Community-Engaged Research Informing Upstream Determinants of Cancer Prevention for People with Criminal Legal System Involvement

Sierra Stites, MPH,[a] Patricia Kelly, PhD, MPH, APRN,[b] Jason Glenn, PhD,[a] Sharla Smith, PhD, MPH,[a] Christina Haswood, MPH,[c] Jacqueline Altamarino Marin,[c] Megha Ramaswamy, PhD, MPH[d]

[a] University of Kansas School of Medicine, 3901 Rainbow Blvd, Kansas City, KS 66160, sstites4@kumc.edu, jglenn4@kumc.edu, ssmith37@kumc.edu

[b] Thomas Jefferson University, 901 Walnut St, Philadelphia, PA 19107, patriciajanekelly@gmail.com

[c] Community members. christina@haswoodforks.org; altamirano.jacqueline@gmail.com

[d] University of Washington School of Public Health, 3980 15th Ave NE, Seattle, WA 98195, drmegha@uw.edu

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ABSTRACT

Background: Cancer prevention and early detection efforts traditionally focus on knowledge about and access to screening services; however, upstream approaches such as healthcare policy interventions are equally important. Our research team collaborated with women with criminal legal system involvement (CLSI) to prioritize upstream determinants of cervical cancer for future intervention.

Objectives: To convene stakeholder groups of women with CLSI involvement, public health researchers, and healthcare providers to identify upstream determinants of cervical cancer and to create policy priorities for prevention and early detection.

Methods: We combined storytelling methods and community-engaged research to enhance the collaborative relationship of a community advisory board (CAB) composed of our stakeholder group. In this article, we describe the processes and effects of our work.

Lessons Learned: The combined method of storytelling and community-engaged research methods allowed us to create meaningful narratives that enriched our outreach efforts but hindered full collaborative leadership of the work. All processes were affected by COVID-19 restrictions and by the preference of women with CLSI to participate independently. As the work evolved, the reach of our CAB extended beyond its original mandate to broaden the strategic vision of our research team.

Conclusions: Partnering with community members through community-engaged research and storytelling informed not just the research at hand, but also moved the work of a team beyond their funded initiatives.

KEYWORDS: Criminal legal system, Justice system, Cancer prevention, Community Engagement, Cervical Cancer, Early detection, Storytelling, Medicaid policy

Background

Women with a history of criminal legal system involvement (CLSI) are five times more likely to develop cervical cancer in their lifetimes; however, research on upstream prevention and early detection measures is limited.[1,2] After incarceration, barriers to reentry complicate the receipt of not only cervical care but overall comprehensive health care services for this population.[3,4] These barriers include a lack of health insurance, a scarcity of primary care providers, reestablishing and reuniting broken families, payment of court fines, and limited opportunities for employment, stable housing, food, and community support.[5-7] Additionally, many women in this population have competing and pressing priorities upon release after incarceration – addressing non-emergent healthcare becomes a distant priority.[7-9]

The health of formerly incarcerated women does not exist in a vacuum. Formerly incarcerated women are often parents, siblings, and primary caregivers, and their absence and health affect their communities and families in unique ways.[10,11] For example, when a woman is incarcerated, she can no longer participate in the social network of her family and community.[11] Families experience economic disruption when a parent is incarcerated,[13] and children of women with CLSI show poor physical and mental health compared with their peers, including increased risk for antisocial behavior, asthma, and poor performance in school.[12] Women with CLSI must meet not only their own needs, but those of their children, parents, and families, highlighting the gendered impact of incarceration.[14] Addressing these and other reentry needs of women and understanding upstream cancer prevention and early detection measures requires a gender-informed and gender-affirming approach.[15,16]

Upon release from incarceration, women report that their priorities are reuniting family, identifying housing, and finding employment.[17] Barriers to achieving these goals are significant

and woman-specific reentry guidance provided by the correctional system does not address the inadequate social support and lack of access to housing, food, employment, and healthcare experienced by these individuals. Being incarcerated acts as a traumatic rupture to one's social existence and civic participation, with consequences lasting long beyond the time behind bars. Pre-incarceration housing is often no longer available, and publicly accessible criminal records make employers and landlords much less likely to hire or rent to persons with CLSI. Expired or lost identification documents present an additional impediment to finding employment and housing. Without employment, securing food and transportation also becomes difficult.

