HEALTHY TRANSITIONS EVALUATION

Kelli E. Canada, PhD, LCSW
March 2019

CENTER FOR
CRIMINAL AND JUVENILE
JUSTICE PRIORITIES

School of Social Work
University of Missouri

BACKGROUND

The months following release from prison are some of the most vulnerable and highest risk for recidivism, homelessness, health problems, overdose, suicide, and homicide.[1-4] As of 2015, the United States held 25% of the world's prisoners.[5] In the past forty years the prison and jail population in the United States grew over 500%.[6] The largest facilities housing individuals with mental illness in the United States are jails and prisons. As the prison population grows so too does the medical and mental health needs of the individuals exiting prison. A study in 2012 found that 80% of individuals released from correctional facilities had at least one chronic mental, physical, or substance use problem.[7] Healthcare is one of the top concerns for individuals leaving corrections.

Approximately 95% of all people in prison are released back into the community.[8] Medical continuity of care upon release plays a vital role in a justice-involved individuals' success. In a 2007 study in San Francisco, researchers found that 32% of the sample population did not receive needed medication upon release.[7] In other communities, people leaving corrections get two weeks of medication upon release. Given justice-involved individuals visit the emergency room more often than the general public[9] this short duration of medication may be insufficient.[8] Stakeholders recommend justice-involved individuals have access to medications and refills in order to promote successful transition to the community.

HEALTHY TRANSITIONS

Programs, services, and support are critical in promoting health and mental health, community engagement, and prosocial involvement in activities, all of which can reduce the risk of recidivism. In order to evaluate services, participants were surveyed, stakeholders were interviewed, and administrative data on recidivism were analyzed. Nearly 68% of Healthy Transition survey respondents reported they never went without medication since their release from prison while just under 70% reported no visits to the emergency room since release. These indicators of health are important components of successful community transitions. Given over half the sample does not have insurance, it is likely that enrollment in Healthy Transitions played a key role in these promising findings.

Healthy Transitions serves people across Missouri in both urban and rural communities. In our survey of Healthy Transitions participants, more people in rural communities went without medications since release compared to people living in urban communities. Although it is unclear why this difference exists, rural homelessness, unstable housing, and limited or no residential service facilities are known challenges facing people who exit prison back to rural communities.[10-11] Medications from Healthy Transitions are sent directly to residences which may not be stable for rural recipients.

Stakeholder Interviews. In addition to surveying Healthy Transitions participants, program participants and providers (e.g., case managers, housing directors, agency directors) who are familiar with Healthy Transitions were interviewed in order to have a better

understanding of how this program helps people leaving prison. Both participants and providers note the importance of having a 90-day supply of medication. Participants talked about multiple barriers to medication including transportation to pharmacies, long waits at the pharmacy, co-pays, and not having a doctor/nurse to write current prescriptions. Even if planning begins the day a person is released from prison, providers and participants note the long waits to see healthcare providers.

Without Healthy Transitions, participants state they would have gone without medications due to waitlists of two or more months to see primary care and/or psychiatry. One participant notes the anxiety she experienced at the thought of going without her medication: "So, I was a little stressed, thinking okay, I'm not going to be able to make these meds stretch, until I see them, and I was really relieved when [caseworker] got the meds here for me." The participant goes on to say what would happen without medications:

> "…it keeps me where I should be. If I didn't take my medication and I was just released or being out of it or what have you, I would probably be returning to prison in a very short amount of time. My depression would set back in. I mean, it would be different things like that. So, it's keeping me balanced, and where I'm able to think straight and everything."

Similarly, another participant said "Well because I'd ran out and I didn't have my meds, I started using again, and I ended up back in DOC" about a time she went without medications before Healthy Transitions. Another participant states:

> "Since I was locked up for a couple of years, my disability is not going to kick in right away and what have you. So, I really don't have the funds, and a lot of these medicines are expensive. So, me worrying about how I'm going to have to pay for them and everything else, and it gives me – if I get them for three months, it gives me a little bit of time to find a part-time job and get on my feet, without having to worry about well, am I going to relapse."

