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Medication Access Using An Evidence-Based Adaptive Transitional Care Guidance Tool For Planned Release Of Older Inmates

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Abstract

The aging population is growing faster in the correctional system than in the overall U.S. population. Yet, an effective geriatric transitional care process is not available for older persons released from jail. This article documents the development and results of an evidence-based, adaptive transitional care tool guided by Meleis' transitions theory to improve access to medications for older persons released from jail. Three sources of evidence were used to develop the tool: different categories of literature, expert panel determination of the tool's domain and content relevance and importance, and a focus group interview of five people working in a transitions clinic. More research is required to validate the tool in the field.

Keywords: Correctional system, geriatric, transition, medication, community providers

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The growing U.S. prison demographic has shifted to older inmates (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). Older incarcerated persons often have multiple chronic conditions and physical disabilities common to aging (Kim & Peterson, 2014). Prisoners who have undiagnosed or untreated health conditions, such as mental illness, often re-offend and return to jail (Kim & Peterson, 2014). Although incarcerated persons receive health care, including medications, an effective model of a geriatric transitional care process is not available in anticipation of being released to the community health system. Due to strict correctional facility policies, this population lacks knowledge about their disease, self-management skills, and the ability to take multiple daily medications (Thomas, Wang, Curry, & Chen, 2016).

The increasing aging population has a significant impact on the growing health crisis in the correctional setting, which further influences state and local budgets because 95% of inmates are released and health care costs shift to the state or county where the person is released (Williams et al., 2012). Most incarcerated persons return to disadvantaged neighborhoods and place an added strain on the health care systems there (Nowotny, Cepeda, James-Hawkins, & Boardman, 2016). Little research exists on older incarcerated persons, creating a need to understand who they are and the nature of their health care needs, especially if they are eligible for Medicaid upon release (Nowotny et al., 2016).

A person's Medicaid benefits are suspended or terminated when incarcerated (National Reentry Resource Center, 2013). Officials in most states either do not understand that they have the option to suspend Medicaid (versus terminate) or do not have a system in place to do so since Medicaid redetermination is required every 12 months (National Reentry Resource Center,

2013). Reinstating Medicaid is more difficult for inmates at the time of release due to the documentation required, and medication supply may deplete before reinstatement. With little or no income upon release, incarcerated persons rely on medication coverage through Medicaid.

Although the Medicaid application process is an essential first step, it does not guarantee that an individual will get an appointment to see a primary care provider or understand how to manage a complex medication regimen. Improved communication between the correctional system staff and community providers may contribute to more effective transitions and improved outcomes. A geriatric transitional care tool, therefore, may help to reduce avoidable emergency department visits, hospitalizations, or even deaths.

Current care in a correctional facility is often episodic and fragmented, creating a high risk for the interruption of and eventually a breakdown in patient care (Strugar-Fritsch & Follenweider, 2016). The multiple health care needs of older incarcerated persons are often addressed separately with minimal sharing of information, including medical records. This lack of disclosure poses the biggest problem for older incarcerated persons with severe mental illness who also have other comorbidities (Strugar-Fritsch & Follenweider, 2016). To prevent loss of primary care, medication delays, and overlooked medical issues, a team-based approach for the inmate's health care needs and collaboration with community health providers is needed. Effective transitional care requires communication; hence a transitional care tool to support relevant communication is a necessary first step.

The Transitional Care Model is a rigorously-tested, nurse-led model that addresses the health of populations with complex health care needs, such as older adults (Hirschman, Shaid, McCauley, Pauly, & Naylor, 2015). It is a collaborative approach that provides continuity of care and assistance with self-management of health conditions to reduce hospitalization and

improve health outcomes (Hirschman et al., 2015). Core concepts found in the Transitional Care Model influenced the development of the evidence-based guidance tool described in this article. These include health screening, current symptoms of chronic and acute health problems, cognition, mental illness, substance use and current medications.