These challenges mean that community reentry after incarceration is precarious. Local community organizations supporting reentry at the community level are unable to meet the breadth of demand, particularly in addressing a women's health care needs from either the individual or the policy level. To understand how to best focus on the healthcare challenges faced by women in community reentry in the Kansas City metropolitan area, members of our research team formed a community advisory board (CAB) using a community-engaged approach. We strove to center the voices of women with CLSI and the stakeholders, community organizations, and policymakers who support them. Our goals were to understand the following:

- upstream cervical cancer prevention strategies and early detection interventions for women with CLSI;
- changes required at the policy levels; and
- strategies to make these changes happen.

Community is a wide and variable definition. For the purposes of this manuscript, community includes individuals with CLSI and three groups of stakeholders: local advocates who work in the private and public sector to improve the lives of people with CLSI;

policymakers who represent people with CLSI; and researchers whose work focuses on improving health outcomes for people with CLSI.[18,19]

Community-engaged research involves investigating a problem, formulating research questions, and identifying potential solutions as a community. Such research focuses on building an equitable, bilateral relationship between the community and a research institution, and it endeavors to instill certain principles into that relationship. These principles include "clarity of purpose, willingness to learn, time, understanding differences, building trust, communication, sharing of control, respect, capacity building, partnership, and commitment."[19] These principles can be divided into two categories: knowledge and collaboration, which is how this manuscript is organized. Knowledge includes defining purpose, being willing to learn and devote time, and understanding differences. Collaboration includes building trust, establishing communication standards, sharing control, respecting each other, building capacity, developing partnerships, and showing commitment. Our community-engaged research model for this CAB focused on collaboration and knowledge to develop an intervention model and workshop that model with the CAB. Future research will implement the model.

Throughout this process and in writing this manuscript, we aimed to be inclusive in our approach. That attitude extends to our language. Unless otherwise noted, the collective pronoun "we" includes the members of the community advisory board (CAB) gathered to understand upstream determinants of cervical cancer to better focus our prevention and early detection efforts. Members of the community advisory board include criminal legal system researchers, a physician, a policymaker, and community advocates. The research team refers to the university-based team of faculty and staff who have been conducting research with women with CLSI since 2014.

Step 1: Collaboration

To engage with women with CLSI and stakeholders invested in improving early detection and prevention of cervical cancer, we organized a CAB with the intention of developing a community engagement model to collaboratively develop an intervention model. Identifying stakeholders in criminal legal policy, gynecological oncology, and research was the first step in finding potential members for the CAB. Stakeholders were recruited by identifying their involvement with criminal legal system reform and advocacy; cancer care or research; and community health for underserved populations. The uniting thread for each of these groups was a commitment to health equity. Our participants included two policy expert (n=2), a community advocate (1), two researchers specializing in health interventions for women with CLSI (2), and a historian specializing in criminal legal system ethics (1). We recruited women with CLSI by posting on Facebook pages created by our research staff for our previous studies. The University of Kansas Medical Center Institutional Review Board determined that there was no risk to participants of the CAB, and we received an exemption from the IRB for this portion of the study.

When considering the construction of our community advisory board, we wanted to be mindful about our knowledge-gathering process and our collaboration efforts. Based on our previous experiences, we determined that there would need to be two separate arms informing our community-based research: one for women with CLSI and one for stakeholders. The reason for this distinction was that, as we recruited women with CLSI for this project and in our previous work, they told us of their discomfort in sharing their stories in mixed settings; they relayed that they were more comfortable sharing among their peers.[20-23] The inherent power

imbalances between the women with CLSI and stakeholders are often played in mixed settings. Joint times between the groups were not planned given this preference.