Providers note the importance of having medications to ensure people can get to work and stay working. One caseworker noted the impact of going without medications on employment and self-esteem: "…guys can get a job, and they're doing okay, because their body hasn't, I don't know, fully gotten used to not having medication, or they ran out of that little supply. And they just got a job, and they're like, "I have to take off for two days 'cause I'm in the hospital." And talk about feeling defeated." A consistent theme across interviews is the importance of having access to medications which allows people to focus on their transition back to the community without an additional stressor. For example, a caseworker notes:

> "…having that for 90 days would just take one more thing that we have to worry about for them or they have to worry about for themselves, so really trying, 'cause, I mean, I think the biggest deterrent to success is just being overwhelmed in health care, especially if you need medication or health, is a huge concern, especially if it's something that your life depends on. So that would just eliminate that barrier, so that would just make it easier."

In sum, providers and participants alike see Healthy Transitions as a "safety net" and critical resource to successful reentry. Participants suggested additional information about Healthy Transitions be provided by the Department of Corrections upon release (e.g., a pamphlet or posters) so people know how to contact Rx Outreach with address changes. All participants viewed Healthy Transitions as an important program that is critical to successful re-entry and are thankful to have had access to the program.

Descriptive Information—Overall Sample. The data listed below include information regarding the overall sample of healthy transition participants who completed surveys. All data were collected between January and December 2018. At the time of the survey, participants had been released from prison an average of 143 days prior with a range of 0 to 805 days.

Table 1

Summary of Answers—Overall Sample (n = 276)

		Frequency/Count	% of Survey Respondents
Type of Program	Mental Health HT	124	45.6
	HT	148	54.4
Funder	None or info missing	56	20.3
	BF	124	44.9
	LF	58	21.0
	MFH	32	11.6
	Corizon	6	2.2
Without meds since release		92	33.3
Seen a doctor	Yes	154	55.8
	No	99	35.9
	Scheduled	23	8.3
Length of time to schedule apt.	1 month	101	37.0
	2 months	56	20.5
	3 or more months	25	9.2
	No apt scheduled	91	33.3

Went to ER or Hospital		88	31.9
Reason	Mental	6	9.5
	Physical	48	76.2
	Both	9	14.3
Condition	New condition	21	35.6
	Existing condition	35	59.3
	Both	3	5.1
Employment Status	Part time	39	14.3
	Full time	111	40.7
	Not looking	8	2.9
	Unable to work	29	10.6
	Unemployed	86	31.5
Insurance	No	153	56.9
	Yes	100	37.2
	Pending	16	5.9

On a scale of one to four with four indicating very healthy, survey respondents reported an average health rating of 2.85. Survey respondents perceive family and friends to be fairly support with an average rating of 3.12 (scale one to four with four indicating highly supportive).

Figure 1

Length of time to Scheduled Appointments

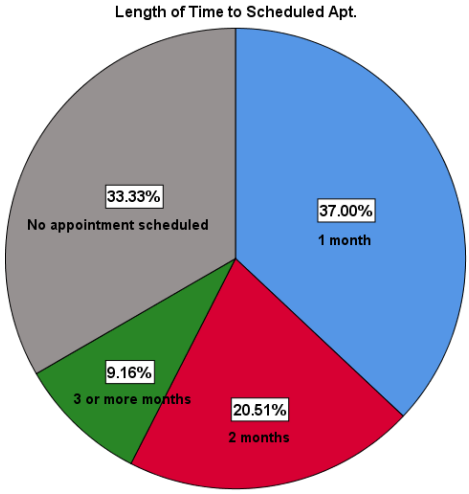
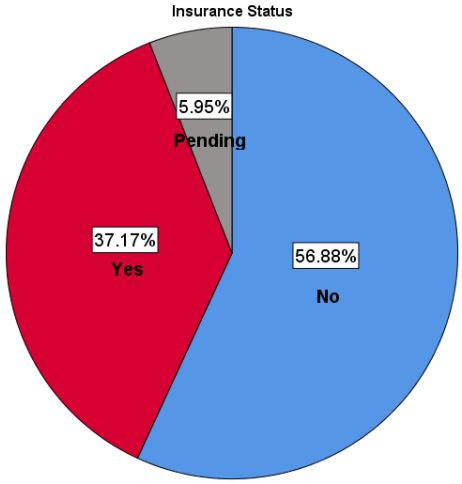


Figure 2

Insurance Status



Descriptive Information—St. Louis Only Sample. The data listed below include information regarding participants from the St. Louis area who completed surveys. At the time of the survey, participants had been released from prison an average of 144 days prior with a range of 85 to 190 days.