The concept of transition is the path between one life situation (e.g., incarceration) to another (e.g., release) and can cause instability for the person transitioning at any age but especially as a person gets older (Schumacher, Jones, & Meleis, 2010). The duration of incarceration, health status, access to primary care and medications, access to stable housing, food security, and support systems can influence a response to transition from the correctional to the community setting. Strategies for a successful transition are the development of new skills and a sense of stability, which only happen over time and are a challenge for older incarcerated persons (Schumacher et al., 2010). The role of the nurse is to help the person transitioning by assessing their needs and by activating the resources required for transition (Schumacher et al., 2010). This article documents the development and results of an evidence-based, adaptive transitional care guidance tool based on Meleis' theory of transitions (Meleis & Trangenstein, 1994) to improve access to medications in the community health system for older incarcerated persons soon to be released from jail.

Methods

Evidence to establish the domains for the tool was obtained from three sources: literature search, expert panel, and focus group. The literature search included peer-reviewed articles obtained from the Ovid Medline, Ovid PsycINFO, and CINAH databases; the National Criminal Justice Reference Service Abstracts Database Search; and government websites and websites related to prisons and prisoners. The later included the National Council on Aging; The Pew

Trust Charitable Fund; Urban Institute; U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; Prison Policy Initiative; and the National Reentry Resource Center. These sources of evidence established the problem addressed in this article - medication access - and was the foundation for establishing the domains for the tool. Table 1 contains summary of relevant literature and is organized as follows: 1) Peer-reviewed research on the Transitional Care Model for older adults; 2) Peer-reviewed research on the characteristics of older incarcerated persons and their health problems and access to medications; 3) Government reports and other reports on the aging incarcerated population; and 4) Peer-reviewed research on reentry programs and access to primary care or medications for incarcerated persons in prison or jail.

The second source of evidence was an online review and rating of the evidence-based domains and content for the tool by an expert panel guided by Meleis' theory of transition (Meleis & Trangenstein, 1994). The expert panel included researchers and clinicians who have published in transitional care related to specific diseases (e.g., HIV infection and substance abuse) and the needs of released persons, as well as experts from the Montgomery County (Maryland) Correctional Facility who prepare jail inmates for transition to the community health system (Table 2). A rating tool was developed to rate each domain and content for the tool aimed at relevance and importance.

The third source of evidence was qualitative data gathered during an in-person focus group interview with five people, all of whom worked at the Transitions Clinic, New Haven, CT. The members included two physicians, one social worker, and two community health workers. Of the five members, two were previously incarcerated. An experienced focus group leader (JC) conducted the focus group discussion using a script with open-ended, probing, and prompting

questions, along with follow-up questions as necessary. Formative evaluation was used for the focus group data analysis to identify and correct errors in the domains and valid content. The analysis employed grounded theory processes to recognize emerging patterns in the interview data (Belgrave & Seide, 2018). Data analysis consisted of reading the transcript from the focus group session and applying the key concept analytic framework and the academic research approach (Krueger & Casey, 2009, pp. 125 & 145).

Results

Literature Search

Synthesis of the literature provided details of studies examining the diseases that were commonly found in the older prison or jail populations and the need for continuity of care especially related to medication at reentry (Table 1). Two research studies revealed that intervention during incarceration provided the best approach and made a positive impact on health outcomes by providing continuity of care for the inmate and for community public health (Jordon et al., 2013; Teixeira, Jordan, Zaller, Shah, & Venters, 2015). These studies confirmed that the seriousness of illnesses was substantially worse in older inmates and had an impact on persons once released from prison or jail. Lack of care coordination was especially problematic for those with substance use disorders, infectious disease, or mental health problems and often led to re-incarceration (Teixeira et al., 2015).