This initial finding led us to take a storytelling approach to our work with women with CLSI to deepen our collaborative approach and more deeply understand the upstream determinants of cervical cancer to identify missed opportunities for prevention and early detection. Storytelling is a recognized public health methodology that can have positive impact on a community's health – particularly when that community has been marginalized or oppressed.[24,25] For women with CLSI, storytelling has been reported to be particularly powerful for its destigmatizing and empowering effects.[26] The aim for storytelling with this group of formerly incarcerated women became twofold: first, to provide an empowering platform for women to share their own stories of strength and resilience; and second, to create a suite of documentary shorts that would inform the work of the CAB and that could be used in future advocacy work.

To learn more about their needs, we elected to invite women with CLSI (n=6) to tell us stories about their challenges with reentry in the Kansas City-metropolitan area in February 2022.[8,23,27] All participants were current enrollees of ongoing projects of the Sexual Health Empowerment Team, specifically the parent study of this project, the Tri-City Cervical Cancer Prevention Study Among Women in the Justice System (R01CA226838). Informed consent was obtained from all participants along with media releases. Participants were paid $100 for the hour-long interview and had the option of having hair and makeup done by a professional hair and makeup artist.

The documentary shorts we created give women with CLSI a platform to share their narrative of navigating life successfully and strategically after incarceration. The objective of

these videos was threefold: 1) to give the viewer a better perspective on the challenges faced by re-entry; 2) to illustrate the fortitude of the women with whom we have the privilege to work; and 3) to give the women a platform to share their story in a safe and positive way that is accessible and available to the general population. The women spoke about the obstacles they faced in reentering society. The interviews laid the foundation for a set of documentary shorts, [publicly available at https://www.kumc.edu/school-of-medicine/academics/departments/population-health/research/sexual-health-empowerment/stories-and-media.html].

To learn more about access to health care upon returning to their community, two additional women participated in one-on-one interviews over the phone. These women were also participants of the parent Tri-City study. Informed consent was obtained from each participant, who were paid $25 for their time. These six women did not directly participate directly with stakeholders in the CAB.

The CAB identified six community organizations providing services to women with CLSI in the Kansas City-metropolitan area, including sober living facilities, domestic violence shelters, transitional housing, and wraparound services for individuals with CLSI. We reached out to the program directors who had expertise in working with formerly incarcerated women and the daily challenges of reentry. Our outreach efforts included personal communication, individual meetings, volunteer training, and volunteer orientations. We established formal and informal engagement opportunities with these organizations by attending community events, meeting one-on-one with program directors, and volunteering with the organizations as sexual health educators, tutors, board members, and activity assistants.

Our focus in interactions with these organizations was to gain their opinions on services and skillsets that we, as researchers, could provide to women with CLSI. In our communications with these organizations, we ensured that we were offering our services as community volunteers rather than as researchers. We felt it was important to demonstrate our willingness to show up consistently, engage thoughtfully and without judgement, and help organizations with whatever they may need. For example, one organization was interested in learning more about how racism affects policing in our region and the demographics of the incarcerated in our state. This organization reached out to the research team, who brought the issue and a draft of the report to the CAB. After the CAB discussed the report, we sent it to the organization so that they could share it with their stakeholders.

Step 2: Knowledge

The community advisory board of stakeholders began meeting bimonthly in January 2022 armed with and galvanized by our background data collection. Members indicated a preference for meeting virtually, so all meetings were held on Zoom.

Establishing priorities

Our first meeting focused on collaboration. We discussed our shared interest: the micro focus of preventing cervical cancer for women with CLSI (the goal of our funded research), and the macro focus of improving the lives of women with CLSI. Our group acknowledged that women with CLSI are constantly triaging priorities; cancer screening, for example, may not be a priority when they are still looking for food to eat and a place to live with their children.