Table 2

Summary of Answers—St. Louis only Sample (n = 38)

		Frequency	Percent of Survey Respondents
Type of Program	Mental Health HT	22	57.9
	HT	16	42.1
Funder	None or info missing	0	0
	BF	22	57.9
	LF	16	42.1
	MFH	0	0
	Corizon	0	0
Without meds since release		3	7.9
Seen a doctor	Yes	29	76.3
	No	6	15.8
	Scheduled	3	7.9
Length of time to schedule apt.	1 month	21	55.3
	2 months	11	28.9

	3 or more months	1	2.6
	No apt scheduled	5	13.2
Went to ER or Hospital		17	44.7
Reason	Mental	1	11.1
	Physical	6	66.7
	Both	2	22.2
Condition	New condition	1	90.0
	Existing condition	9	10.0
	Both	0	0
Employment Status	Part time	9	24.3
	Full time	15	40.5
	Not looking	1	2.7
	Unable to work	3	8.1
	Unemployed	9	24.3
Insurance	No	17	45.9
	Yes	20	54.1
	Pending	0	0

On a scale of one to four with four indicating very healthy, survey respondents reported an average health rating of 2.97. Survey respondents perceive family and friends to be fairly support with an average rating of 3.26 (scale one to four with four indicating highly supportive).

Descriptive Information—Urban vs. Rural Sample. The data listed below include information separated by urban and rural healthy transition participants who completed surveys. At the time of the survey, urban participants had been released from prison an average of 140 days prior and rural participants were released an average of 143 days. Urban was defined as cities with more than 100,000 people and only includes St. Louis, Kansas City, Springfield, Columbia, and Independence.

Table 3

Urban (n = 56) vs. Rural (n = 220) Comparison

		Urban		Rural	
		Frequency	**%**	**Frequency**	**%**
Type of Program	Mental Health HT	26	46.4	98	45.4
	HT	30	53.6	118	54.6
Funder	None or info missing	0	0	0	0
	BF	26	59.0	98	55.7
	LF	16	36.4	42	23.9

	MFH	0	0	32	18.2
	Corizon	2	4.5	4	2.3
Without meds since release*		10	17.9	82	37.4
Seen a doctor	Yes	35	62.5	119	54.1
	No	16	28.5	83	37.7
	Scheduled	5	8.9	18	8.2
Length of time to schedule apt.	1 month	25	46.3	76	34.7
	2 months	12	22.2	44	20.1
	3 or more months	3	5.6	22	10.0
	No apt scheduled	14	25.9	77	35.2
Went to ER		22	39.3	66	30.0
Reason	Mental	1	8.3	5	9.8
	Physical	8	66.7	40	78.4
	Both	3	25.0	6	11.8
Condition	New condition	2	15.4	19	41.3
	Existing condition	10	76.9	25	54.3
	Both	1	7.7	2	4.3
Employment Status	Part time	10	18.2	29	13.3
	Full time	23	41.8	88	40.4
	Not looking	1	1.8	7	3.2
	Unable to work	3	5.5	26	11.9
	Unemployed	18	32.7	68	31.2
Insurance	No	29	52.7	124	57.9
	Yes	25	45.5	75	35.0
	Pending	1	1.8	15	7.0

*Differences between groups are statistically significantly different

On a scale of one to four with four indicating very healthy, urban survey respondents reported an average health rating of 2.87 and rural respondents reported an average of 2.84. Urban survey respondents perceive family and friends to be supportive with an average rating of 3.13 and rural respondents with an average of 3.12 (scale one to four with four indicating highly supportive). These differences did not reach statistical significance

Descriptive Information—Mental Health HT vs. HT. The data listed below include information about mental health and regular healthy transition participants separately who completed surveys. At the time of the survey, MH HT and HT participants had been released from prison an average of 136 days prior.

