Successful Reentry: The Perspective of Private Correctional Health Care Providers

Jeff Mellow and Robert B. Greifinger

ABSTRACT *Due to public health and safety concerns, discharge planning is increasingly prioritized by correctional systems when preparing prisoners for their reintegration into the community. Annually, private correctional health care vendors provide \$3 billion of health care services to inmates in correctional facilities throughout the U.S., but rarely are contracted to provide transitional health care. A discussion with 12 people representing five private nationwide correctional health care providers highlighted the barriers they face when implementing transitional health care and what templates of services health care companies could provide to state and counties to enhance the reentry process.*

KEYWORDS *Correctional health care, Discharge planning, Prison, Reentry.*

INTRODUCTION

It has been 30 years since the U.S. Supreme Court ruled in *Estelle v Gamble* that the government had an obligation to provide medical care for the incarcerated.¹ Correctional health care has evolved on many fronts. Three decades ago, Weisbuch described the poor nature of prison health services where “care provided is usually piecemeal and not part of any comprehensive or coordinated plan to assure even the most elemental aspects of a continuous system of services”.² Now, prison health care includes medical, behavioral health and dental care. In most jurisdictions, there are standards of care for access and nationally accepted guidelines for chronic care and communicable disease and attention to screening and prevention for suicide and communicable disease.

With *Estelle v Gamble*, the constitutional requirement to provide timely access to care for serious medical needs was clearly defined for health care during incarceration, but there was no discussion by the Court about adequate medical discharge planning prior to release. Nevertheless, discharge planning is increasingly prioritized by correctional systems throughout the nation to prepare prisoners for their reintegration into their home communities. Practitioners and researchers alike have a better understanding that public health is critical to public safety. To quote Restum, “Left untreated inside prison, inmates eventually leave...Back home, they risk infecting families, friends, and—if they engage in

Mellow is with the Department of Law, Police Science & Criminal Justice Administration, John Jay College of Criminal Justice, New York, NY, USA; Greifinger is with the John Jay College of Criminal Justice, New York, NY, USA.

Correspondence: Jeff Mellow, Ph.D., Department of Law, Police Science & Criminal Justice Administration, John Jay College of Criminal Justice, 899 Tenth Avenue, New York, NY 10019, USA. (E-mail: jmellow@jjay.cuny.edu)

violent crime—complete strangers”.³ Arguably it is in the public interest to pave the road enabling access to medication and health care services because these services prevent the expensive relapse of communicable disease, chronic disease and mental illness.

Since the early 1980s, the National Commission on Correctional Health Care (NCCHC) has promulgated standards for correctional health care, and since at least 1992, the Commission has had standards for continuity of care on release, requiring discharge planning for inmates with serious health needs.⁴ Current NCCHC standards and correctional health care texts refer to discharge planning.^{5–7} In 2005, the report of the Reentry Policy Council published broad recommendations for enabling access to medical attention, behavioral health care and drug treatment for returning inmates.⁸ The courts have also become involved. For example, in 2000, a New York State judge ruled that comprehensive discharge plans be mandated for the seriously mental ill discharged from New York City Department of Corrections.⁹ Other organizations have recently published strong recommendations for enhancing transitional planning.¹⁰ And although not specific to the prison population, one could argue that under the code of ethics of the American Medical Association, physicians have a moral obligation to provide continuity of care for their patients, even the incarcerated returning home:

The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.¹¹ (Section 5)

Research from several states with formal reentry programs indicate that recidivism rates for those who complete prerelease programs are significantly lower than those who elect to be released without any programming.^{12–14} One model program is the Hampden County Correctional Center in Ludlow, Massachusetts. Early on this facility understood the public health dimension of releasing inmates with health and behavioral needs back into the community without any continuum of care. In conjunction with the public health department, regional medical centers, and community health centers the inmates are part of a seamless health care delivery system, where the community health centers provide the health services inside the facility, develop individualized discharge plans before release, and then continue providing their health care needs in the community after discharge.¹⁵ One needs to recognize, however, that Hampden County’s discharge plan program with coordinated and seamless transitional health care services is the exception rather than the rule. In reality, only small minorities of the more than two million prisoners being released each year are experiencing a multi-session, formalized prerelease program with only 10% of state prisoners discharged receiving any prerelease programs.¹⁶ In essence, Weisbuch’s description of in-prison medical care 30 years ago is more appropriate today in describing the case of discharge planning and post-release health services than the medical care prisoners received during incarceration.

