

# The Role of Health Centers to Provide Primary Care for Justice-Involved Individuals in Medically Underserved Communities

*Community of Practice (CoP)*

Session 3: Improving continuity of care during the 30-day post-release period



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# Housekeeping Items

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email



# National Center for Health in Public Housing

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# Kevin Lombardi, MD, MPH, Director of Research, Policy and Health Promotion



- Serves as Director of Research, Policy and Health Promotion at NCHPH and Vice President for Research and Evaluation at North American Management (NAM), leading national technical-assistance initiatives for health centers and public housing health programs.
- Integrates clinical medicine, public health, and systems evaluation to enhance primary care quality, workforce development, and policy alignment across the U.S. safety net.
- Directs national assessments and program evaluations and has published in major journals.
- Dr. Lombardi holds an MD and MPH from George Washington University, combining medical training with expertise in public health analysis, policy, and data-driven evaluation.

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# Moderators



**Fide Pineda Sandoval,**  
**MPH, CHES**  
Technical Assistance  
Manager



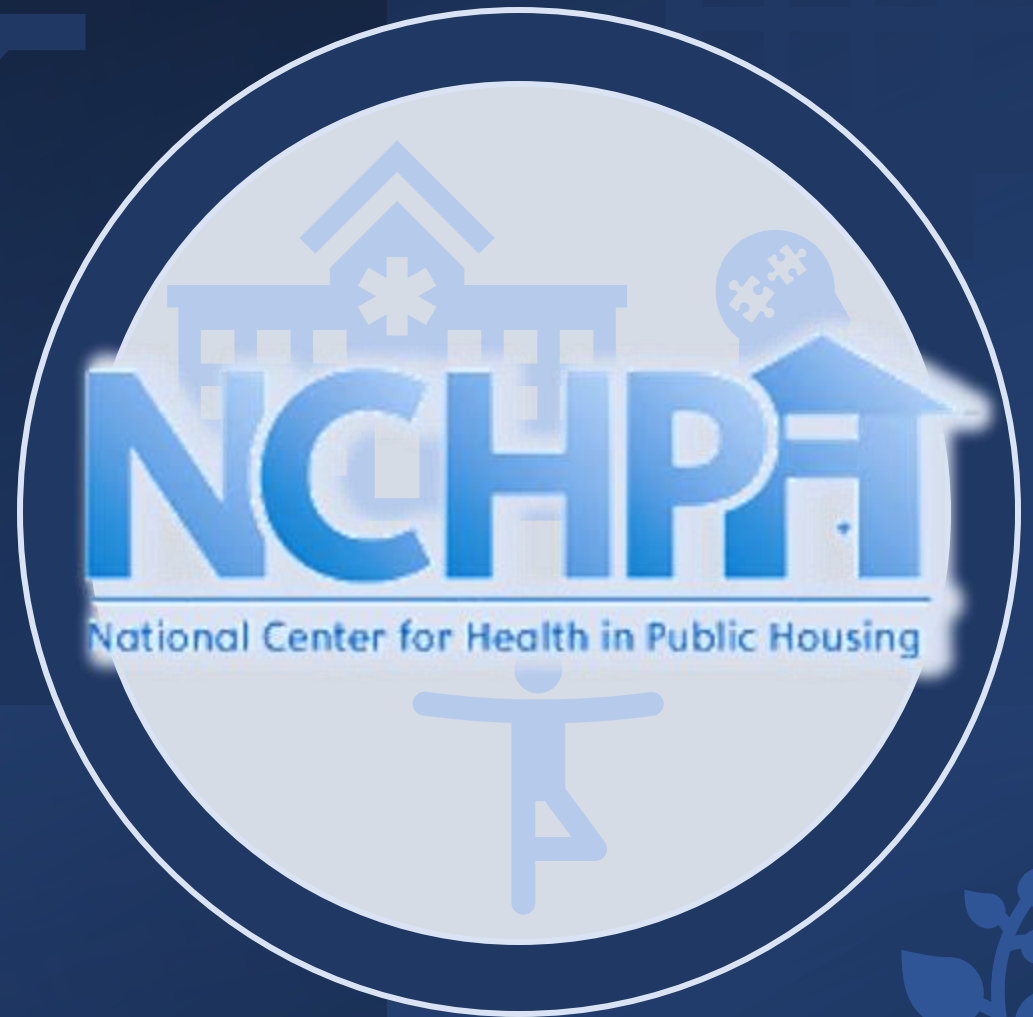
**Olajumoke Oladipo,**  
**MPH**  
Health Communications  
and Research Analyst