Table 4
Mental Health (MH HT; n = 124) vs. Others (HT; n = 148)

		MH HT		HT	
		Frequency	**%**	**Frequency**	**%**
Funder	None or info missing	0	0	0	0
	BF	124	100.0	0	0
	LF	0	0	54	58.7
	MFH	0	0	32	34.8
	Corizon	0	0	6	6.5
Without meds since release		43	34.7	47	32.0
Seen a doctor*	Yes	**78**	**62.9**	**72**	**48.6**
	No	**33**	**26.6**	**66**	**44.6**
	Scheduled	13	10.5	10	6.8
Length of time to schedule apt.*	1 month	**55**	**45.1**	**43**	**29.3**
	2 months	21	17.2	34	23.1
	3 or more months	18	14.8	7	4.8
	No apt scheduled	**28**	**23.0**	**63**	**42.9**
Went to ER		42	33.9	45	30.4
Reason	Mental	3	9.4	2	6.7
	Physical	22	68.8	25	83.3
	Both	7	21.9	2	6.7
Condition	New condition	6	25.0	14	41.2
	Existing condition	16	66.7	19	55.9
	Both	2	8.3	1	2.9
Employment Status	Part time	16	13.0	22	15.1
	Full time	49	39.8	59	40.4
	Not looking	5	4.1	3	2.1
	Unable to work	9	7.3	20	13.7
	Unemployed	44	35.8	42	28.8
Insurance	No	61	50.4	90	62.5
	Yes	52	43.0	47	32.6
	Pending	8	6.6	7	4.9

*Differences between groups are statistically significantly different

On a scale of one to four with four indicating very healthy, MH HT survey respondents reported an average health rating of 2.92 while HT participants reported an average of 2.78. MH HT survey respondents perceive family and friends to be supportive with an average rating of 3.18

compared to HT respondents average rating of 3.06 (scale one to four with four indicating highly supportive). Neither of these differences reach statistical significance.

RECIDIVISM

All Return to Prison Events. Recidivism rates for Healthy Transition participants are calculated multiple ways as listed below. Table 5 outlines the total number of people who recidivated by release year. This includes ALL returns to prison, not just first returns. Table 6 outlines the total number of people in Healthy Transitions by year. Some data appeared to be incorrect when entered. Release years listed as 0, 1952, 1958, and 1978 were omitted from the analysis. Only cases released to probation or parole are included; missing data were omitted.

Table 5
All returns to prison

		Recidivism (number of people who returned to prison)			
		6 months	1 year	2 years	Total
Release_year	2016	72	85	119	276
	2017	106	124	87	317
	2018	264	160	4	428
Total		442	369	210	1021

Table 6
All HT Participants by Year

		Frequency	Percent
Year			
	2016	454	10.7
	2017	949	22.3
	2018	2851	67.0
	Total	4254	100.0

Table 7 and 8 outlines the recidivism rate for all returns to prison. These numbers are calculated from the above two tables – that is, the number of people returned divided by the number of Healthy Transition participants released that year.

Table 7
Percent returns (not cumulative)

Release Year	Recidivism		
	Within 6 months	**6 months – 1 year**	**1 year to 2 years**
2016	(64/454) **14.1%**	(72/454) **15.9%**	(68/454) **15.0%**
2017	(100/949) **10.5%**	(101/949) **10.6%**	(67/949) **7.1%**
2018	(243/2851) **8.5%**	(140/2851) **4.9%**	(3/2851) **0.1%**

Table 8
Percent returns (cumulative)

Release Year	Recidivism		
	Within 6 months	**Within 1 year**	**Within 2 years**
2016	(64/454) **14.1%**	(136/454) **30.0%**	(204/454) **44.9%**
2017	(100/949) **10.5%**	(201/949) **21.2%**	(268/949) **28.2%**
2018	(243/2851) **8.5%**	(383/2851) **13.4%**	(386/2851) **15.5%**

Recidivism—First Recidivism Events Only. Table 9 and 10 outline first-event recidivism numbers and recidivism rates.

