

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



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Background

- People leaving incarceration face disproportionately high rates of ED use, morbidity, and preventable mortality.
- Structural barriers impede outpatient engagement and increase reliance on emergency care.¹
- EDs are frequently the first and sometimes only point of contact during the high-risk re-entry period.⁵⁻⁷
- Post-incarceration healthcare is both an urgent public health challenge and a matter of core clinical relevance for emergency medicine.
- This review synthesizes recent U.S.-based literature to identify system-level drivers of ED reliance and evaluate emerging re-entry care models.

Methods

- Evidence synthesis via PubMed; studies from past 5 years; U.S.-based or global reviews with significant U.S. data.
- Search domains: post-incarceration, healthcare access, continuity of care, care barriers, emergency medicine.
- Screened for medical, psychiatric, substance use, and chronic infectious disease outcomes following release.
- Supplemental studies on healthcare during incarceration included to contextualize post-release risks.
- IRB exempt: review of publicly available literature; no human subjects included.

Results

Medicaid Disruptions

- Pre-release Medicaid enrollment reduces ED visits and hospitalizations and accelerates access to outpatient services and medications.^{4,9}
- Despite ACA expansion, no population-level increases in mental health or SUD treatment were observed; insurance access alone is insufficient.^{11,12}
- Racial inequities persist: Black individuals with SUD less likely to access outpatient care; the mortality benefits of continuous Medicaid enrollment disproportionately accrued to White individuals.¹¹⁻¹⁴

Mental Health & Suicide Risk

- 65% of a Philadelphia cohort of >61,000 prison releases had behavioral health diagnoses; only 27% used outpatient mental health care post-release.¹⁷
- Low outpatient engagement was strongly associated with increased suicide attempts and deaths; therapists were significantly less likely to schedule appointments with justice-involved individuals.¹⁶⁻¹⁸

Opioid Use Disorder & MOUD

- ~27% of national opioid overdose deaths involve recently incarcerated individuals; overdose mortality peaks in first weeks of re-entry.²⁶
- Fewer than half of those started on MOUD during incarceration stay engaged post-release; drop-off most pronounced among Black individuals, younger adults, and those newly started on methadone.²¹

HIV & Hepatitis C

- Communication failures between carceral health teams and community case managers frequently interrupt medication supply at release.²⁹
- Peer navigation and integrated SUD treatment were consistently linked to improved clinic attendance and viral suppression.²⁸

Re-Entry Programs

- Compounding these clinical vulnerabilities are additional social and economic stresses, such as unstable housing, stigma, lack of trauma-informed care, and poor care coordination, that impede engagement with outpatient care and increase reliance on emergency systems.²⁻⁴
- Colorado data: 78% of released individuals had chronic conditions; only 31% accessed any healthcare within 180 days, and only 10% within 30 days.³⁵
- Multidisciplinary models (CA Reentry Health Hub, Transitions Clinic Network) improve linkage to primary care, behavioral health, and social supports.³⁶⁻³⁸

Conclusions

- The post-incarceration period is a predictable and preventable risk window for avoidable ED use, morbidity, and mortality.
- Three structural failures drive acute care reliance: Medicaid discontinuity, behavioral health and MOUD treatment gaps, and unmet chronic disease needs.
- Racial inequities persist across all outcomes; equity-focused implementation is essential to ensure reforms reach those at highest risk.

Implications

- EM clinicians are frequently the first providers encountered during the high-risk re-entry period.
- ED-based opportunities: onsite Medicaid enrollment, MOUD initiation, warm behavioral health handoffs, HIV/HCV medication bridging, reentry care coordinator consultations.
- Future priorities: ED-based linkage protocols, scalable re-entry models, equity-focused Medicaid implementation metrics, and EM provider training.
- ***Embedding re-entry pathways could shift the ED from episodic crisis responder to a stabilizing bridge for continuity of care.***

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References

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