Improving medical care during the transition from inpatient to outpatient services has been a focus of broad efforts for many years. The transition from larger systems such as justice to health, however, has been ignored at considerable cost to individuals and health systems alike.

Of the 10 million individuals released from prison or jail each year, the majority will be uninsured as they return to the community. This population is aging and increasingly burdened by chronic medical conditions such as cardiac disease, diabetes, chronic obstructive pulmonary disease, and malignancy. After release, justice-involved individuals die more frequently and use inpatient services for ambulatory conditions more frequently than their peers. Access to care for mental health and addiction disorders has improved, but chronic medical conditions have received less attention.

There are many immediate needs after release from incarceration that take precedence over establishing care with a primary care physician. These include obtaining safe housing, food, and income as well as avoiding old enemies, reengaging with family, and maintaining sobriety. As a consequence, the most frequent portal into health systems is the emergency room or urgent care clinic—our most expensive sources of health care. Alternatively, chronic conditions may remain untreated, resulting in hospital admission or death. Historically, hospitals and health care systems have been reluctant to address the needs of released prisoners as new patients because they rarely have health insurance and are often non-paying patients.

Anyone released from a correctional facility will face barriers to accessing health care, but there are predictable differences between transitions from jail and transitions from prison.

Jails are responsible for those recently arrested or awaiting sentencing. Their jurisdiction can be as short as a few hours or may last many years. Acute health issues in jailed individuals are often untreated and may influence the circumstances prompting arrest. Substance use, addiction, and undertreated psychiatric disorders are prevalent. With rapid turnover of inmates, chronic conditions may not be fully addressed before charges are dropped and the individual leaves the facility.

Prisons hold people who have been convicted and sentenced; prison stays may range anywhere from one year to life. During imprisonment, health care is institutionalized, structured, and managed within a single system. At the moment of release or parole, the prison no longer has any obligation to provide health care for these individuals. People frequently leave prison with only a few weeks of medication (or less) and no plan for health care follow-up.

In both prisons and jails, cessation of care at the time of release is abrupt, and resumption of prior health insurance benefits is not guaranteed. Inmates are not eligible for social security payments while incarcerated. The Social Security Administration offers a $400 incentive payment for each inmate reported within 30 days of arrest. In many states, this reporting is linked to the Centers for Medicare and Medicaid Services (CMS), which suspends or cancels their insurance. Therefore, prisons and jails are paid to suspend benefits but have no incentive to reinstate them upon release. The patient you enroll in Medicaid during a visit to your emergency room or clinic can be arrested and released only to be uninsured again by the time of the next clinic visit a week later. Thus begins the revolving door of insurance, incarceration, cancellation, and release. There must be solutions to these problems. If we act together, efforts to develop partnerships between the health care and justice systems can improve outcomes for patients while reducing costs.

The Affordable Care Act (ACA) has dramatically changed eligibility for criminal-justice populations. This is most notable in states that have accepted Medicaid expansion. By including those with income below 133% of the federal poverty level and eliminating the need for disability or dependent family members, the majority of current inmates are now eligible for Medicaid coverage once released. Seeking out criminal-justice populations is no longer a financially risky proposition for health systems.

Financial incentives for justice facilities that enroll or screen their populations for Medicaid also exist. Under the ACA, the federal government pays for inpatient admission to hospitals and offers meaningful use payments to justice facilities if they institute an electronic health record (EHR). These incentives are successfully leading prisons and jails to screen and enroll their populations in health care in many states.

The financial “carrot” of payments may, however, soon be followed by a federal “stick.” Just as hospitals dread readmissions, justice facilities loathe the recidivism. It is conceivable that future payments will depend on good transitions. To continue on page 2
ceive the full Medicaid payment, a fac-
cility may need to demonstrate plans
that avoid return to prison or avert an
inpatient admission soon after re-
lease. Cooperation across disciplines
is therefore necessary.

Transition clinics offer a bridge
from justice to health. They can be
implemented in a variety of ways.
One model imbeds specialized tran-
sition clinics within the justice facility.
Medical teams can be incorporated
into probation offices, and justice
staff can be encouraged to collabo-
rate with community clinics. A pa-
tient navigator for health care can be
included in release planning teams
for those with chronic medical condi-
tions. Responsible health systems
can fund the first month of medica-
tions and initiate the first outpatient
appointment rather than bear the
cost of an emergency visit or inpa-
tient admission.

We can share our medical knowl-
edge of patients. Compatible EHRs
will shorten length of stay, improve
the quality of justice intake screen-
ning, and maintain uninterrupted spe-
cialty services from the correctional
setting to the community.

Some of the most challenging pa-
tients are often those affected by the
criminal justice system. Those most
vulnerable patients—the emergency
department “frequent flyers”—may
be well known to the local jail as
well. Incarceration may provide a pe-
riod of opportunity for health inter-
ventions for these patients.

Management of conditions such as
hepatitis C, drug addiction, mental ill-
ness, and diabetes can be facilitated
by institutional collaboration. By en-
suring continuity or preventing dis-
ruption of treatment, costs and
duration of expensive care plans can
be appropriately managed.

The delivery of health care and
justice are political but bipartisan.
Solutions require local and national ef-
fort. Partnerships between prisons
and health care systems can form a
strong voice for change. We can
lobby state governments to suspend
Medicaid rather than terminate it
upon incarceration. We can add our
voice to sentencing reform and com-
passionate release for elderly pa-
tients with high health care needs.

The cost of a poor transition
from justice to health is high, but
the potential for benefit is signifi-
cant. There are solutions to these
problems. We can combine our ex-
pertise to affect change for the sake
of our patients and the welfare of
our communities.

References
Bureau of Justice Statistics,
September 2014, NCJ 247282.
2. Opportunities for criminal justice
systems to increase Medicaid
enrollment. Justice Center,
December 2013.
3. Williams B, Goodwin J,
Baillargeon J, et al. Addressing
the aging crisis in US criminal
justice health care. J Am
4. Binswanger I, Kruger P, Steiner J.
Prevalence of chronic medical
conditions among jail and prison
inmates in the USA compared
with the general population. J
Epidemiol Comm Health 2009;
5. Bingswanger I, Stern M, Deyo R,
et al. Release from prison—a
high risk for death for former
6. Kim K, Peterson B. Aging behind
bars. Trends and implications of
graying prisoners in the federal
prison system. Urban Institute,
August 2014.
7. At America’s expense: the mass
incarceration of the elderly.
American Civil Liberties Union,
June 2012.
8. Rosen D, Schoenbach V, Wohl D.
All-cause and cause-specific
mortality among men released
al. Factors associated with
mortality in a cohort of Australian
prisoners. Euro J Epidemiol 2007;
10. Spaulding A, Seals R, McCallum
V, et al. Prisoner survival inside
and outside of the institution:
implications for health-care
planning. Am J Epidemiol 2011;
173:479-87.
11. Zlodre J, Fazel S. All-cause and
external mortality in released
prisoners: systematic review and
meta-analysis. Am J Public
Health 2012; 102:e67-e75.
A high risk of hospitalization
following release from
correctional facilities in Medicare
beneficiaries. A retrospective
matched cohort study from 2003
to 2012. JAMA Internal Medicine
Increased hospital and
emergency department utilization
by individuals with recent criminal
justice involvement: results of a
national survey. J Gen Intern Med
2014; 29:1226-33.
14. Incentive payments for state and
local institutions. Social Security
Administration 2003; SSA
Publication No. 05-10088.