Reentry as an Emergency: Continuity of Care Failures and Healthcare Utilization After Incarceration

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ABSTRACT

Introduction: Individuals transitioning from incarceration to the community experience disproportionately high rates of morbidity and mortality, driven by both the sequelae of confinement and the structural barriers that disrupt access to health services. Emergency departments (EDs) frequently become the first, and sometimes only, point of contact during this re-entry period, making post-incarceration healthcare directly relevant to emergency medicine. This paper synthesizes recent U.S.-based literature on healthcare utilization and unmet needs after incarceration to identify system-level factors that drive emergency care reliance, with a focus on implications for emergency medicine practice.

Methods: An evidence synthesis was conducted using PubMed to identify studies published in the past five years examining healthcare needs, disruptions in care, and ED utilization among recently incarcerated individuals in the United States. Papers were screened for relevance to medical, psychiatric, substance use, and chronic infectious disease outcomes after release. Supplemental studies on healthcare during incarceration were included when needed to contextualize post-release risks.

Results: Medicaid discontinuity emerged as a central driver of fragmented care. Pre-release Medicaid enrollment is strongly associated with improved outpatient engagement and lower ED utilization, although racial inequities persist across the Medicaid-to-care continuum. Mental illness and opioid use disorder substantially elevate suicide risks and acute care needs. This is exacerbated by low continuity of behavioral health treatment and restricted access to medications for opioid use disorder after release. Integrated re-entry programs consistently improve continuity of care when implemented alongside insurance activation and social supports.

Conclusion: The post-incarceration period is a predictable and preventable risk window in which structural barriers and unmet behavioral health needs drive avoidable emergency care utilization. Strategies that synchronize Medicaid activation, mental health and substance use treatment, trauma-informed programming, and coordinated care navigation hold promise for reducing morbidity and shifting emergency medicine encounters from episodic crisis responses to supportive continuity of care.

Keywords: *incarceration; reentry; emergency department utilization; Medicaid; continuity of care; opioid use disorder; behavioral health; health equity*

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