Table 9
First Event Recidivism Counts

		Recidivism (number of people who returned to prison)			
		6 months	1 year	2 years	Total
Release year	2016	68	76	71	215
	2017	104	108	71	283
	2018	258	146	3	407
Total		430	330	145	905

Table 10
Percent First Returns (cumulative)

Release Year	Recidivism		
	Within 6 months	**Within 1 year**	**Within 2 years**
2016	(68/454) **15.0%**	(144/454) **31.7%**	(215/454) **47.4%**
2017	(104/949) **11.0%**	(212/949) **22.3%**	(283/949) **29.8%**
2018	(258/2851) **9.0%**	(404/2851) **14.2%**	(407/2851) **14.3%**

Recidivism by Program. Recidivism rates are calculated below by program. All data displayed in Tables 11 to 14 are grouped by Healthy Transitions (HT) and Mental Health Healthy Transitions (MH HT). Recidivism rates are only calculated for first returns to prison. As noted above, some data appeared to be incorrect when entered. Release years listed as 0, 1952, 1958, and 1978 were omitted from the analysis. Only cases released to probation or parole are included; missing data were omitted.

Table 11
Program Total by Release Year

		No program listed	HT	MH HT	Total
Release Year	2016	454	0	0	454
	2017	271	382	296	949
	2018	0	1335	1516	2851
Total		725	1717	1812	4254

Table 12
First Return Totals

		Program type		
		HT	MH	Total
Release Year	2017	107	87	194
	2018	175	227	402
Total		282	314	596

Table 13

First Returns by Program and Year (not cumulative)

Program type			Recidivism 6 months	1 year	2 years	Total
MH	Release Year	2017	30	43	14	87
		2018	155	71	1	227
	Total		185	114	15	314
HT	Release Year	2017	42	46	19	107
		2018	100	73	2	175
	Total		142	119	21	282
Total	Release Year	2017	72	89	33	194
		2018	255	144	3	402
	Total		327	233	36	596

Table 14

Percent first returns (cumulative)

Release Year	Recidivism					
	Within 6 months		Within 1 year		Within 2 years	
	HT	MH	HT	MH	HT	MH
2016	**Not calculated –data not split by program**					
2017	**Not calculated – 271 people had program data missing**					
2018	(100/1335) **7.5%**	(155/1516) **10.2%**	(173/1335) **13.0%**	(226/1516) **14.9%**	(175/1335) **13.1%**	(227/1516) **15.0%**

In sum, MH HT participants have a slightly elevated rate of recidivism in comparison to HT participants.

References

1. Binswanger, I. A. et al. (2010). Release from prison: A high risk of death for former inmates. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/.
2. Binswanger, I. A. et al. (2013). Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5242316/.
3. Urban Institute (2018). Health care after incarceration. Retrieved from https://www.urban.org/sites/default/files/publication/96386/health_care_after_incarceration.pdf .
4. Petersilia, J. (2001). Prisoner reentry: Public safety and reintegration challenges. Retrieved from https://journals.sagepub.com/doi/pdf/10.1177/0032885501081003004.
5. Hoke, S. (2015) Mental illness and prisoners: Concerns for communities and healthcare providers. *OJIN: The Online Journal of Issues in Nursing, 20(1),* 1-10. doi: 10.3912/OJIN.Vol20No01Man03.
6. Sentencing Project. (2018, June). *Trends in U.S. Corrections* [Fact Sheet]. Retrieved from https://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf.
7. Wang, E., Hong, C., Shavit, S., Sanders, R., Kessel, E., Kushel, E. (2012). Engaging individuals recently released from prison into primary care: A Randomized trial. *American Journal of Public Health*, 102 (9), 22-30.
8. Binswanger, I., Nowels, C., Corsi, K., Long, J., Booth, R., Kutner, J., & Steiner, J. (2011). "From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry, 34,* 249-255. doi:10.1016/j.jilp.2011.07.002.
9. Rich, J., Wakeman, S., Dickman, S. (2011). Medicine and the epidemic of incarceration in the United States. *Massachusetts Medical Society, 364(22),* 2081-2083. doi: 10.1056/NEJMp1102385.
10. Wodahl, E. J. (2006). The challenges of prisoner reentry from a rural perspective. Retrieved from http://www.westerncriminology.org/documents/WCR/v07n2/wodahl.pdf
11. Housing Assistance Council (2011). Rural reentry: Housing options and obstacles for ex-offenders. Retrieved from http://ruralhome.nonprofitsoapbox.com/storage/research_notes/rural_reentry_12-2011.pdf.