To that end, we collaboratively established our mission and vision (see Table 1):

Table 1. Mission and Vision

Mission	To improve the lives of women with CLSI and advocate for decarceration through carefully designed and executed interventions at the individual, provider, and policy level.
Vision	A world where prisons are obsolete and women with CLSI have full access to compassionate, equitable, and affirming care that empowers them to lead healthy, fulfilling lives where they are the experts of their own bodies.

In the meetings, we discussed the storytelling interviews conducted with the women which reflected and exemplified the challenges faced by women with CLSI. The CAB received links to the shorts via email as they were completed; members were asked to watch the videos in advance of meetings with the goal of having a productive discussion about what themes emerged from the videos.

The CAB discussed the findings in the style of a focus-group. Discussions were led by a member of the research team, who also shared qualitative research methods with the CAB. What we found echoed what is reflected in the literature and what women we have worked with for nearly a decade consistently tell us: their barrier to cancer prevention is knowledge; access; and what one researcher on this project called "triaging priorities." Women with CLSI are constantly having to address not only their own needs, but those of their children, parents, and families, highlighting the gendered impact of incarceration.[9,28,29] As one woman shared, "Once I've done my time, I'm still doing time."

We also identified themes around priorities upon release: family reunification; housing; employment; maintaining parole; obtaining identification; accessing health care. They described the hopelessness and powerlessness they felt as they encountered a seemingly endless number of hurdles. The barriers to navigating these obstacles are significant, particularly when most transitional support for individuals leaving incarceration is geared towards men. The CAB discussed the themes of inadequate social support and lack of access to housing, food,

employment, and healthcare. Because of their criminal records, women with CLSI are often limited in what they receive in terms of governmental support, and many of our women describe a wariness and mistrusts of a system that repeatedly wronged them in the past. Local community organizations that support reentry for recently incarcerated folks are overwhelmed with demand, and while their services save the lives of many, this model is not sustainable, particularly when it comes to addressing a women's unique health care needs. For women to have the psychological space to consider their cancer prevention needs, they must receive more community and social support.

Based on these interviews, we identified three priorities that women with CLSI had shared upon reentry: 1) community support; 2) family reunification; 3) access to health care. Our CAB determined that intervening at the policy level would have the greatest impact. There were four specific policy avenues the CAB elected to focus on that would address these priorities and help women before, during, and after incarceration: 1) Reduction of the lookback period in background checks when applying for public housing; 2) elimination of copays for healthcare received while incarcerated; 3) decriminalization of sex work; and 4) revising the state of Kansas Medicaid reentry policies. Based on the CAB's expertise, personal network, and connections, we elected to review Medicaid reentry policies.

Gathering information

We learned that after release from extended periods of incarceration longer than ninety days, people in Kansas must reapply for Medicaid benefits upon reentry. This reapplication process was a barrier because of the lack of stable housing upon release—without an address, it is not possible to receive benefits. Women are also confronted with an inability to complete the paperwork necessary for applications. Many reported relying on their social support network –

moms and sisters, or other formerly incarcerated women – to help them. Women without such a network often find themselves without healthcare.

The CAB reviewed local statutes affecting access to determine the impact of Kansas state Medicaid policy on access to health care for women with CLSI during community reentry and the potential for facilitating access to medications, primary care and continuity of care for those with chronic illness and mental health challenges.[2,30] During a working meeting over Zoom, our CAB identified potential policies in Kansas (our focus) that could better support the reentry process. We learned that Kansas is one of seven states that "terminates" rather than suspends Medicaid benefits for incarcerated individuals because of the Medicaid Inmate Exclusion Policy.[31] Our neighboring states – Missouri and Nebraska – began suspending benefits for all incarcerated individuals after the passage of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.[32] The SUPPORT Act, which our CAB members with legislative experience helped us understand, became law in October of 2018. The overall intent of the SUPPORT Act is to address the opioid crisis.