PRIVATE CORRECTIONAL HEALTH CARE PROVIDERS

One group which has been surprisingly absent from the public discourse about discharge planning is the for-profit private correctional health care providers (PCHCP). Their voices have not been heard, nor has a discussion about the role these providers play as boundary spanners; “individuals who can facilitate communication across agencies and profession to coordinate policies and services” to facilitate discharge planning.¹⁷ Some would say that PCHCP are ideally suited for this role because of their first hand knowledge of the medical and behavioral health needs of the prisoners and because they have the independence to bring the right people together to make quick decisions without going through a maze of bureaucracy. Others would say that there is no basis for this assertion, in that PCHCP may have little experience in community health care and have their own bureaucracies. There are no data on these latter points.

But the presence of private correctional health providers cannot be ignored. Increasingly, correctional systems are contracting for medical services for inmates to managed correctional health care providers.¹⁸ Though there is national debate about the pros and cons of managing care in the community and privatizing any aspect of the correctional system, states have contracted with private correctional healthcare providers for staffing, pharmaceuticals, and outside specialty and hospital care. Some governments’ argue that the advantages include better inmate health care, a more effective way to budget for rising health care costs, and the belief that the PCHCP expertise will prevent health related lawsuits.¹⁹ It is certainly easier for some jurisdictions to hire and retain high-quality physicians and other health professionals when they are not constrained by civil service rules and salary scales. For example, according to the second author, the Commonwealth of Pennsylvania and the State of Michigan both contract for physician services only, and not nurses, because of inadequate civil service salary scales for physicians. PCHCP account for approximately \$3.0 billion of the almost \$7.5 billion budgeted each year for correctional healthcare (G. McWilliams; Vice President, Correctional Medical Services; oral communication; May 2006).

MATERIALS AND METHODS

Realizing that the private correctional health care providers have a unique perspective about the barriers to effective discharge planning, a roundtable discussion was organized in early 2006 at the Prisoner Reentry Institute at John Jay College of Criminal Justice to discuss the health care aspects of reentry. An action research model was utilized to best develop the knowledge, from the perspective of PCHCP, of the barriers involved in developing a comprehensive discharge plan for inmates returning home. French and Bell define action research as “the application of the scientific method of fact-finding and experimentation to practical problems requiring action solutions and involving the collaboration and cooperation of scientists, practitioners, and layperson”.²⁰ An action research model argues that change comes about when all parties, not just scientists, define the problem, determine how to go about collecting the information, and assess the outcomes.²⁰

There were 16 participants, including 12 from large private nationwide correctional medical and behavioral health care providers.* For the first time, PCHCP came together in a noncompetitive situation to discuss ways to bridge the health and behavioral needs of inmates from incarceration to the community. Participants were selected for their experience and wisdom as physician and psychologist executives, marketing executives or correctional health care operations executives. No individuals from government agencies were invited to this first of several planned action research focus groups so that the PCHCP perspective could be fully explored.

The discussion was held as a roundtable brainstorming session moderated by one of the authors of this paper (RBG). Staff from John Jay College of Criminal Justice took notes on easel paper pads. The moderator facilitated the discussion and charged the group with the following three tasks. First, to outline barriers to successful reentry; second, to define a basic template for a reentry product that might be sold to states and counties; and third, to describe supplemental services that might be offered to enhance value to the community. The majority of the participants knew the moderator and his expertise in correctional health care. This allowed for an open and honest discussion to take place due to their comfort level with the moderator. For example, the most difficult task was to discuss barriers to reentry. As might be expected, the group began articulating external barriers which they had no control over, but after a little prodding by the moderator, opened up and discussed barriers which they recognized are internal problems they can change. Each discussion topic began with the moderator calling on each participant to solicit their thoughts on the subject and then recorded their answers on flip chart paper sheets which were then posted on the blank walls in the room. Discussions ensued throughout the day regarding what reentry products should be part of a basic plan and supplemental plan. In most cases, the participants arrived at a consensus on what the templates should be. However, opinions varied greatly on some issues, such as how much if any medication should be provided at release. When there was no consensus on an issue, the various options were all articulated. At the end of the 6-hour session, the moderator summarized the main findings.