Two studies addressed cardiovascular disease in released inmates and had a common theme of cardiovascular disease risks factors in inmates that led to death while in prison or once released from prison (Binswanger et al., 2007; Thomas et al., 2016). Thomas et al. (2016) reported that justice-involved persons suffer disproportionality from chronic conditions including

hypertension, diabetes, and other diseases that are risk factors for cardiovascular disease. Both studies described barriers to receiving continuity of care to manage cardiovascular disease and its risk factors, which created a health disparity because a large majority of inmates are non-white males (Binswanger et al., 2007; Thomas et al., 2016).

According to Mallik-Kane and Visher (2008), persons returning from incarceration are high users of emergency departments and hospitals. The report stated, "Many prisoners with health conditions did not receive treatment while incarcerated, and treatment rates decreased further upon release," (Mallik-Kane & Visher, 2008, p.1). Use of the Transitional Care Model by nurses has shown a reduction in emergency department visits and hospitalization in aging adults with multiple chronic conditions (Hirschman et al., 2015); studies are needed to determine if the same or a similar model could produce positive effects for persons released from jail.

Expert Panel Ratings

A ratings tool was developed for the expert panelists based on the evidence in the literature. Four domains were relevant to transition of older persons from the correctional health system to the community provider: cognitive impairment, chronic illness, acute illness, and medication management (Table 3). Within each domain, the following contents were found either relevant or important for the transition process: type of release, pattern of release, access to services, and personal readiness for re-entry. The expert panelists rated each of the domains and content based on a four-point Likert scale for relevance and importance (1=Not relevant at all, 2=Somewhat relevant, 3=Moderately relevant, 4=Very relevant). The same scale was used for rating importance. Each domain and content had to reach ≥ 78% agreement for relevance and importance for it to be considered a valid, evidence-based criterion for inclusion in the tool (Polit & Beck, 2008). If the content met this threshold for relevance but not importance, the content

was not included in the tool. The total percent score was calculated for each expert panelist's rating of the domains and content items. A second round of review, based on feedback from the first round, improved clarity of responses.

Some expert panel findings regarding the type of release (supervised, unsupervised, planned, and unplanned) and pattern of release (first versus multiple incarcerations) are noteworthy. Type of release was the only element rated ≥ 78% for the chronic illness domain. Pattern of release did not score ≥ 78% for any of the domains, indicating that the panelists did not consider first or multiple incarcerations to be an important factor. Access to services rated high for importance under all domains except acute illness. The expert panelists noted that acute illness during transition to the community health system likely involved admission to a hospital or rehabilitation facility.

Focus Group Themes

Three themes associated with medication access emerged from the focus group analysis: transition concerns, medication complexities, and change in environment (Table 4).

Transition Concerns. Focus group participants shared that neither the correctional system nor community health system takes responsibility for the health of the person returning from incarceration or connecting them with a primary care provider. One of the limiting factors for an incarcerated person's establishment of a relationship with a primary care provider soon after release is the amount of time to get an appointment, possibly due to lack of insurance. Focus group participants noted the lack of communication between clinicians in the community health system and clinicians/other professional staff in the correctional system. They believed that this lack of communication goes against the best interest of the person needing medical attention,

and that it was considered unethical especially when harm occurs. One focus group participant stated, "It's distorted in the fact that…we look at our patients with 'do no harm,' so how do you translate 'do no harm' in the context of lack of information, lack of, in some ways, humanism?"

Medication Complexities. Many older, incarcerated persons take medications for multiple chronic conditions, including those that require ingestion of food to avoid harmful side effects. The focus group discussed food insecurity related to being homeless or living in a shelter. While incarcerated, medications are distributed by nurses removing any responsibility from incarcerated persons for managing or knowing their medications. Furthermore, there is no plan to verify knowledge and skills prior to release from jail. These issues are exemplified in this respondent's comment:

> What we see happen…is that because people do have access to medication and they get that 30-day voucher [in Connecticut]…and they have so many other things that they need to do, they need to get an ID, they have to find a place to live. They're like, 'Oh, I have meds for 30 days,' so then they don't even go seek primary care, even if they know that they're going to need these meds. Then they get to like a week out from the meds running out, and…say, 'Oh, let me see if I can get an appointment.' And their appointment is like 2 months from there and they run out. And then… 'Oh, I'm going to have to go to the emergency room and see if they'll give me enough to last me until I can get in to see a doctor.'
>
> So even though they may document that, oh, everybody came out with a voucher…all these other competing factors can be for those who didn't get the medication. If there's some condition again, the population of low health literacy…if it's not something that's aching or at the time is not important because there's no immediate pain or fever, so it's

like, 'I don't feel anything.' So, the medications don't really matter at that time. So that education part at times is missing.

Change in Environment. Older incarcerated persons are leaving a structured environment with food, housing and medication to a very unstructured environment. The older person must plan where to live, how to get food, transportation and other immediate considerations, making access to medications less of a concern. This is further described by one respondent's comment:

> Imagine a person that is staying at a shelter. The important part is holding onto his medication, so nobody takes his medication. Because if a physician fills his medication…he's got a medication from his vouchers for 30 days and it gets stolen, then you have to fill out a police report….
>
> …this man came to our office and was just like, 'Look at all these freaking pieces of paper that I have.' And he was just like an older man who had just used alcohol through the years, and probably, that's had some effect on him, you know, brain functioning. He took out a mountain of papers. It was probably informational stuff he got here and there…and it was in a pile, and he just took that pile and put it on the desk.

The focus group participants agreed about the lack of coordination of any aspects of care when people are released, and medications are often not a priority for the returning older person who has no place to live and no food. Someone released under probation may have a better chance of getting connected with services because of the efforts of the probation officer, but probation was described as "having a dog chain around your neck."

Relevant and important domains identified through the literature, expert panel findings and focus group remarks included the impact that cognitive abilities, chronic and acute illness, and medication management skills have on successful medication access during transition. These were used to construct an evidence-based tool that is brief yet comprehensive (Figure 1).

Discussion

A surprising finding from the expert panel was that pattern of release from jail was not important. In comparison, unhealthy transitions may have occurred after each release such as lack of options (e.g., access to primary care), restructuring life routines (e.g., established medication routines), and decline in health due to lack of continuity of care for the older person released (Schumacher et al., 2010). Transitional care efforts focusing on process indicators or measures of readiness for release from jail, especially for someone incarcerated multiple times, were not considered.

Lack of communication between two systems described by the focus group may be related to insufficient nursing staff in the correctional system or other competing priorities for the nurses, but this was not mentioned. A limitation related to the focus group interview was that some discussions centered on prison and not jail and were not considered in the analysis but raised awareness that medication access for older persons released from prison was also important. Another limitation was that the qualitative data analysis was based on one focus group and ideally, more data were needed from several focus groups to reach thematic saturation.

Strengths of both the expert panel and focus group members included their level of knowledge and experience working with the incarcerated population. A strength of the literature was the various types of correctional facilities and geographic locations providing insight into

the similarities and differences across facilities and locations. Synthesis of the literature provided a foundation to develop the domains and content for the expert panelist to rate. The literature also reflected age and gender gaps as most of the research included only young men in prison or jail.

Conclusions

Review of the literature, expert panel, and focus group provided information that guided the development of the tool with the Meleis' theory of transition (Meleis & Trangenstein, 1994) as the framework. Although some reentry programs for incarcerated populations begin to build the bridge between life incarcerated and life outside, communication on the health of older incarcerated person and access to medications upon release is lacking. A simple, evidence-based, tool may provide the communication needed between the correctional system staff and the community health provider, prevent unnecessary health care utilization, and improve the health outcomes of older persons returning to the community from jail.

Further research is needed to test the usefulness and completeness of the tool. Its effectiveness in conveying important information, ease of use, and any gaps in information or lack of clarity need to be determined. In addition, research is needed to determine how the tool can assist in development of more comprehensive programs of transitional care for this population, such as a nurse-driven Transitional Care Model targeting this high-risk group.