One provision of the law (Section 1001) requires that state Medicaid programs suspend rather than terminate a juvenile's eligibility for medical assistance while incarcerated.[32] Coverage can be suspended while the juvenile is in custody; however, coverage must be reinstated upon release without requiring a new application. This provision does not extend to adults; however, many states changed their Medicaid policies to include both juveniles and adults, anticipating that the suspension rather than termination of benefits for adults would eventually become required as well. Previously, in many states, coverage would be completely terminated upon incarceration for juveniles and adults, and a person would have to reapply for

benefits after release. The reapplication process interrupts access to health care and receipt of important medications because, for example, many people do not return to stable housing after incarceration to complete the paperwork and receive the necessary correspondence.

In Kansas, the process is similarly complicated. The CAB spent time reviewing standards of procedure from the Kansas Department of Health and Environment (KDHE) and meeting with representatives of the state's Medicaid office (KanCare) to learn more about how the termination process works for individuals returning to the community after incarceration. In a meeting with KDHE, staff members reported that there is no functional difference between termination and suspension of Medicaid benefits for people in county jails. Essentially, the state does not immediately terminate benefits and require a new application for Medicaid after someone has been incarcerated. Instead, they terminate benefits when someone is incarcerated and reinstate those benefits based on length of incarceration, timely submission of paperwork, and Medicaid eligibility.

If incarcerated for less than 90 days, an individual will be evaluated for reinstatement as quickly as possible, and benefits will be reinstated as quickly as possible unless the agency has been notified that the person no longer meets eligibility criteria. If incarcerated for more than ninety days, the benefits reinstatement process becomes more complicated. Medicaid benefits are reinstated for pregnant women and Supplemental Security Income (SSI) recipients, along with those "eligible for continued coverage based on information immediately available."[33] Everyone else is enrolled through the MediKan Reintegration program, which provides coverage for up to ninety days while a review of Medicaid eligibility is conducted. Each recently released person enrolled under the MediKan Reintegration program is sent a form that they must return within 12 days for their Medicaid eligibility review to be completed. Failure to return the review results in

loss of eligibility. If incarcerated for over a year, a person's coverage is terminated, and new Medicaid applications are required.

By reviewing standards of procedure from the KDHE, we also determined that the state uses a data exchange system, APPRISS, to facilitate communication between carceral facilities and Medicaid offices.[33] This system sends an alert from the jail to the Medicaid office when someone is booked so that an employee can turn off their benefits; when they are released, the system sends another alert so that those benefits can be turned back on within 24 hours of release. This system is presumably more efficient than a corrections employee calling a health department employee to let them know who has been released that week and can have their benefits reinstated, which is the case for many states.[31]

What complicates this process is that, if someone has been incarcerated for more than ninety days and less than a year, they are sent paperwork and required to submit that paperwork within twelve days to have their Medicaid eligibility reviewed. If that eligibility paperwork is not received, their benefits are terminated. This can be a barrier for the women with CLSI because they often do not return to stable housing upon release, do not receive this mail and are often unable to fill out or have the resources to submit paperwork.

The collaborative efforts of the CAB and the knowledge generated from policy investigation, discussion of the documentaries, and conversations with two additional participants led us to reach out to KDHE and the Kansas Sheriff's Association (KSA) to share our finding that women with CLSI in Kansas have trouble reenrolling in and navigating health insurance after incarceration, leading to interruptions in care. They recognized the benefits termination mechanism as a barrier to care and were eager to work with us and to hear our purposed solutions. While federal law requires the suspension of public benefits during

incarceration, the timely and seamless reinstatement of those benefits – with minimal burden to the beneficiary – is important to maintain continuity of care and to reduce recidivism.[31] They shared that changes would be challenging given that Kansas is not an expansion state, and they expressed interest in collaborating with us and supporting our work moving forward.