APPENDIX A:

State by state programming

State	Care Continuity Services	Duration of Bridge Medication
Alabama	All medical supplies deemed not personal is returned to the prison	None
Alaska	The amount of bridge medication provided varies from seven days to 30 depending on the amount remaining on an inmate's prescription.	14-30 days for select individuals
Arizona	Medicaid enrollment is suspended for individuals entering the prison system with a year or less remaining on their sentence. For all others, enrollment is terminated.	None
Arkansas	Medicaid enrollment was generally completed, the department of corrections does not track this information. The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	7- 30 days for select individuals (varies depending on condition). All inmates on medication are to be provided with a minimum supply of seven days of medication, and those with chronic conditions or mental health needs are to receive a 30-day supply.
California	Medicaid enrollment was generally completed, the department of corrections does not track this information. The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community. Limited information about the prevalence of coordination between prison facilities and community supervision personnel.	Limited information on the supply of bridge medication provided to departing inmates.
Colorado	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
Connecticut	Community providers receive partial health records at release. Re-entry planning typically starts one year before release for those with a serious mental illness. For all others, it begins 31-60 days before release.	14-30 days for all individuals
Delaware	Medicaid enrollment was generally completed, the department of corrections does not track this information. The prevalence of coordination between prison facilities and community supervision personnel was unclear.	14-30 days for select individuals
Florida	Inmates do not continue working with providers who are dually based in the prison and the community after release. Inmates with HIV may do so, however. Through Ryan White funds, these inmates are seen by county health departments and may continue to see these providers after release. It should be noted that the timing varies by	14-30 days for select individuals

	condition as to when care continuity planning begins. In some cases, it begins up to six months before release.	
Georgia	Medicaid enrollment was generally completed, the corrections department does not track this information.	14-30 days for select individuals; The supply of bridge medication provided varies by condition and how quickly individuals can be seen by a community provider. *This may not be the case for anxiety, mood or personality disorders
Hawaii	The department refers individuals to a methadone treatment provider only if they were prescribed methadone during their incarceration in order to continue treatment begun in the community. In addition to providing care continuity services for those with mood and psychotic disorders, the state provides services to anyone hospitalized at the time of release.	14-30 days for select individuals *The state provides bridge medication only for mood and psychotic disorders.
Idaho	Medicaid enrollment was generally completed, the department does not track this information. The timing of the beginning of care continuity planning varies by condition.	14-30 days for all individuals
Illinois	Medicaid enrollment was generally completed, the corrections department does not track this information.	14-30 days for all individuals * Most inmates receive a two-week supply of bridge medication and then a prescription for an additional two weeks. Those with HIV are given a full 30-day supply at release.
Indiana		>30 days for select individuals
Iowa	Medicaid enrollment was generally completed, the department of corrections does not track this information. The prevalence of coordination between prison facilities and community supervision personnel was unclear.	>30 days for select individuals
Kansas		None
Kentucky	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
Louisiana	Those with "a significant disability," such as "hearing or visual impairment," are targeted for care continuity services.	14-30 days for all individuals
Maine		14-30 days for all individuals
Maryland	Though neither the inmate nor the community provider receives a copy of health records at release, information on an inmate's medication and chronic care needs are entered into the state's health information exchange.	14-30 days for all individuals