# The Role of Health Centers in Providing Care for Justice- involved Individuals in Medically Underserved Communities

Session 3: Improving continuity of care during  
the 30-day post-release period

*Dr. Kevin Michael Lombardi MD, MPH*

*Director of Research  
The National Center for Health in Public Housing  
North American Management*



# Learning Objectives

- 1. Describe the key failure points** in post release care after initial clinical stabilization
- 2. Define and operationalize** a closed-loop follow-up model in a health center setting
- 3. Identify strategies** to improve retention in Opioid Use Disorder (OUD) treatment and chronic disease management
- 4. Apply interdisciplinary roles** to sustain patient engagement beyond the first visit

## Case Study Recap: Mr. Stevenson

**Mr. Stevenson** is a 41 year-old male who was recently seen at a health center **after a 3-year sentence in a state correctional facility**. His medical history is significant for hypertension, type 2 diabetes and a **longstanding history of OUD with multiple past overdoses (2021, 2023)**.

At his PCP appointment he was noted to be hypertensive (168/82) and to have been **off his medications for 5 days**. He also noted symptoms of **fatigue, depression and increasing cravings** to use opioids.

## Case Study Recap: Mr. Stevenson

**He re-established care at your health center, and was treated with buprenorphine 8mg, with resolution of symptoms observed. He was also provided with a Naloxone kit and overdose prevention education.**

**In addition to other support, he was provided with 7-days worth of medications, assigned to a CHW for coordination and support, and referred for OUD treatment. He was scheduled for a follow-up in 7 days.**

## Case Study: Missed Follow-up

**Mr. Stevenson** is noted to be absent at **his 7-day follow-up**.

His CHW notes that the patient was **unreachable for 3 days** prior to his appointment by phone or email. He also note that the patient **was not present at his listed address** the day prior to his appointment.

At the address, his sister indicated that he had **left the property abruptly after an argument with a relative** to go live with a friend. The patient's sister also recounted that Mr. Stevenson had been **increasingly irritable**, she **did not observe any indications of opioid relapse**.

## Case Study: First Month Post-Release

**Mr. Stevenson** is contacted by his social worker with the help of his sister, who was able to locate him and call while in his vicinity.

On the call the patient noted that he had not overdosed but that he was “angry” and experiencing mood swings. He has also found himself in conflict with several close social contacts, including his brother and a close friend who have persisted in using opioids while in his vicinity.

## Case Study: First Month Post-Release

At the time, the patient also reported intermittent adherence to medications (including buprenorphine), uncontrolled blood pressure, and worsening depressive symptoms.

While on the phone the social worker schedules Mr. Stevenson for an appointment in 3 days and begins providing referrals to social services that can support continuity of care.

**She reviews the results of a recently completed health-related needs screen to guide her.**



# Case Study: First Month Post-Relapse

## Appendix

### WellRx Questionnaire

DOB \_\_\_\_\_ Male \_\_\_ Female \_\_\_\_\_

### WellRx Questions

- 
1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?  
 Yes \_\_\_\_\_ No
2. Are you homeless or worried that you might be in the future?  
 Yes \_\_\_\_\_ No
3. Do you have trouble paying for your utilities (gas, electricity, phone)?  
 Yes \_\_\_\_\_ No
4. Do you have trouble finding or paying for a ride?  
 Yes \_\_\_\_\_ No
5. Do you need daycare, or better daycare, for your kids?  
\_\_\_\_\_ Yes  No



## Case Study: First Month Post-Relapse

6. Are you unemployed or without regular income?

Yes

No

7. Do you need help finding a better job?

Yes

No

8. Do you need help getting more education?

Yes

No

9. Are you concerned about someone in your home using drugs or alcohol?

Yes

No

10. Do you feel unsafe in your daily life?

Yes

No

11. Is anyone in your home threatening or abusing you?

Yes

No

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The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

[Link: To Resource](#)

Please take a moment to type your response to the following:

**What unmet needs are preventing Mr. Stevenson from meeting his appointments?**

**Could the missed appointment have been avoided by earlier use of the screening tool results?**

**Please take a moment to type your response to the following:**

**What is the next step when the closed-loop fails at first contact?**

## **Path A: Unstructured Follow-up**



- **Loss to follow-up**
- **High emergency department use risk**
- **Increased risk of overdose**
- **Poor medication compliance**

## **Path B: Structured Follow-up**



- **Flexible scheduling**
- **Better retention in care**
- **Reduced risk trajectory**
- **Improved medication compliance**



## Quantifying the Post-Release Safety Risk

*By initiating prevention efforts early, health centers can provide critical support to the justice-involved (J-I) individuals during the period of highest safety risk.*

For Mr. Stevenson and other patients in the post-release window, risk of death is highest in **the first 2-weeks post-release.**



Studies have quantified overdose risk as **10-40 times** the general population, emphasizing the need for early prevention.

# Care Cascade Framework

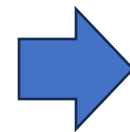
*Health Centers should embed screening and early detection systems into their workflow to ensure the J-I individuals are identified during the post-release period.*



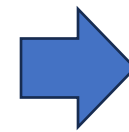
**Identify**



**Engage**



**Treat**



**Retain**

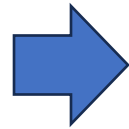


# Quantifying the Benefit of Retention



Identify

0.6

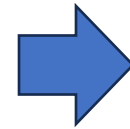


X



Engage

0.8

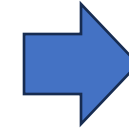


X



Treat

0.5



=



Retain

0.24

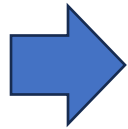


# Quantifying the Benefit of Retention



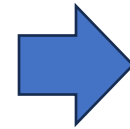
Identify

0.95 X



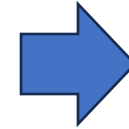
Engage

0.92 X



Treat

0.93



Retain

= 0.81



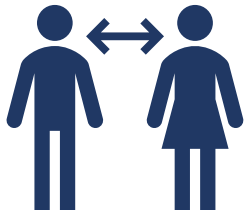
## Non-Medical Support and Retention



Early involvement of CHW, social work, and case management **improves appointment adherence and chronic disease outcomes.**



This impact is particularly clear in **medically underserved populations with high levels of social instability**, as many lack local and family networks

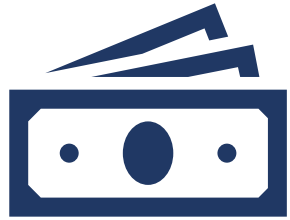


This improvement is not just driven by education and continuity; **trust has a primary role**



## Resource Utilization and Value-Based Care

*By focusing on retention during the post-release window, health centers can impact the wellbeing of their patients and of their organization at the same time.*



Early intervention and patient retention lowers the need for emergency resources, **including Emergency Medical Services (EMS) and Emergency Department (ED) use.**



In the context of value-based care, this **decreases the overall cost of treatment per patient** by a significant margin, with implications on Health Center finances and program breadth

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# Q & A Session



# Complete Our Post Evaluation



# Upcoming Sessions

<b>The Role of Health Centers to Provide Primary Care for Justice-Involved Individuals</b>	<b>Data &amp; Time</b>
Session 4	April 20, 2026 at 1:00 pm EDT

Registration link: <https://us06web.zoom.us/meeting/register/jwfYbCsjRcGAZM4R7KRllQ>

## CONTACT INFORMATION

<p><b>Robert Burns</b> Program Director Bobburns@namgt.com</p>	<p><b>Jose Leon, MD</b> Chief Medical Officer jose.leon@namgt.com</p>
<p><b>Kevin Lombardi, MD, MPH</b> Director of Research Kevin.lombardi@namgt.com</p>	<p><b>Fide Pineda Sandoval, MPH, CHES</b> Training and Technical Assistance Manager Fide@namgt.com</p>
<p><b>Olajumoke Oladipo, MPH</b> Health Communications and Research Analyst Olajumoke@namgt.com</p>	<p>Please contact our team for Technical Support at 703-812-8822 or info@nchph.org</p>

THANK YOU!

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