” study assesses how Connecticut’s expansion of Medicaid coverage to all halfway house residents may affect care seeking, improve health care usage, and decrease criminal recidivism. This first qualitative report describes how residents and staff experienced and perceived the transition to Medicaid in access to care, health care usage, and program operations. Future research will use quantitative data from DOC and Medicaid records to examine whether residents actually use more care and whether having Medicaid helps decrease recidivism.

For this report, we conducted numerous resident focus groups and staff interviews between October 2016 and May 2017 to gather information from multiple perspectives: those of the residents, halfway house staff, correctional health providers, correctional officers, and state-level DOC officials from the Division of Parole and Community Services and the Division of Health Services. Importantly, our research team spoke with residents and staff separately and confidentially to obtain their candid responses. Further, to identify widespread successes and challenges in the transition to Medicaid, we conducted focus groups and interviews in all five regional parole districts in the state. Finally, we visited each DOC correctional facility where halfway house residents historically received health care to interview staff from the DOC medical units and correctional officers, to document the process of returning to DOC medical units for health care. (All study activities were approved by the Urban

Institute's institutional review board and the DOC's research advisory committee; the appendix of this report describes the data collection in detail.)

We synthesized resident focus group, staff interview, and site observation findings to provide a statewide, systemic view of the transition to Medicaid for all halfway house residents. This report emphasizes common findings conveyed by respondents from a majority of districts across the state. Where informative, the report also includes insights from individual districts and respondents. It discusses

- how halfway house residents formerly accessed care in DOC facilities;
- how residents and staff experienced the change from DOC- to community-based care;
- what factors helped and hindered halfway house residents in getting health care—in both DOC- and community-based settings; and
- how the transition to Medicaid affected halfway house and correctional facility operations.

Accessing Health Care Used to Require Going Back to Prison

Before Connecticut's policy change in September 2016, most halfway house residents were ineligible for Medicaid benefits because of their legal status as "inmates." DOC remained responsible for these halfway house residents' health care, so they had to go back to prison and jail medical units for any nonemergency health services, including chronic disease management, prescription adjustments, mental health visits, dental and vision care, pain, and other acute but nonemergency concerns. (Halfway house staff took residents to local emergency rooms in urgent situations; these required a follow-up visit to a DOC medical unit the next day.)

Each halfway house was assigned to a DOC facility. Five correctional facilities across the state provided halfway house residents with health care: three men's jails, one men's prison, and one women's prison.⁷ Medical staff at each correctional facility reported that halfway house residents formed a small portion of their overall caseloads—at most about 12 people a week at the largest facility. As we detail below, halfway house residents were highly averse to returning to a correctional facility, and the logistics were burdensome. DOC and halfway house staff felt this sometimes led to potentially dangerous delays in getting needed care.

Residents Had Profoundly Negative Views of DOC-Provided Care

Halfway house residents in every district shared profoundly negative opinions of the quality of DOC-provided health care based on their past incarcerations, which made them reluctant to return. They thought DOC did not care about their welfare, and they perceived the health services they received as substandard, unresponsive to their needs, ineffective, and sometimes even harmful. Additionally, some residents perceived correctional health care staff as uncaring and disrespectful.

I just hate going to the doctor in jail...I'd rather be sick in jail than go see the doctor, because it's just...jail is the worst. It takes about three weeks. By the time you see them you're probably gonna be dead.
—Halfway house resident

Four specific concerns were widespread, raised by residents across the state:

- **Medication problems.** Residents in nearly every district complained about the medications prescribed by correctional health providers, perceiving that they were either over- or undermedicated. Residents recalled that medications they had used effectively in the community were not available but felt the alternatives were inadequate: “If you say, ‘I’m on this medication,’ they’ll say, ‘Oh well, we don’t do that medication; it’s too expensive.’ So, they’ll give you some other medication—and I’m not saying they’ll give you the generic brand. They’ll give you a completely different medication that is not even for the right thing.” Some residents described distressing side effects from changes in medication: “They put me on so much lithium I couldn’t hold my tray, because my hands were like this [shows hands shaking] all the time...I had to actually go to the [inpatient] mental health unit to get the correct medication.” In addition, people described medication errors, such as receiving something incompatible with a known drug allergy.
- **Lack of individualized responses to health problems.** Residents often thought DOC preferred cheap, expedient one-size-fits-all solutions over more individualized care. People recalled that DOC dentists’ solution to most problems was to extract the affected tooth instead of attempting more conservative, long-term treatment. Another common refrain was that correctional health providers prescribed Advil for everything, no matter the presenting problem.

- **Long wait times to get medical attention.** Residents commonly perceived that facilities avoided providing medical services unless there was an emergency. They reported that overt problems like bleeding received immediate attention, but that care was deferred for less visible issues like pain. Residents recognized this was partly because of staffing; the medical units within correctional facilities are predominantly staffed by nurses, with doctors and specialists only available on certain days.
- **Mistrustful and indifferent staff.** Residents attributed some delays in care to skepticism about their problems; one said, “They think you’re playing with them. And I’ve seen that a lot.” Residents felt that skepticism lengthened their wait time to see a clinician and that anticipation of such attitudes sometimes deterred individuals from even seeking care.

Inside the facility, I don't think they take the medical situation as seriously as if you were a free man. Because we inmates or whatever, ex-inmates or whatever...they don't jump to your medical concerns.

—Halfway house resident

Two other problems were reported in fewer areas:

- **Inability to discuss concerns with providers.** A few residents felt DOC providers did not discuss their treatment options. One said, “There’s no say-so in DOC. Either you take it or you don’t take it.” Another felt there were disciplinary consequences for speaking up: “If you got an opinion you go to seg [administrative segregation], you get locked up with cuffs and thrown in seg. So, you have no opinion on none of your medical. You have no say on medical. The doctor does what he want to do, this is what you get and that’s the end of it.”
- **Disregard for privacy of medical information.** One participant recalled, “[DOC staff are] talking at the top of their lungs, spitting out what meds you’re on. You can’t do that. You can’t yell out in front of 15 inmates in line what kind of meds I’m taking. I may not want people to know that I have...What if I had like, you know, something where people are scared of, like AIDS or something, and now all of a sudden people are beating me up or something.”