Massachusetts	The corrections department is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community. The prevalence of coordination between prison facilities and community supervision personnel was unclear.	Bridge medication supplies are determined by health care personnel on a case-by-case basis.
Michigan	Care continuity services are offered to inmates with only certain conditions.	None
Minnesota	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	6-13 days for select individuals
Mississippi		14-30 days for all individuals
Missouri	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
Montana	Medicaid enrollment was generally completed, the department of corrections does not track this information. The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
Nebraska	Unclear whether Medicaid managed care plans are required to provide care continuity programs/services to inmates transitioning from prison to the community. Unclear whether a majority of prison facilities generally make use of presumptive eligibility when inmates apply for Medicaid. Unclear whether individuals or their community providers receive a copy of health records at release.	14-30 days for all individuals
Nevada		14-30 days for all individuals
New Hampshire		Medication Bridge Program available for uninsured individuals; unclear how long medication is given and only for select facilities
New Jersey		14-30 days for select individuals with HIV/AIDS; information on the duration of bridge medication provided to those with other conditions or health needs was not reported.
New Mexico	The prevalence of coordination between prison facilities and community supervision personnel was unclear.	14-30 days for all individuals
New York	While a 30-day supply of bridge medication is provided for most prescription medications, a 14-day supply is provided for any controlled substance.	14-30 days for all individuals

North Carolina	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
North Dakota	Medicaid enrollment was generally completed, the respondent reported that the department of corrections does not track this information. The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	14-30 days for all individuals
Ohio		A 14-day supply of bridge medication and a 90-day prescription is provided for most prescription medications. For HIV and mental health medications, a 30-day supply is provided along with the 90-day prescription.
Oklahoma		14-30 days for select individuals
Oregon	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community. The prevalence of coordination between prison facilities and community supervision personnel was unclear. In addition to expanded care continuity services being offered to those with HIV/AIDS, active tuberculosis, psychotic disorders, end-stage renal disease, dementias or neurodegenerative diseases, cancers, those needing palliative care or hospice, or those in danger of suicide and self-harm, such services are offered to those with "severe medical condition[s]" and those requiring nursing home placements.	>30 days for all individuals
Pennsylvania		A 30-day bridge supply is provided for most medications, and a 60-day supply of psychiatric medications is provided.
Rhode Island	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community.	A minimum seven-day supply of bridge medication is provided, with up to a 20-day supply provided on a case-by-case basis.
South Carolina	Medicaid enrollment was generally completed, the department of corrections does not track this information.	1-5 days for all individuals
South Dakota		South Dakota Rx Card provides free prescription assistance to all residents; unclear about specific programs targeting inmates.
Tennessee	Medicaid enrollment was generally completed, the respondent reported that the department of corrections does not track this information.	Bridge medication supplies of either 14-30 days or more than 30 days are provided, depending on an individual's condition(s). Tennessee

		indicated that neither supply duration is more prevalent than the other.
Texas	Medicaid enrollment was generally completed, the department of corrections does not track this information. Care continuity planning begins once the inmate's release date is known or parole vote is received.	6-13 for select individuals; the supply of bridge medication provided varies by condition. Controlled substances are not provided. The duration of medication typically provided for chronic hepatitis C was unclear.
Utah	Release planning begins one to 20 days before release for Medicaid applications, and over 90 days from release date for those with chronic noncommunicable and infectious diseases. A 30-day bridge supply of psychiatric medication, and a 14-day supply of medication for chronic medical conditions, is provided.	14-30 days for select individuals
Vermont		14-30 days for all individuals
Virginia	In addition to the care continuity services in the survey, Virginia provides case management for HIV-positive offenders.	14-30 days for all individuals
Washington		14-30 days for all individuals
West Virginia	The department of corrections is not aware of any requirements for Medicaid managed care plans to provide care continuity programs/services to inmates transitioning from prison to the community. It was unclear whether facilities have care continuity programs/services.	
Wisconsin	Unclear whether Medicaid managed care plans are required to provide care continuity programs/services to inmates transitioning from prison to the community. Medical records are not provided to individuals or their community providers at re-entry, individuals do receive a discharge summary. It is unclear whether coordination occurs between prison facilities and community supervision personnel. In addition to targeting those with HIV/AIDS, chronic hepatitis C, mood disorders, personality disorders, and psychotic disorders, the department also targets care continuity services for those with "complex medical needs."	14-30 days for all individuals
Wyoming		14-30 days for all individuals