Following the meeting, the authors then compiled the notes and drafted a summary of the proceedings. This summary was circulated to all who attended the meeting and comments were solicited.

*Private Correctional Healthcare Provider Meeting on Reentry, John Jay College of Criminal Justice, February 24, 2006; Falhowe, Renee, MD; Regional Medical Director; Correctional Medical Services, Inc.; Gallemore, Jr., Johnnie L., MD, JD; Director, Mental Health Services; Prison Health Services, Inc.; Haddad, Jane, PsyD; Vice President, Clinical Operations; MHM Services; Hubling, Jesse; Vice President of Marketing and Business Development; Prison Health Services; Keldie, Carl J., MD; Chief Medical Officer; Senior VP Clinical Services; Prison Health Services; King, Lambert, MD, PhD; Director, Internal Medicine; Queens Hospital Center; Lundquist, Tom, MD, MMM; Vice President and Chief Medical Officer; Wexford Health Services; Marshall, Tere, RN; Wexford Health Services; Rieger, Dean, MD, MPH; Chief Medical Officer; Corporate Medical Director; Correct Care Solutions; Smith, Hal, MPS, CCHP; Corporate Consultant for Clinical Operations; MHM Services; Wheeler, Steven H.; President and Chief Operating Officer; MHM Services.

BARRIERS TO A SUCCESSFUL DISCHARGE PLANNING PROGRAM

There are a wide range of barriers to successful reentry programs in the realm of public health and medical care. Though not listed in an order of importance, the following 13 barriers demonstrate the macro-, mezzo-, and micro-level issues affecting discharge planning.

Few Executive Level Champions

There is too little attention to reentry from public policy makers in the executive and legislative branches of government. Without this championship, it makes it difficult for correctional administrators to provide clear leadership to adapt correctional programs to consider reentry as part of the continuum of incarceration, whether it be a few days in a county jail or many years in a state prison. One reason for this lack of attention may be due to the average tenure for correctional administrators, which at the state level is 3 years. The frequent turnover of correctional administrators, in large part because they are political appointments that change with new administrations, has been attributed to many things, including, “a change in gubernatorial administration, or an account of some crisis or scandal or simply to take advantage of another job opportunity”.²¹ Regardless of the reason, Gibbons and Katzenbach argue that “rapid turnover of senior administrators destabilizes the entire system, sidelining reform initiatives as new leaders become acclimated”.²² In a 6-year period in New Hampshire, for example, the Department of Corrections had “five commissioners, three division medical directors, three division administrative directors and three chief medical officers”.¹⁹

Limited Financial Resources

Perhaps because of the leadership vacuum in the area of reentry, precious few dollars are allocated for discharge planning and continuity of care on release. The annual correctional budget nationwide is \$60 billion with approximately 12% devoted to prisoner medical and behavioral health care. There are no data available to measure how much is budgeted for the discharge planning process. Without dollars, states and counties cannot staff these programs themselves and they can hardly hold their private health care vendors accountable for providing services that were not explicitly required in their contracts. According to the PCHCP, states and counties rarely include reentry services in their requests for proposals, except in some cases for a small supply of medication to be delivered to the returning inmate.

Scant Data Resources

Without electronic medical records and electronic databases for morbidity, special needs plans and medication, it is difficult to provide continuity of care and medication. Without comparable data systems across jurisdictions and across programs, it is difficult to bridge correctional facility with community resources. There is scant connectivity between correctional health care programs and community medical and behavioral health programs.

Little Continuity of Care

With certain exceptions, there is very little communication and sharing of medical information on patients who receive care serially in the community, behind bars,

and back again in the community. The discontinuity of information leads to lapses in medication and redundant diagnostic testing.

Loss of Benefits

Behind bars, inmates lose their entitlements to Medicaid, Medicare and other public benefits. The termination of benefits creates difficulty for inmates to get these benefits reinstated on release, in large part because jurisdictions are loathe to suspend the benefits, instead of terminating them, but also because they are reluctant to begin processing an application for reinstatement until the individual is actually residing back in the community. The disruption in benefits virtually precludes the returning inmate from receiving any preventive or primary care. Their access to care is limited to emergency rooms and the few charitable or public institutions that might provide care.