Residents Feared Returning to a Correctional Facility

The experience of returning to a place of incarceration—even the possibility of the experience—provoked fears of being reincarcerated. Residents commonly deferred seeking care as long as possible. Halfway house staff across the state added that residents were reluctant to let them know about medical issues in order to avoid a visit to the DOC medical unit.

As detailed in the next section, just walking into a DOC facility reminded people of being booked into jail, as security procedures sometimes included being strip searched and held in a cell. Although correctional staff considered these precautions and procedures as routine, residents perceived the procedures as traumatic and unfair because they were no longer incarcerated.

Additionally, residents feared being kept in prison for various reasons. One particular situation was the fear of a so-called “medical remand,” whereby DOC clinicians could recommend reincarcerating someone for medical observation or treatment if his or her health could not be managed safely within the halfway house (e.g., a diabetic person with uncontrolled blood sugar who could not manage self-monitoring and medication).⁸ Though medical remands occurred rarely—between 1 and 2 percent of halfway house residents experienced them⁹—some residents delayed seeking health care from DOC to avoid this risk. Relatedly, residents worried about losing their halfway house placements in the event of a lengthy medical remand because DOC policy prohibits a bed from being held longer than two weeks. (Paradoxically, deferring care may contribute to the sort of acute health crises that residents feared.) More generally, staff remarked upon an “anything could happen” mentality, and some residents worried about the potential to get stuck in a facility lockdown.

You sign yourself in, you're taken over to the jail you just left. Just to see the doctor, you're walking back into prison. That's traumatizing for some guys. Nobody wants to go back to the prison they just left.

—Halfway house resident

Staff and Residents Described Burdensome Logistics and Operational Challenges

Despite the small number of halfway house residents who sought care from DOC medical units, both halfway house and DOC staff found getting residents into correctional facilities cumbersome and time consuming. Scheduling appointments, traveling to, and entering a correctional facility involved complex logistics, as detailed below. Staff and residents alike found the process inefficient, burdensome, and disruptive to routine operations.

APPOINTMENTS REQUIRED COORDINATION BETWEEN HALFWAY HOUSES AND DOC

Residents were not allowed to contact DOC directly to schedule appointments. Instead, halfway house staff faxed appointment request forms to DOC, served as the go-between to communicate residents' health concerns, and finalized appointment times. Though some appointments were straightforward, halfway house staff explained that finalizing appointments could take anywhere from minutes to hours to days, including "several phone calls."

Demonstrating the urgency of a resident's health needs proved challenging. Some halfway house staff perceived that DOC clinicians expected them to screen appointment requests. One staff member was particularly troubled by this: "[DOC would say,] 'You guys are calling us for this?' [and I'd think,] We're not medical physicians. We don't know what warrants a guy going over there." This staff member further perceived that "the physician on call you'd have to deal with was always on the side of less care."

Available appointment times were limited. Halfway house residents and staff perceived DOC as inflexible around appointment times, even when residents' work schedules were in conflict. As one resident put it, "It's DOC, so you'll be seen when they feel like seeing you." Similarly, staff noted that DOC would "tell" them when to bring in a resident irrespective of time conflicts. DOC personnel recognized the challenge, yet lacked flexibility because of their time and resource constraints—for example, physicians and specialists were only available on certain days of the week.

TRANSPORTATION TO DOC COULD BE TIME AND RESOURCE INTENSIVE

When possible, residents walked to the DOC facility or used public transportation, with halfway houses providing bus passes as needed. Distances varied, however, and the one-way travel time to a DOC facility by public transportation sometimes approached 1.5 hours. Round-trip travel plus the appointment itself meant that residents could spend half a day or more to get health care. Working residents sometimes had to miss a day of work, which they found particularly concerning because they recognized they are already a hard-to-employ population. Additionally, one halfway house program director described extended time away from the house as an accountability risk.

Halfway house staff transported residents when public transportation was not feasible (e.g., in areas where public transportation was not available or for residents who were medically compromised and could not walk). Depending on the distance, staff waited for residents at the correctional facility. Staff in multiple halfway houses recalled clearing their schedules for a half- or full-day visit to DOC. This diverted staff resources from regular responsibilities (e.g., reentry assistance) and increased the workload of other employees who remained in the house. When possible, staff grouped appointments for multiple residents on the same day. That meant, however, that residents had to wait in DOC for others before they could return to the halfway house.

SECURITY PROCEDURES WERE BURDENSOME, ESPECIALLY IN LARGER DOC FACILITIES

Security is the top priority in a correctional facility. Providing halfway house residents with health care required coordination between custody staff (e.g., correctional officers) and medical staff to verify the residents' identities, process them into the facility, prevent the entry of contraband items (e.g., drugs, money, cigarettes, or cell phones), escort them to and from the jail or prison medical unit, and keep them separated from currently incarcerated individuals to restrict the exchange of any items.

DOC entry and search procedures varied but were often reminiscent of those for incarceration. Halfway house residents typically used the same back entrance as new jail admissions and underwent a pat-down search. Further, in half the facilities, residents were strip-searched and waited for their appointments in large holding cells.¹⁰

To keep halfway house residents separated from currently incarcerated people, some facilities “locked down” hallways as residents were escorted to the medical wing, similar to when members of rival gangs were transported. In one facility, the medical unit had to clear out all other patients before a halfway house resident could be seen.

While DOC clinicians perceived the volume of halfway house residents as a negligible addition to their day-to-day workload, some felt the process of bringing them in detracted from the primary responsibility of caring for currently incarcerated people—particularly in the facility where the medical unit had to be cleared of other patients. In some facilities, medical staff also noted they lacked storage space for filing halfway house residents' charts.