The members of the KDHE Medicaid team were receptive and understanding when we articulated the challenges of access to health care upon reentry for folks with CLSI, and they embraced the economic and public health benefits for the state of residents maintaining health insurance. One example they shared is that it is less expensive for their office if people retain and use coverage than if, for example, they lose coverage and seek care in an emergency room. Their commitment to public health inspired us to pursue this policy action. They recommended arranging a meeting with KSA. This group was also amenable to a meeting to discuss ways to improve the health of individuals (women and men) with CLSI. We anticipated that working with legislators in a conservative state to address a public health issue would be a challenge; however, working with the executive branch of government was not a challenge.

In our joint meeting with KDHE and KSA, both institutions reaffirmed their commitment to public health and to supporting healthy reentry policies for individuals leaving incarceration. We discussed that in one of our studies, 28.3% of formerly incarcerated women living in Johnson, Wyandotte, and Douglas counties have Medicaid.[2] We discussed that while this percentage of formerly incarcerated women in three counties in Kansas may not reflective of the state, it likely does not represent the number of women – many of whom are mothers and do not have stable employment – might be eligible for Medicaid. The meeting participants discussed how it is safer and less expensive for families and for the state to have eligible people consistently enrolled in Medicaid. Representatives from KDHE and KSA also agreed that

navigating reentry is a key intervention point. For both groups, keeping individuals enrolled in health benefits and out of incarceration was a goal, and their interest and engagement in our work was high.

Step Three: Targeted Policy Action

With the support of these the KDHE Medicaid team and KSA, the CAB designed a pretrial Medicaid enrollment program for individuals in pretrial detention in three counties in Kansas. We shared this program with the Medicaid team at KDHE, the executive director from KSA, and colleagues interested in implementing the program. The program, modeled after a similar program in Connecticut, is designed to employ 3-5 formerly incarcerated individuals as community research assistants to inform the development, design, and execution of the project.[34] We drafted three aims for the program: a short term goal is for a quick activation of health insurance upon release from incarceration; an intermediate goal for released individual to have continued activation and use of health insurance; and a long-term goal for the released individual to have improved self-efficacy regarding ability to access care and health insurance literacy. Future research will implement this program.

Lessons Learned

What worked

Through a process of knowledge-gathering and collaboration, the CAB had three main findings: 1) In Kansas, health insurance access and navigation is a challenge for women with CLSI, which inhibits access to early detection and cancer screening services; 2) the Medicaid Inmate Exclusion Policy is a barrier to women maintaining health insurance coverage, but women do not know about it and find it difficult to reenroll in insurance after incarceration; and 3) working with individuals held in pretrial detention to enroll in Medicaid and improve health

insurance literacy and self-efficacy has the potential to improve access to care and activation upon release. The CAB accomplished this work by developing a community-engaged research model focused on knowledge and collaboration, adapting and developing a pretrial Medicaid enrollment program to address health insurance access and literacy deficits in women with CLSI in Kansas, and workshopping the intervention with stakeholders in the community, government, and non-profit sectors.

Working with advocates, community members, and women with CLSI outside the context of researcher-participant allowed for enhanced bilateral learning. As researchers, we can be myopic in our focus on one very specific goal; our CAB members outside of academia could see the bigger picture and could move and act nimbly to effect change. As our CAB evolved, it began to inform the work of our research team as a whole. We have used the documentary shorts as tools for advocacy and raising awareness. They screened in a variety of community and academic settings, including at the American Public Health Association Annual Meeting in 2022. Furthermore, the CAB brought to the researchers' attention that our work needed to include those identifying as transwomen or identifying as nonbinary. Inspired by our colleagues in the field, we co-wrote a statement to reflect our commitment to inclusivity (Appendix - Table 1).[35]

Continuing Challenges

The transition from the development of priorities to the implementation of needed policy change continues to be a challenge for our CAB. We collected observational data and reporting activity to describe and document progress and engagement activities. It was challenging to document the finer details of our progress, particularly in these planning stages of our work, which consisted mostly of meetings with stakeholders external to the CAB. We recommend electing a secretary and a formal leadership structure to document methodology consistently.