Restricted Public Health Programs

For a variety of reasons, especially because of the way they are funded by the Centers for Disease Control and Prevention, public health departments can only provide care in certain categories, for example, sexually-transmitted diseases, tuberculosis, hepatitis B and C, and HIV (through Ryan White Funding).

Internal Barriers

Correctional institutions have internal barriers that impede smoothly operating reentry programs, including high health care staff turnover, high vacancy rates, poor information systems, weak policy, training and supervision, and reluctant communication between correctional physicians and community practitioners. There is often a disconnect between substance abuse treatment and mental illness programs, and some substance abuse treatment programs actually deny access to patients who are on psychotropic medication. Furthermore, there is very limited communication between custody staff and correctional health care staff. Among other consequences, health care staff typically does not know when patients are released. For jails, who predominantly house pretrial detainees, the notice of impending release is even more difficult, because the decisions are made by courts and are often not able to be anticipated by correctional administrators.

Limited Communication of Cost-Effectiveness

Public health professionals have amassed a broad array of data on the cost-effectiveness of public health interventions with inmates, particularly for HIV counseling, TB screening, screening for sexually transmitted disease and suicide prevention.²³ There are also data demonstrating the cost-effectiveness of screening and treatment of chronic illnesses such as diabetes and hypertension in inmates.²⁴ But public health scholars and practitioners have not been able to educate public policy makers on the value of investments in public health interventions for returning.

Scarce Evaluation of the Cost-Effectiveness of Enabled Access to Care on Reentry

Too few correctional programs have measured performance and published successful outcomes of reentry programs, mostly because there are so few extant programs and little attention from the research community. One study has shown powerful effects of health insurance and employment on drug use and rearrest rates.²⁵

No Incentives for Correctional Agencies

Correctional agencies typically do not accrue benefits from programs that save public health care dollars or reduce rearrests. Further, the results may not be immediate. This complicates decision-making for public policy makers. These incentives might change to the extent correctional agencies can incorporate the community in their missions.

Community Receptivity

So many communities are less than welcoming to released inmates. Returning inmates are too often not considered the “deserving poor.” This is a stigma for inmates returning home. There is a high concentration of returning inmates in a small number of communities in urban America, communities who have deeply felt the impact of the war on drugs psychologically, economically, politically, and socially.

Few Training Programs in Correctional Health Care

There are very few academic programs in correctional health care for health professionals. This limits health professionals’ exposure to correctional health care and limits recruitment of high quality leaders and professional staff.

Correctional Health Care Standards Are Different

Standards of care within corrections are unique. Overall, they are neither higher nor lower than community standards. Inmates have no choices of providers and depend on well-organized programs to insure timely access to care. Timely access to care for serious medical needs is a constitutional requirement, unique to inmates, under the 8th and 14th Amendments to the Constitution.^{1,26} On the other hand, some jurisdictions allow practitioners to practice medicine, psychology or social work using lower standards than would be allowed in the community.

BASIC DISCHARGE PLAN TEMPLATE

The barriers described above span a broad range of political, social, economic, and organizational arenas, each of which can be addressed. To get started, the roundtable participants recommended that state and local governments can begin to offer a simple package of services focused on returning inmates’ immediate serious medical needs. To accomplish this, state and local governments must write specific criteria for their programs. The programs should have strong leadership emphasizing collaboration between health care and custody staff and collaboration with agencies and health care providers in the community. The reentry programs must then be staffed accordingly. For correctional agencies that contract out for services, the program requirements should be explicit in requests for proposals and contracts. Of course, resources must be allocated for any new services.

The members of the PCHCP roundtable set out to describe a basic set of services that can be provided at modest cost to inmates who are returning home. These services are focused on inmates with ongoing medical needs. There are eight elements to the basic reentry package:

Decide Strategy

Once a correctional agency incorporates successful reentry as part of its mission, an agency executive should define the targeted patient population. Once the range of

an services is decided, the agency can get a handle on the operational and cost aspects of the program. Depending on the strategy, reentry programs focusing on the health and behavioral needs could apply from as few as 5% of the discharged inmates up to 25–30% including those with medical and psychiatric problems. If drug abuse treatment is included, the proportion would be higher. As boundary spanners, the PCHCP are in the position to work with correctional agencies to determine how narrowly the services will be limited. A checklist of services could be provided with the following as examples of potential services provided.