Further—and particularly in the three large county jails—halfway house appointments had to be accommodated within the DOC facilities' daily schedule of mission-critical activities, such as booking new arrestees, transporting currently incarcerated people to and from court, and providing medical

care to currently incarcerated people. To paraphrase one deputy warden, halfway house residents were one more moving piece in an already busy system

Collectively, interviews with DOC and halfway house staff echoed the same concerns: DOC visits were time consuming for staff, who had to coordinate residents' medical visits with their regular duties, and stressful for residents, which led them to defer and downplay potentially serious health concerns.

Psychologically, they did not want to [go there] ... We had to go with them, so I would walk with a client, walk through the doors and everything, and you'd actually be in the medical unit in the prison with them. And I could see after a few times, okay, if I had ever lived here in a place like this, I wouldn't want to come back either. So, you had cases where guys would just push the envelope on needing to see a doctor, but just would refuse because they did not want to go back to jail. There was always the fear that "oh, they're not gonna let me back out."

—Halfway house director

Medicaid Facilitated Access to Health Care in the Community, Despite Some Limitations

Since all halfway house residents became Medicaid eligible in September 2016, they were generally able to access care in the community as anyone else would, freeing up halfway house and DOC staff resources. Residents in all districts identified having health insurance as facilitating community-based care. Within two months of the policy change, many residents had sought medical and behavioral health care in the community.

Residents and staff had positive views of community-based health care, especially when contrasted to DOC-based health care. Residents reported making their own appointments or using walk-in clinics and transporting themselves in the community. Further, halfway house staff universally supported the transition to community-based care for all residents. At the same time, residents, halfway house staff, and correctional medical personnel noted limitations to Medicaid coverage; logistical challenges related to transportation, time, and halfway house policies; and concerns about continuity of care.

Benefits and Challenges of Using Medicaid while Living in a Halfway House

The structure and services halfway houses offer are designed to help with reentry but can also introduce unique challenges. Halfway house staff are in a dual role of supporting reentry and supervising residents to maintain accountability. In the sections that follow, we describe how aspects of the halfway house setting intersected with residents' access to health services.

Briefly, halfway houses routinely assist residents with

- Medicaid enrollment,
- navigating community resources, including finding local providers, and
- storing and managing prescription medications.

However, aspects of halfway house placement sometimes constrained residents' willingness and ability to seek care, including

- residents' limited familiarity with the geographic area,
- rules governing daily movement in and out of the house, and
- the inherently temporary nature of living in a halfway house.

Enrolling in and Using Medicaid Coverage

Residents and program staff described Medicaid enrollment as a critical early step in the transition from correctional facilities to the halfway house, particularly for individuals with chronic conditions or daily medications, for whom obtaining or transferring prescriptions was essential to avoid medication lapses. Preparations for Medicaid enrollment and continuity of care began during incarceration. DOC partnered with the state Department of Motor Vehicles to help people obtain valid identification upon release (e.g., renewed drivers' licenses or nondriver IDs as appropriate). People with high medical or mental health needs (defined as a DOC classification score of 3 or higher) were assigned facility-based medical discharge planners to initiate Medicaid applications and set appointments with providers in the community. Additionally, a few individuals with high mental health needs (e.g., people who previously received services from the state Department of Mental Health and Addiction Services) were assigned to a specialized mental health parole supervision unit to provide additional reentry support.

Regardless of need, DOC prepared a discharge summary listing a person's diagnoses, current medications, and allergies. DOC then provided prescriptions and a small supply of transitional "bridge"

medication to those who had been receiving medication at the time of their release. Once in the community, people would need to fill their prescriptions at community-based pharmacies and use local health care providers for ongoing care.

Halfway house staff reported that Medicaid enrollment or reactivation usually occurred during intake, though some residents arrived with coverage already established through DOC discharge planning efforts. (At the time of the study's 2016–17 data collection, universal Medicaid enrollment before halfway house placement was not feasible because facility-based discharge planning staff were at limited capacity. DOC reported it has since reorganized its discharge planning services so applications are generated before release.)

DOC and DSS, the state Medicaid agency, developed a process for checking each person's Medicaid status and, if needed, facilitating enrollment upon entry to the halfway house. Halfway house staff faxed an inquiry form to a designated criminal justice–focused unit within DSS to determine if the person had existing coverage. Based on the person's status, either DSS reactivated their coverage or the house staff assisted with applying for Medicaid coverage. This process was designed to ensure coverage within one to two business days. According to halfway house staff, most people had coverage activated within a week or two of halfway house entry. Further, DOC and DSS implemented a voucher system that allowed people to fill prescriptions in the interim.¹¹

Residents generally described applying for and using Medicaid as easy. From an administrative perspective, halfway house staff in one district acknowledged that submitting Medicaid inquiries and applications for residents took time; however, halfway house staff in most districts perceived that, on balance, Medicaid enrollment saved staff time over coordinating medical appointments with DOC and transporting residents when needed. Further, staff identified broader system changes that facilitated timely enrollment. First, DOC had begun to ensure more often that people had state IDs, birth certificates, Social Security cards, and other critical forms of identification before leaving correctional facilities. Second, staff in three districts reported that having a DSS contact person familiar with reentry was helpful in troubleshooting problems and facilitating enrollment.

However, a few focus group participants reported that they were uninsured, some because they were experiencing initial difficulties obtaining coverage¹² and others because, over time, their income had exceeded the threshold for Medicaid coverage (and these individuals did not have employer-based or marketplace coverage). Among those who were insured, some described coverage limitations with respect to certain medications, medical equipment, dental care, and other specialist services.

Logistics of Finding and Getting to Health Care Providers

Many residents found providers in the community in varied ways and successfully accessed health care services. At the same time, some experienced difficulties related to their familiarity with the community surrounding the halfway house, transportation, the time needed to attend appointments, and halfway house rules.

DEALING WITH GEOGRAPHIC UNFAMILIARITY

The process of matching an individual to a halfway house could be complex. Before leaving prison, halfway house residents were asked to choose their top two (out of five) geographic districts in the state for placement, but some complained of being placed in an unfamiliar part of the state where they did not know the area, health care providers, or transportation system.