Balancing process with action and outcomes is another ongoing challenge. We found ourselves taking too deep a dive into our knowledge and collaboration steps, which ultimately took time away from targeted policy action. While these steps were valuable and provided important insight into our goals and activities, in the future, we would recommend incorporating action items and outcomes along the way, shortening the knowledge/collaboration steps, or including more CAB members with implementation expertise. Furthermore, we are mindful of the impact of not directly including women with CLSI in the CAB. In the future, we would include someone with CLSI who is further removed from that history to serve as a bridge and peer mentor. We do not want to ignore the express wishes of the women with CLSI whose trust we have gained.

Conclusions

The work of our CAB has evolved based on the needs of women with CLSI and the policy landscape in our state. This constant evolution is both a challenge and a benefit, as well an important lesson for those of us used to the rigidity of academia because it reflects the reality of the world for people with CLSI. Our approach leverages their flexibility and the adaptability of community-engaged research. Furthermore, partnering with community members informs not just the research at hand, but the wider work of a team beyond their funded initiatives.

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Appendix

Table 1. Sexual Health Empowerment Team's Commitment to Gender Inclusivity.
People of all gender identities have sexual and reproductive healthcare needs. Historically, the research focus of the Sexual Health Empowerment team has been cervical

cancer prevention for currently and formerly incarcerated individuals. We acknowledge and honor that people with cervices do not all identify as women, and we are committed to using inclusive language that respects the experience of individuals of all gender identities. Prior to 2023, our content includes gendered language; however, moving forward, we are committed to using inclusive language and have updated previous content where possible.

The Sexual Health Empowerment team is also committed to using person-centered language. We use terms and phrases like "individual who has intersected with the criminal legal system," "currently/formerly incarcerated individual," or "person experiencing incarceration" rather than "inmate" or "felon." Furthermore, we prefer to use "criminal legal system" in lieu of "criminal justice system." Our aim with these practices is to ensure that every individual accessing our materials and interacting with our team feels included, seen, and witnessed.

Note: Statements of commitment on a research team's website have limited direct implications for the group's target population; however, their inclusion improves the visibility of a commitment to equity, which can improve the recruitment of diverse students to the research team.[35,36] A diverse staff, in turn, can best meet the needs of a diverse target population.[37,38]

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Appendix 1.

Conversation Guide for Reentry in Kansas: Medicaid Experiences of Formerly Incarcerated Women

Thank you for taking the time to speak with me. My name is Sierra Stites, and I am a member of the Sexual Health Empowerment team at the University of Kansas Medical Center. I would like to ask you a few questions about your experience with getting your Medicaid benefits turned back on after leaving jail in Kansas. Your answers are anonymous, and you do not have to answer any questions you don't want to. Your participation is also completely voluntary, and you will still be in your other study if you don't want to participate This call is not being recorded, but I will be taking notes during our conversation. You will be paid $25 for your participation. Do I have your permission to continue?

Thank you! As always, we can stop whenever you want to.

1. When and where were you last incarcerated?
2. Did you have KS Medicaid at the time of your incarceration? Do you currently have KS Medicaid?
3. How long was your last incarceration?
4. Now I have a few questions about what your prerelease and reentry experience was like.
    a. Were you told that your health insurance would be getting turned off when you were booked?
    b. Did someone at the facility help you prepare for release? Give you any medications?
    c. Did someone connect you with a hospital or doctor on the outside?
    d. Did someone talk to you about your Medicaid benefits? Did they tell you what would happen or how long it would take?
5. Tell me about your experience with getting your Medicaid turned back on. What was that like?
    a. Once you were out, how long did it take for your Medicaid to get turned back on?
    b. Did you need medication or doctor visits while you were waiting? If so, what did you do?
    c. Did you have to submit any paperwork to get your Medicaid turned back on? Did anyone help you with the paperwork?

Thank you for sharing your thoughts and experience with me. Is there anything else you'd like to add?

Thanks! Have a great day.