- Incompletely treated communicable disease such as tuberculosis, HIV, skin infections and sexually transmitted disease.
- Acute medical conditions, such as alcohol withdrawal, organ failure (e.g., heart, kidney or liver failure), fevers, trauma and those who are recovering from surgery.
- Patients at risk of serious illness, such as those with abnormal pap smears, pregnancy, abnormal laboratory tests.
- Suicidal behavior or uncompensated psychosis.
- Well-compensated chronic mental illness (on medication), such as major depression, schizophrenia, bipolar disorder, post-traumatic stress syndrome; any mental illness being treated with medication.
- Severe chronic diseases, such as uncompensated cirrhosis, moderate or severe asthma, poorly controlled diabetes, and symptomatic coronary artery disease.
- All chronic diseases, including hypertension, asthma, diabetes, stroke, arthritis, viral hepatitis and partially treated latent tuberculosis.
- Non-emergent dental or gum disease.
- History of drug and/or alcohol abuse.

Contractual requirements for inmates with ongoing medication needs post-release would be negotiated between the PCHCP and the agency. Medication issues include:

- How much medication (e.g., 3, 5, 7, 14, 30 days supply) to provide at release?
- Are written prescriptions and an address of a pharmacy that might fill the prescriptions for impoverished patient provided, in addition to the medications dispensed?
- What are the limitations on distributing certain medications at the time of release (e.g., antipsychotic medication, narcotics, benzodiazepines, medication for tuberculosis)?
- Is there a need to require the approval of the prescribing practitioner immediately prior to release?

Develop Formal Linkages

Once the strategy is decided, the facility should develop formal linkage with the most commonly accessed providers in the community. At a minimum, this would include linkages with public health departments and public or private hospitals. The breadth and number of formal linkages will depend on the strategy selected. The releasing facility should have a list of local health care facilities, community health centers, community mental health centers, drug treatment programs, STD counseling and test sites, TB clinics, Medicaid offices, hepatitis C services, Ryan White providers for HIV infection and social service agencies.

Determine Risk

As early as the intake process, health care staff would flag patients with special needs who may require discharge planning. This would establish the broad pool of patients who may be provided with treatment planning and continuity of care on release. The records of these patients would contain relevant information for a discharge summary and sufficient information for bridging medication supplies and linking to community resources for continuity of care. Custody staff provides timely notification to health care staff for planned discharges and last-minute notices for unplanned discharges. Once the parameters of the program are clear, the health care staff can consult their disease registries, if these internal logs of patients with various chronic illnesses are in good shape. They can also use pharmacy data and/or the patient's medical record to determine if this patient is eligible for reentry services. A well-operated program will have flag systems in the facility computer to inform both custody and health care staffs who is entitled to the discharge planning services.

Summarize Essential Information

Each eligible patient should have a concise and accurate summary of pertinent information. This would include a problem list, medications, results of laboratory and diagnostic tests, scheduled tests or visits, third-party coverage for medical care (if known or arranged), and any other information that would be important for the subsequent practitioners to know. This information should either be given to the patient or sent to the community provider who will be caring for him. Ideally, one copy would go to each. Providing this document to the patient requires good coordination between custody and health care staff.

Provide Medication or a Combination of Medication and Written Prescriptions

Assure that the released patient has medication and/or prescriptions as defined in the strategic plan for reentry. The medication should be clearly labeled and the patient should be instructed on why and how to take it. Providing medication and this information to the patient requires good coordination between custody and health care staff.

Enable Access to Care on Release

The patient should have a specific appointment for medically necessary care in the community, whether that be physical, psychiatric, dental or drug treatment, made for him or her prior to release. The patient should be given the information in writing, with the address and telephone number of the community facility. If the patient has an acute or fragile condition, the correctional facility should arrange for suitable transportation for the patient. To the extent possible, local health departments should be notified in advance of the release of any patient with diseases such as active tuberculosis.