While DOC knew individuals' halfway house eligibility dates and broad geographic preferences in advance, the specific date and location of placement depended on the bed space available once people reached their eligibility dates. Placement occurred quickly once a space became available in a chosen district; halfway house staff had three business days to review an individual's file and accept or decline the placement.¹³ As a result, people could be placed in an unfamiliar town, even within a preferred district, with limited time to prepare for where they would be going.

Further, DOC noted that in rare cases, geographic preferences could not be honored if a person lacked a sponsor or support system in that community. Upon arrival to a halfway house, each person went through an intake process and was assigned a case manager; this was meant to orient individuals and help them navigate local resources. In limited circumstances, people could request a transfer to another district after placement (e.g., if they found employment closer to another district).

FINDING HEALTH CARE PROVIDERS

Residents and staff in most districts reported that case managers helped people find local providers upon request. Staff typically recommended or referred residents to primary care and behavioral health providers. This was particularly true for behavioral health treatment, which a sizable portion of residents was mandated to receive, because halfway house providers had established relationships with local providers.

When residents needed other types of care (e.g., a specialist) or preferred to locate their own providers, programs varied in the extent to which staff offered assistance or resources for residents to do their own searching. Staff and focus group participants in most districts perceived that the majority

of residents had smartphones. Yet, residents' computer- and internet access could be limited because the halfway houses generally did not provide residents with wireless internet access.¹⁴ House phones and computers were available as an alternative, though residents were occasionally reluctant to ask to use them. DOC parole officials further noted that residents could request to use the public library (e.g., for internet access).

NAVIGATING PROVIDER AND APPOINTMENT AVAILABILITY

Residents generally perceived making an appointment to be easy once they found a provider, and appreciated their ability to use a walk-in clinic or schedule on short notice when needed. However, the ease of getting an appointment depended on the type of care needed. Residents and staff reported long wait times for appointments with psychiatrists and other specialists in some districts because few accepted Medicaid. This was particularly concerning for people newly admitted to a halfway house; although DOC typically provided residents with a small supply of “bridge” medication and a prescription refill, residents and staff cited instances when they had been unable to transfer prescriptions to a new provider in time, leading to medication gaps and subsequent physical or psychiatric consequences.

Although DOC provided prerelease discharge planning services—including scheduled appointments and, in some cases, specialized mental health parole supervision—to individuals with the most severe needs, the targeted nature of these services suggests capacity was limited. Care-coordination services were targeted to those with medical or mental health needs rated as a 3 or higher during incarceration. Over one-quarter (28 percent) of halfway house residents met this threshold for prerelease discharge planning services. However, the majority (53 percent) had less severe medical or mental health needs and therefore received standard services.¹⁵ It stands to reason—and DOC staff concurred—that limited provider availability in the community would have had a greater impact on those with mild to moderate treatment needs than on the more severely ill people targeted for prerelease service linkages.

GETTING TO AND FROM HEALTH CARE VISITS

Halfway house residents thought transportation and time were the most significant barriers to accessing community-based care in nearly all districts. As noted earlier, residents perceived that they were required to walk or use public transportation to reach all destinations, including health care appointments, barring any special circumstances or hardships. (Staff had the discretion to transport individuals when needed.) Residents typically understood that this transportation policy was intended to promote self-sufficiency but noted that distance, limited public transit in some areas, and their unfamiliarity with the geographic area made getting to appointments cumbersome and time consuming

in practice. In response, DOC parole officials commented that Med Cab transportation¹⁶ is available through the Medicaid program, but neither halfway house staff nor residents mentioned this option. Lack of awareness may have been an issue. A few residents perceived they needed to conduct independent research because the staff did not know about all available transportation resources.

NEEDING COMMUNITY PASSES TO LEAVE THE HALFWAY HOUSE

Program rules govern daily movements in and out of the halfway house. Because halfway houses are accountable for residents' whereabouts, people must get a pass from staff before leaving and provide documentation upon their return. Residents completed a pass request to be signed by their case managers or other designated staff.

Both halfway house staff and residents perceived that medical passes were typically granted without issue and rarely denied. Staff in some districts reported denying passes if they had doubts about the veracity of the appointment (e.g., stemming from previous noncompliance) or if the pass form was incomplete or improperly submitted. Some houses did not grant passes on weekends, which created conflict with work schedules.

Both DOC and house policies governed pass durations, so specific pass lengths varied across houses and with the purpose of the trip. Passes for health-related appointments had a typical maximum of three hours. DOC parole staff reported that their policy allows for passes to be extended when an appointment requires more time, but the implementation of this policy created challenges.

MANAGING CHALLENGES RELATED TO PASS DURATIONS AND EXTENSIONS

In nearly every district, residents stated that three hours was often insufficient when accounting for transportation to appointments and back, time spent in the provider's waiting room, and the actual appointment.

While most halfway houses allowed residents to call in to extend pass time, the manner in which staff handled these requests varied. Residents in some houses perceived that staff were open to extensions as long as they called; in others, residents felt that their requests for extensions were sometimes mistrusted, that it could be difficult to reach the correct staff member, or that sanctions could be imposed as a result of being late, regardless of whether they called. In some cases, these barriers led residents to avoid or put off seeking care.

Similarly, the manner in which halfway houses required residents to verify appointments or request extensions when running late sometimes deterred residents from seeking care. According to parole

staff, DOC policy is for residents to call from a provider's landline to confirm their presence at that location. Program practices varied, however, according to residents and halfway house staff. Some programs accepted written documentation from an appointment as sufficient or allowed residents to call from their cell phones, while others required residents to call from a provider's landline or ask provider staff to call in addition to providing written documentation. Residents found the latter embarrassing and stigmatizing. A few residents also worried about the burden on health care providers, as busy doctors or nurses might neglect to follow through on calling the halfway house.