Distribute Information for Access to Community-based Organizations

In addition to the specific written appointment for follow-up care, health care staff will have a ready supply of information on other community-based organizations that might be appropriate for the patient, specifically programs

such as HIV support, drug treatment, parenting, etc. When feasible, it would be ideal to have the community organization, or health care providers, or case managers, or others actually enter into the correctional facility and meet face-to-face with inmates pre-release to enhance successful linkage after release. These meetings would be facilitated by the health care providers and the correctional administration.

Designate Staff with a Clearly Defined Discharge Planning Function

No reentry program can be effective without a specifically designated person who is accountable for getting the work done. That is not to say that it requires a full-time person. Small and medium-sized facilities might have one or several people who are accountable for the function, but who may also have other duties. Large facilities will need dedicated staff.

BEYOND A BASIC DISCHARGE PLAN

Once the basics are designed, funded, and operational, the PCHCP roundtable recommends, based on the availability of state or county funds, additional discharge planning services a correctional agency could incorporate. The agency could arrange or contract for any of the following services, each of which could provide crucial benefits to the public health, to communities to which inmates return, and to the patients themselves. This section is a menu of options:

Time-limited Services

Contracts or program descriptions would specify the time limitations on transitional services. Do they begin 2 days before release, at the time of admission or somewhere in between?

In-reach and Outreach

This would include individual case management by nurses or social workers who would build bridges for homebound patients. The case managers will have working collaborative relationships with public health departments and community providers. Health care staff could broker relationships with public health departments and for primary care or specialty care in the community, both for the release cohort generally and for individual patients with special needs. Health education and disease management during the discharge planning process could be provided, for example, videos and brochures, group sessions and individual counseling. Such staff could build bridges for continuity of medication with public programs (such as AIDS Drug Assistance Program for HIV) and pharmaceutical companies who have *pro bono* prescription programs for impoverished patients, although these *pro bono* programs are labor intensive for the providers and may not contribute substantially to the health care of reentering prisoners.

Discharge Planning Groups

Contract staff would provide life-skills or reentry education for patients with special needs, at a defined time during the incarceration.

Electronic Record Access

Increasingly, medical information is electronic. However, there are many different formats and programs. Respecting legal requirements for privacy, contract staff could develop electronic linkages of correctional and community databases, ranging from immunization registries, appointments, and laboratory results to full electronic medical records. This would enhance continuity of care and reduce waste and rework at each transition in care.

Health Care Liaison with Probation or Parole Agencies

For patients with special needs, especially behavioral health care and drug treatment, health care staff could be assigned to link health information with assigned probation or parole officers.

Training for Program Services and Parole Staff

Contract staff could provide training for program services and parole staff on building community linkages and accessing existing linkages. They could also provide training and education for community health care organizations on working with correctional staff and returning inmates.

Enabling Access to Government Entitlements

This would include helping with applications and processing for Medicaid, disability, and/or Medicare, working with Medicaid-managed care organizations, coordinating with federally-qualified community health centers, community behavioral health centers and Assertive Community Treatment Programs (ACT).

EVALUATION

The public health mission is a key element when supporting and implementing transitional health care. In times of budgetary constraints, it is unlikely that transitional health care will be implemented nationwide unless PCHCP, correctional health care practitioners and criminal justice administrators can convince public policy makers that these programs have a long-term cost saving value. Anecdotal evidence of success, however, is no longer acceptable. The recent acceptance of evidenced-based practices requires the use of valid and reliable performance measurement as part of program evaluation. Not only will this save money by weeding out unsuccessful programs, but it will also provide useful information for correctional administrators, correctional health care practitioners and PCHCP when requesting funding or a reallocation of funds.

At the most basic level, evaluations need to be conducted to answer three questions: 1) is the program producing the desired results; 2) is the program having the greatest possible impact; and 3) is the program making the most efficient use of public funds.⁸ A process evaluation which “examines the theory underlying the program, how the program is administered and ultimately whether the program is administered in accordance with its intended design” is the first step during an evaluation.⁸

Process evaluations are important because programs tend to start off with lofty goals, but budgets, staffing and bureaucracy can interfere with its implementation. Too often programs are solely focused on public safety outcomes without considering a reduction in health care costs and medical improvements of the returning inmates

as objectives. Though the numbers of those rearrested and reincarcerated within 3 months, 6 months, 1 year, and 3 years are still valid measures of a program's success, the following objectives are also advantageous: 1) increased utilization of necessary health care services after release, 2) increase in contacts with primary care physicians; decrease in emergency room contacts, 3) improvement in medication adherence, and 4) decrease in the number of psychiatric hospitalizations.