I'm telling them, "Hey, I'm in a halfway house, I gotta report this, you gotta sign this thing" ... It's embarrassing, you know, when you're in the community. And now you got little kids, you got a family right here [in the waiting room] hearing this stuff. And it's "Oh, that's a convict, get away."

—Halfway house resident

Underpinning many of the DOC and halfway house pass practices were concerns about accountability. Halfway house staff stated that they are liable for knowing where residents are at all times and expressed concerns that some residents might use passes—including medical passes—for purposes other than intended. However, the degree to which staff perceived medical passes might be misused varied greatly. One halfway house director attested that "90 out of 100 times...people are not using medical appointments to do mischievous things," while another director was more suspicious of malingering: "They use medical as an opportunity to go out for a couple hours. You know, if they don't have a pass in for a job search, they're stuck in the house... A lot of times [a resident] will try to use medical as a way to get out of the house unattended and meet his family down at the ER for a visit." Halfway house staff reported calling providers to verify typical wait times and described establishing firm boundaries with residents to foster compliance.

That's why the passes are very strict [to prevent misuse]. It's something where you really do have to look into detail, make sure that wherever they're going, the place, the establishment isn't closed...But if you really make sure when the individual comes to your caseload, you let them know, "Listen, I'm here to work with you guys, well, we need to do business and we need to be really stern with each other," they understand that, and they make sure not to cross those boundaries, and really make sure that they adhere to the rules and policies.

—Halfway house case manager

Engagement with and Quality of Community-Based Care

Residents almost universally viewed the quality of care as better in the community than in DOC. Some called it “excellent,” and others said it was “way better than what we’re used to.” Focus group participants appreciated the following aspects in particular, as illustrated by these quotes:

- *Individualized attention and treatment:* “She said we’re gonna sit down for 45 minutes next time so she can learn more about me.”
- *Professionalism and knowledge:* “The two doctors that I have had dealings with since I’ve been here have been really good. Pleasant bedside manner, medical skills... just all around good experiences.”
- *Feeling listened to and cared for:* “I have an opinion now. I can go to a doctor now just like anybody else that’s free, and he understands my opinion, and this is how I’m feeling, and he works with you and gives you what you need, and the right thing.”
- *Responsiveness:* “If medication isn’t working for me and I tell them, they listen.”

Residents in most districts also appreciated being able to choose their own providers and to change if needed, contrasting this freedom with DOC: “If you don’t like that doctor you can go somewhere else. You can’t do that in jail.”

You spend real time with the doctor, where the jail—they just try to get you in and out. The doctor will try to really see what's going on with you and, as far as meds, really try to get something that will help you, where in jail they just throw something at you. So, it's different in that way.

—Halfway house resident

Overall, most staff and residents thought that residents were more likely to seek care through Medicaid as opposed to the previous system because of these positive views. A case management supervisor in one district observed residents seeking more proactive and preventive care: “The big change I’ve seen is, we’re now doing less dealing with the medical issues with the client other than little routine visits, because they come prepared to go. And the process now is a lot easier as opposed to sending the client back in the institution.” Some staff members also felt that having Medicaid promoted greater self-sufficiency and accountability.

MANAGING PRESCRIPTION MEDICATIONS

While most halfway houses promoted residents’ independence with respect to making and getting to appointments, all halfway houses took a more active role in storing, refilling, and dispensing medications for safety and liability reasons.¹⁷ DOC staff reported that their policy is for halfway houses to store controlled substances, order medication refills, and monitor self-administration. One halfway house director described using a hybrid model for promoting self-sufficient medication management while maintaining accountability:

When it’s time to fill their pill trays, the client fills their pill tray and the case manager is sitting there watching the count, because it’s also teaching them how to manage their own, you know, independence, basically. Because a lot of things they have to learn. You’d be surprised that you have to teach them. Because in jail it’s like, “Here’s your stuff, here’s your stuff, here’s your stuff.” Here it’s like, “Here are your things, let’s see. You have to take this in the morning, this you take in the evening, so we’re going to fill the AM slots.”

Because residents were generally not allowed to keep medications on their person,¹⁸ staff functioned as gatekeepers. For example, in one program, residents were required to take their medicines at specific program-wide medication times. Some residents viewed this tight control as a barrier, with one person deciding to stop taking medications as a result. Others expressed frustration that they were unable to keep medications with them, since this meant they were reliant on staff

availability to obtain prescription or over-the-counter medications when needed. Additionally, some residents and staff voiced concerns about halfway houses' capacity and training to manage residents' medication, given their primary mission as work-release programs. Residents expressed concerns with staff familiarity with their medications and related needs, and in one case expressed concerns about staff professionalism when the privacy of medications was not maintained.

From a staff perspective, one employee described feeling underequipped to deal with more complex medication regimens: "The issue is when you have somebody who has a lot of meds...[for example,] an insulin diabetic...we control the medicine, we allot what they take, but they come to us [with questions]. Nobody here has been certified. We're not required to have been certified in a work-release program." While DOC officials concurred that the halfway house staff are not responsible for administering medications or answering medical questions, residents might not appreciate the distinction when staff are dispensing medications. Some halfway house staff felt the need to educate themselves to be better prepared to respond to residents' medical questions and issues. As one case manager stated, "If a guy's on medication, we have to look [it] up through the internet, look up the medication, find out the side effects so that we'll know what we're dealing with. Because you know, we're not medical professionals."

ESTABLISHING CONTINUITY OF CARE FOR CHRONIC HEALTH CONDITIONS

While some medical staff working in correctional facilities anticipated that Medicaid access would improve continuity of care, others were concerned about lapses as individuals began managing their own care. These staff members pointed to the way people with chronic mental and behavioral health needs cycled in and out of jail as evidence of their inability to manage their own care on the outside. Medical staff at one facility also asserted that returning to DOC for mental health services had been particularly helpful to patients because it was faster to get a mental health appointment with DOC than with the providers who accepted Medicaid in their surrounding communities. A few staff and residents also noted lags in obtaining medical records from DOC facilities so residents and their providers could access information about prior treatment.

The transition after release from the halfway house was not a central focus of this study, but the topic arose spontaneously in many focus groups as another turning point for continuity of care. While some residents planned to settle in the community surrounding the halfway house—because they embraced a fresh start or found employment locally—others intended to return home or go to a different city after leaving the halfway house, which would require them to repeat the process of finding providers and figuring out transportation. Some residents expressed concern about where they would

live, their ability to maintain or renew their health insurance from an uncertain new address, and their ability to remain connected with newly established health services.

EASING FEARS OF “MEDICAL REMANDS” AND OTHER BARRIERS

Although the new system reduced fear of medical remands,¹⁹ some residents remained concerned that they could be returned to custody in a DOC medical unit for severe health issues. One resident preferred to delay appointments for potentially severe issues until after being released from the halfway house for this reason. Staff had varying perceptions of whether or under what circumstances medical remand may still occur in concert with Medicaid access. In fact, staff in three districts believed it was still possible, suggesting a lack of clarity six to nine months after the policy change. (In a subsequent interview with the research team, the DOC parole staff confirmed that halfway house residents are no longer returned to custody to receive medical or mental health treatment. However, people may be remanded for substance use violations, either for disciplinary reasons or for placement in residential substance abuse treatment.) Finally, individual residents in some focus groups expressed more idiosyncratic deterrents to care similar to those in the general population, such as fear of needles or general aversion to doctors.

Implications

These halfway house resident focus groups and staff interviews provided several important insights about access to health care when many halfway house residents became eligible for Medicaid coverage and community-based care. Residents and staff generally felt this policy change increased access to care. Residents and staff perceived that obtaining Medicaid coverage was straightforward, given recent initiatives to ensure that people are released with valid identification. Staff estimated that the added effort to enroll people into Medicaid was offset by the efficiencies gained from no longer coordinating medical appointments with DOC facilities. Further, correctional staff thought Medicaid access eliminated a logistical burden for jails and prisons because they no longer had to search and escort people coming in from halfway houses.

However, Medicaid coverage was not without limitations. In addition to the factors that facilitated getting care, residents and staff identified factors that hindered access to care. Barriers and facilitators to care were sometimes similar to those experienced by the general population, but often specific to reentry after incarceration and the halfway house environment:

1. **Obtaining Medicaid was viewed as an important prerequisite allowing access to care, but the coverage had some limitations.** While residents were generally able to find most types of providers, psychiatrists and other mental health professionals who accepted Medicaid were scarce in some locations. DOC targeted prerelease discharge planning and care-coordination services toward the most severely ill individuals. Yet, provider availability was problematic for other residents who used prescription medication for psychiatric needs and needed appointments soon after release to prevent medication lapses. This suggests DOC's capacity to provide discharge planning and care-coordination services should be increased. Alternately or in addition, it may be necessary to increase the number of refills available on the transitional prescriptions given to people as they leave prison.
2. **A few residents were uninsured because they earned income exceeding the Medicaid threshold.** They acknowledged needing to transition to other insurance but did not know how or perceived other plans as too expensive. These individuals may be eligible for subsidized Marketplace health plans through the Affordable Care Act. Since halfway house residents are still under DOC supervision, existing DOC-DSS partnerships might help these individuals with Marketplace enrollment.
3. **Some correctional health providers were concerned that people would not independently manage their chronic health conditions, despite residents' positive views of Medicaid coverage and DOC's provision of prerelease discharge planning services.** Recent research focused on Connecticut parolees found that some would only seek care when sick or injured, but others were motivated to get preemployment physicals or to proactively have their health checked after being incarcerated (Mallik-Kane, Paddock, and Jannetta 2018). Collectively, these findings suggest a need for health education and coaching, as well as referrals to primary care, because chronic conditions are both latent and prevalent among incarcerated people. Halfway house staff might encourage residents to seek preemployment physicals as part of their overall work-release mission, noting the benefits of a postincarceration checkup, as people mistrusted or avoided receiving health services while incarcerated. Referrals should emphasize primary care providers over urgent care clinics to facilitate long-term management of chronic conditions.
4. **Continuity of care may be enhanced in a variety of ways.** Community-based health providers may benefit from education about working with formerly incarcerated people. The Transitions Clinic Network has developed several strategies for engaging and retaining formerly incarcerated people in care (Shavit et al. 2017).²⁰ Additionally, some individuals may be eligible

for Medicaid initiatives, such as whole person care or health homes, that are designed to improve care management for people with multiple chronic care needs. Another potential strategy is to make the discharge summaries that DOC medical personnel prepare for halfway house staff also available to residents. Residents might also sign additional release of information forms to facilitate information sharing with community providers.

5. **Halfway house residents' familiarity with local providers and transportation options varied.** So did their perception of staff helpfulness on this front. In most programs, halfway house staff provided some assistance navigating local providers and transportation, which facilitated access while in the halfway house. Staff training should emphasize the need for such assistance. Refresher trainings on halfway house and DOC policies and practices may also help improve the consistency of services across the state.
6. **Halfway house residents faced a subsequent transition to independent living once they reached the end of their sentences.** The health care connections residents establish while in the halfway house may be temporary if they move to another area. This underscores the importance of teaching residents how to navigate health care services. Halfway house programs are advised to review their transition planning protocols and ensure they also discuss health care transitions with residents. This may include reviewing how to process a change of address with the Medicaid agency and referrals to health care providers in the new geographic area. Because DOC oversees both in-prison discharge planning and halfway houses, it may be well positioned to maintain a clearinghouse of local health care information using existing resources developed by correctional discharge planners, individual halfway house programs, and local parole offices.
7. **Pass policies designed to ensure halfway house residents' accountability affected their perceived access to care.** Although health care passes were typically granted without issue, residents were reluctant to ask for them when they felt passes were monitored in onerous ways—for example, if staff resisted extending time limits when needed, or if passes were verified in ways perceived as embarrassing, disrespectful, or stigmatizing. Residents' willingness to seek health care passes varied across halfway houses, suggesting that halfway houses may benefit from exchanging information about their pass policies and monitoring strategies. Additionally, staff training may help ensure that passes are monitored respectfully in ways that promote both flexibility and accountability.
8. **Medication management presented various challenges.** Halfway house staff dispensed medications and monitored refills because medications needed to be kept locked to prevent