Important parts of process evaluation are analysis and potential restructuring of the facility's data collection process to assure that reliable and valid data can be used to improve the impact of the program. Official records will always have data on the individuals who were rearrested and reincarcerated, but a broader data collection process must be implemented to measure the long-term health care costs and improvements in health status.

A data collection and reporting system must be implemented prior to the start of a project. At a minimum, the discharge staff should complete a detailed discharge plan on each soon-to-be-released inmate. Ideally, the information would be entered directly into an electronic database. This will save time and money, and reduce errors. The database would include all inmate discharge activity with a special emphasis on health care needs. Ideally, agencies working with the returning inmate would share the same electronic database platform allowing data to be obtained on the number of inmates served and the type of intervention they receive.

Poor quality data is a widespread problem and can severely impede any evaluation. Problems include staff using inconsistent terminology so that the data cannot be easily integrated with other agency databases working with the same population. For example, in an analysis of a recent data set by the first author, the New York City borough of Brooklyn was spelled 38 different ways in 1 year of data, not only increasing the time to geo-code the information but also putting into question the reliability of the data. It is imperative that staff be trained in data entry and familiar with any codes that are used and how to accurately record an inmate's discharge plan. Data should be able to be accessed at the individual and aggregate level.

Once the process evaluation and data collection have been implemented, the data can be analyzed and used for outcome evaluation. The goal here is to identify the impact of a program, the reasons behind the program's success or failure, and whether the program is cost-effective. In this situation, this would include measurement of whether patients receive the services they are supposed to get in the facility and measurement of successful linkages in the community.

CONCLUSION

This paper is a summary of the unique observations of PCHCPs with substantial input from academics who work on correctional health care issues. Public sector correctional administrators and practitioners may well have quite a different perspective. The dialogue between public and private correctional health practitioners is a logical next step.

The participants in this forum agreed that there are several logical and critical steps for correctional agencies who are concerned with improving continuity of care on discharge. A basic template for discharge planning would include:

1. Decide strategy, i.e., determine which categories of patients would be offered discharge planning and develop a method to stratify risk for outgoing inmates.

2. Develop linkages with community providers and agencies.
3. Determine the risk for individual inmates.
4. Summarize essential information.
5. Provide medication or prescriptions to bridge the time of release until the patient can access care.
6. Enable access with an appointment and clear instructions to the patient; provide transportation where medically necessary.
7. Distribute information to patients on access to community health care resources.
8. Designate staff to perform the discharge planning function.

The group also outlined more advanced services that could be provided by correctional health care providers to the extent the correctional agency could commit resources. The group agreed that evaluation of these programs is imperative to provide a sound basis for the development of public policy in this area.

The matter of successful reentry is increasingly important for public health and for reducing recidivism. This public health model is based on the premise that better continuity of health care has a salubrious effect on the community. Earlier intervention should have more positive effects than later ones. Once the leadership and financial resources are in place, correctional agencies can promote successful reentry through a basic medical and behavioral health reentry program. Moving in a stepwise fashion, programs can be developed beyond the basics with supplemental services customized to the facility and the community. The participation of health care staff in reentry programs is an ethical responsibility. This participation is likely to increase professional satisfaction and performance.