inappropriate use. While staff management of medication seems likely to increase adherence in the short term, it is also important to teach residents how to manage their own medications to facilitate longer-term adherence—for example, some program staff involved residents in filling their pill trays and taking stock of when to order prescription refills. At the other end of the spectrum, some residents complained of working around staff members' schedules to take their medications; they wanted to keep nonaddictive and over-the-counter medications on their person to take when needed. DOC may wish to review its policies on self-carry medications to facilitate greater independence. Further, some staff were concerned about dispensing medications because they lacked medical training or certification to answer residents' questions. DOC may wish to consider what resources are available to support halfway house residents and staff in this respect; Medicaid may have nursing helplines like some private insurance companies do, or DOC medical personnel may be able to answer certain questions.

9. **Fears of “medical remands” persisted, though focus group participants were more willing to access care in the community than they had been to return to DOC for care.** Residents remained concerned that severe medical conditions could still lead to being reincarcerated in a DOC medical unit; for some, this concern deterred them from seeking care until they left the halfway house. This suggests a need to clarify and communicate DOC's current policy on medical remand to both residents and staff. It is also an opportunity to educate halfway house residents about the importance of preventive care to maintain health and avert health crises.

Conclusion

These early results from the first several months of expanding Medicaid to halfway house residents suggest that people may now be more likely to seek care. Residents no longer have to contend with their fears of returning to the medical unit of a correctional facility for care, and they perceive that Medicaid gives them access to their choice of higher-quality providers. Further, the increased flexibility and ease of getting to health care appointments ease logistical difficulties and conflicts with work. From a staff perspective, an added benefit is the increased efficiency from no longer coordinating the onerous process of getting residents into a DOC facility for medical care. However, some correctional health providers were concerned that people would not successfully maintain continuity of care for chronic conditions on their own.

Do halfway house residents actually use care now that they have Medicaid? Our research is ongoing and is collecting quantitative data to examine the impacts of Medicaid access for this

population. We are comparing residents' recorded Medicaid health care usage with historical data about the health care they received from the DOC. Additionally, we will examine whether Medicaid access and health care usage contribute to changes in reoffending. Findings from these quantitative impact analyses are expected in December 2019.

Appendix. Study Methodology

Our data collection procedure was guided by three priorities:

1. Collect statewide information from multiple locations to identify broad systemic concerns about health care access, rather than specific issues confined to a particular geographic area.
2. Gather multiple stakeholder perspectives, including male and female halfway house residents, halfway house program staff, correctional officers, correctional medical personnel, and state-level administrators.
3. Compare halfway house residents' firsthand experiences and perceptions of accessing health care under the previous system of returning to DOC facility medical units with using Medicaid to access community-based services.

We organized our data collection according to Connecticut's system of parole districts (figure A.1) to include every geographic region of the state. Connecticut managed its halfway houses and health care delivery through a system of five parole districts. Halfway houses for men were located in each of the five parole districts and, historically, "inmate" residents returned to a designated DOC correctional facility for the district. Because the number of incarcerated women was smaller, there were fewer houses for women; all halfway houses for women across the state were assigned to the one women's prison for their health care. We conducted the study in five men's halfway houses—one in each district—and one halfway house that served women statewide.

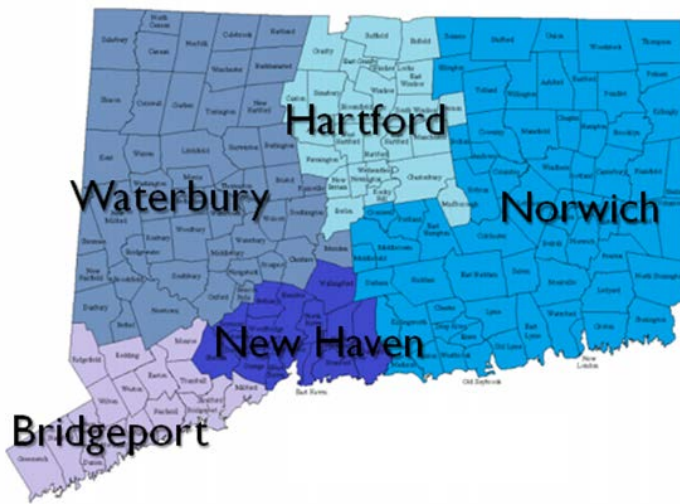
We conducted the following complementary data collection activities in each halfway house:

- focus groups with residents, including separate focus groups for "inmates" who historically returned to DOC for care and "parolees" with long-standing access to Medicaid in the community
- interviews with halfway house program staff
- facility observation and staff interviews at the designated jail or prison where the house's residents historically returned for care

Additionally, we interviewed state representatives about halfway house policies, Medicaid enrollment procedures, and systemic health care access issues. Table A.1 details each part of our data collection.

FIGURE A.1

Connecticut Parole Districts



Source: CTDOD Directory of Contracted Community Programs, July 2016.