REFERENCES

1. *Estelle v Gamble*; 429 97 (U.S. 1976)
2. Weisbuch J. Public health professional and prison health care needs. *Am J Public Health*. 1977;67:720–722.
3. Restum ZG. Public health implications of substandard correctional health care. *Am J Public Health*. 2005;95:1689–1691.
4. National Commission on Correctional Health Care. *Standards for Health Services in Jails*. Chicago, Illinois: National Commission on Correctional Health Care; 1996.
5. National Commission on Correctional Health Care. *Standards for Health Services in Jails*. Chicago, Illinois: National Commission on Correctional Health Care; 2003.
6. Puisis M, ed. *Clinical Practice in Correctional Medicine*. 2nd ed. Philadelphia, Pennsylvania: Mosby Elsevier; 2006.
7. Anno J. *Guidelines for the Management of an Adequate Delivery System*. Washington, District of Columbia: National Institute of Corrections; 2001.
8. The Council of State Government. *Report of the Re-entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*. New York, New York: The Council of State Government; 2005.
9. *Brad H. v City of New York*, 729 2d 398 (NYS Sup.Ct. 2001).
10. National Academy of Public Administration. *Public Health and Corrections: An Intergovernmental Perspective and the Need for Connectivity*. Washington, District of Columbia: National Academy of Public Administration; 2006. Accessed on: September 16, 2006. Available at: http://www.napawash.org/Pubs/Public_Health_and_Corrections.pdf.
11. American Medical Association. *Fundamental Elements of the Patient–Physician*

- Relationship: Code of Ethics E-1-.01* [Web page]. Chicago: The Association; 2006. Accessed on: May 15, 2006. Available at: <http://www.ama-assn.org/ama/pub/category/8313.html>.
12. Barr H. Transinstitutionalization in the courts: *Brad H. v. City of New York*, and the fight for discharge planning for people with psychiatric disabilities leaving Rikers Island. *Crime Delinquency*. 2003;49:97–123.
 13. Finn P. *Texas' Project RIO: Re-integration of Offenders*. Washington, District of Columbia: National Institute of Justice; 1998. Accessed on: September 18, 2006. Available at: <http://www.ncjrs.gov/pdffiles/168637.pdf>.
 14. Nelson M, Trone J. Why Planning for Release Matters. New York, New York: Vera Institute for Justice; 2000. Accessed on: September 18, 2006. Available at: http://www.vera.org/publication_pdf/planning_for_release.pdf.
 15. Conkilin T, Lincoln T, Flanigan T. A public health model to connect correctional health care with communities. *Am J Public Health*. 1998;88:1249–1250.
 16. Angiello E. Prerelease programs. In: Bosworth M, ed. *Encyclopedia of Prisons and Correctional Facilities*. vol. 2. Thousand Oaks, California: Sage Publications; 2005:711–715.
 17. Conly C. *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program*. Washington, District of Columbia: National Institute of Justice; 1998. Accessed on: September 18, 2006. Available at: <http://www.ncjrs.gov/pdffiles1/175046.pdf>.
 18. Robbins IP. Managed health care in prisons as cruel and unusual punishment. *J Crim Law Criminol*. 1999;90:195–237.
 19. Scott M. Inmate health care. *Law Order*. 2004;52:116–118.
 20. French WL, Bell CH Jr. *Organizational Development: Behavioral Science Interventions for Organization Improvement*. 5th ed. Englewood Cliffs, New Jersey: Prentice Hall; 1995.
 21. Jacobs JB, Olitsky E. Leadership & correctional reform. *Pace Law Rev*. 2004;24:477–496.
 22. Gibbons JJ, Katzenbach NdB. *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons*. New York, New York: Vera Institute of Justice; 2006. Accessed on: September 18, 2006. Available at: <http://www.prisoncommission.org/>.
 23. National Commission on Correctional Health Care. *The Health Status of Soon-to-be-Released Inmates: A Report to Congress*. vol. 2. Chicago, Illinois: National Commission on Correctional Health Care; 2002. Accessed on: September 18, 2006. Available at: http://www.ncchc.org/pubs/pubs_stbr.vol2.html.
 24. Tomlinson DM, Schechter CB. Cost-effectiveness analysis of annual screening and intensive treatment for hypertension and diabetes mellitus among prisoners in the United States. In: *Health Status of Soon-to-be-Released Inmates: A Report to Congress*. vol. 2. Chicago, Illinois: National Commission on Correctional Health Care; 2002:141–156.
 25. Freudenberg N, Daniels J, Crum M, Perkins T, Richie BE. Coming home from jail: the social and health consequences of community reentry for women, male adolescents, and their families and communities. *Am J Public Health*. 2005;95:1725–1736.
 26. Greifinger RB. Health care quality through care management. In: Puisis M, ed. *Clinical Practice in Correctional Medicine*. Philadelphia, Pennsylvania: Elsevier; 2006:510–519.