TABLE A.1

Data Collection Activities

Data source	Dates collected	Number and description
Focus groups with halfway house residents	October 2016	<ul style="list-style-type: none"> 6 halfway houses: 5 men's (one per district) and 1 women's Goal of two groups per house: <ol style="list-style-type: none"> Residents who previously returned to DOC medical units because of legal status as "inmates" Residents with longstanding Medicaid access because of legal status as "parolees" 11 groups conducted. Average group size: 5 (range 2 to 11) 58 residents participated in total <ul style="list-style-type: none"> 79% men and 11% women 37% white, 43% black, 18% Hispanic, and 2% other race 52% "inmates" and 48% "parolees"
Interviews with halfway house program staff	March–May 2017	<ul style="list-style-type: none"> 10 semistructured staff interviews: 5 case managers and 5 administrators At least one staff member per halfway house In person or via telephone
DOC facility observation and staff interviews	May 2017	<ul style="list-style-type: none"> 5 facility visits: 3 jails and 2 prisons These were all the correctional facilities used for halfway house residents' health care Staff-guided tour of admission, search, and processing areas; waiting areas; and medical units Semistructured interviews with custody staff (e.g., deputy wardens, correctional officers) and medical staff (e.g., doctors, nurses, administrators)
Interviews with state administrators	March–May 2017	<ul style="list-style-type: none"> DOC health and addiction services DOC Division of Parole and Community Services Department of Social Services

We convened focus groups with halfway house residents in October 2016, approximately one month after the policy change, to gather people’s perceptions and experiences of the transition to Medicaid-provided services. This rapid timing was necessary to reach current residents before their release. Halfway house stays are four to six months long, and focus group eligibility was restricted to residents who had been in the halfway house for a minimum of two months (so we would interview those who had had an opportunity to use health services). Consequently, we planned separate “inmate” and “parolee” focus groups within each halfway house. The “inmate” groups were designed to compare DOC- and community-based care experiences among those who had recently gained access to Medicaid, while the “parolee” groups were designed to focus on barriers and facilitators to community-based care among those with more experience with Medicaid. In reality, we found that members of both types of groups had experience with both systems of care from prior halfway house stays.

Staff interviews and facility observations were conducted between March and May 2017, six to eight months after the policy change. This timing allowed staff respondents the opportunity to reflect on how practices may have changed beyond the initial implementation of the policy change.

The qualitative data collected through all these activities were analyzed and synthesized. Focus groups with residents were audio recorded, transcribed verbatim, and coded using qualitative analysis software (NVivo). This allowed us to document the frequency of health care access issues and distinguish between DOC- and community-based care experiences. Staff interviews and facility observation notes were summarized manually. Staff perspectives were compared with the resident focus group findings. This report focuses on findings reported by a majority of parole districts. However, where informative, we note findings from individual respondents and districts.

Notes

- ¹ Work-release programs were the most common type of halfway house in Connecticut, making up 20 of 31 contracted programs. These residential programs are designed to help people who have been incarcerated obtain meaningful employment. “The goal upon discharge is for each individual to have stable employment, an acceptable place to live, and sufficient savings to live independently” (Semple and Haggan 2016, 4). Other halfway houses serve more specialized functions (e.g., inpatient substance abuse treatment, sex offender rehabilitation, scattered-site housing).
- ² Halfway house staff may provide transportation when walking to an appointment or using public transportation is not feasible. Further, medical transportation is sometimes available through the state Medicaid program.
- ³ It is sometimes possible for residents to drive or get rides, but drivers need to go through an extensive application and background check.
- ⁴ The average length of stay in Connecticut’s work-release halfway houses is four to six months (Semple and Haggan 2016).
- ⁵ This is similar to the residential mobility documented among other reentering populations (La Vigne and Parthasarathy 2005).
- ⁶ Additionally, Urban Institute analysis of 2015 Connecticut DOC data found 97 percent of halfway house residents had some type of health concern: 69 percent were assigned a medical score of 2 or higher, indicating subacute or chronic disease requiring occasional treatment or medication; 53 percent had a mental health score of 2 or higher, indicating a history of mental illness or a current illness under good control through therapy or medication; and 87 percent had a substance use score of 3 or higher, which met DOC’s threshold for receiving substance use treatment services.
- ⁷ In general, all the male halfway houses in a parole district were assigned to a single correctional facility within that district. However, male halfway house residents in one parole district traveled to DOC facilities in neighboring districts for their care. All women were assigned to the single statewide women’s correctional facility.
- ⁸ The official term is “remand without prejudice.” Medical personnel could request a parole supervisor to authorize a remand without prejudice when they deemed a halfway house resident’s health would be in serious jeopardy without continuous access to medical care.
- ⁹ Urban Institute analysis of DOC data found that 14 halfway house residents were “medically remanded” (i.e., had a remand without prejudice) among the 892 on community release between April and May 2015.
- ¹⁰ In contrast, two facilities let halfway house residents enter through the front lobby as visitors. One of the larger facilities had attempted this but found the process too disruptive. Further, in all facilities, people were allowed to remain in their personal clothing and were not handcuffed.
- ¹¹ The development of these procedures was made possible by a long-standing collaboration between the DOC and DSS. For example, DSS has a dedicated prerelease entitlements unit that specializes in processing Medicaid applications from criminal justice agencies. Mallik-Kane and colleagues (2016, 5) describes this collaboration in detail.
- ¹² Some residents did not have Medicaid coverage because of issues with immigration status or invalid Social Security numbers.
- ¹³ Specific reasons for declining an individual included victim impact or arson history.
- ¹⁴ Policies regarding smartphone ownership and internet access were not systematically assessed as part of this research.

- ¹⁵ Urban Institute analysis of 2015 Connecticut DOC data.
- ¹⁶ In some circumstances, halfway house residents can use Med Cabs or Medicaid Non-Emergency Medical Transportation (NEMT) to assist with medical appointments. This service is intended for Medicaid members who need transportation to commute to and from Medicaid-covered medical services. Those enrolled in Connecticut's public health coverage program (HUSKY A, C, or D) and limited benefit members who cannot drive are eligible for this service. More information about NEMT can be found at <https://portal.ct.gov/DSS/Health-And-Home-Care/Non-Emergency-Medical-Transportation>.
- ¹⁷ According to the Division of Parole and Community Services, current policy governing medication storage and dispersing ensures medication compliance, but this policy also focuses on preventing offenders' medications being stolen, lost, or misplaced.
- ¹⁸ Residents were not allowed to keep medications, with some exceptions: one staff person specified that residents could keep their own asthma inhalers, and one resident in one district noted that the halfway house now allowed them to keep over-the-counter medications.
- ¹⁹ As noted earlier, the technical term is "remand without prejudice."
- ²⁰ See also the Transitions Clinic Network at <http://transitionsclinic.org>.

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