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Table 1 Summary of Relevant Literature

Transitional Care Models for Older Adults Going from Hospital to Home		
Authors	**Short Titles/Journals**	**Key Findings**
Naylor et al., 2017	"Components of Comprehensive and Effective TC"—*Journal of American Geriatrics*	Patient Centered Outcomes Research Institute–funded study showed that health systems should employ strategies that address all critical components of a transitional care model and target patient and caregiver's optimal outcomes, though at varying degrees (p.1119).
Hirschman et al., 2015	"Continuity of Care: The Transitional Care Model"—*Online Journal of Issues in Nursing*	Provided a detailed summary of the evidence for the transitional care model (p. 1). Multiple studies found that poorly-managed health care needs of older adults with multiple chronic conditions lead to poor outcomes (p.1).
Nelson & Pulley, 2015	"Transitional Care Can Reduce Hospital Readmissions"—*American Nurse Today*	Identified problem with readmission rates, compared transitional care models, and discussed strategies for effective care transitions (p.1). A bundle of activities effectively decreased hospital readmissions (p.8).
Naylor et al., 2013	"High-Value Transitional Care: Translation of Research into Practice"—*Journal of Evaluation in Clinical Practice*	Research demonstrated that the transitional care model for older, chronically ill adults provides real-world evidence that achieves high value for a health system (p.727).
Characteristics of Older Incarcerated Persons: Health Problems and Access to Medications		
Authors	**Short Titles/Journals**	**Key Findings**
Peer-Reviewed Journals		
Nowotny et al., 2016	"Growing Old Behind Bars: Health Profiles of the Older Male Inmate Population in the United States"—*Journal of Aging and Health*	Awareness of older inmates' complex medical conditions helps to prepare proper care once released and provides crucial information for community health care providers (p.950).
Williams et al., 2012	"Addressing the Aging Crisis in U.S. Criminal Justice Health Care"—*Journal of American Geriatrics Society*	Research on the growing aging population in the prison required for appropriate programs based on geriatric care models (p.1155).
Government Reports		
Office of the Inspector	"The Impact of an Aging Inmate Population on the	Aging inmate demographics creates higher costs for care (pp.1-14). Staff training also

General—U.S. Department of Justice	Federal Bureau of Prisons" (2016)	necessary for older inmates (p.14). Facilities are understaffed for older prison inmates (pp.17-23).
Other Reports		
Kim & Peterson, 2014	"Aging Behind Bars: Trends and Implications of Graying Prisoners in the Federal Prison System"—Urban Institute	Number of older inmates is expected to grow (p.24). More guidance is needed on how best to handle the growing crisis due to substantive gaps in the research (p.24).
Reentry Programs and Access to Primary Care/Medications for Incarcerated Persons in Jail or Prison		
Authors	**Short Titles/Journals**	**Purpose/Outcome of Interest**
Riedel et al., 2016	"Medicaid Enrollment Initiative"—*Journal of Correctional Health*	A semi-structured interview of 17 subjects who planned or implemented the Medicaid program in Cook County Jail (p.190). Several strategies increased Medicaid enrollment (pp.191-192).
Springer, Altice, Brown, & Di Paola, 2015	"Retention in Naltrexone Treatment in HIV-infection and Release"—*Drug and Alcohol Dependence*	Double-blind, placebo-controlled RCT examined extended-release naltrexone for inmates who are HIV infected and either alcohol or opioid use disorders (p. 158). Subjects often failed treatment (return to clinic post-release for second injection) due to relapse in drug use (cocaine) (p.164).
Dennis et al., 2015	"HIV Care and Adherence to Medication after Release"—*Journal of the Association of Nurses in AIDS Care*	"Most HIV-infected inmates leave prison with a suppressed viral load; many, however, become disconnected from care and nonadherent to medications during reentry to community life" (p.554).
Fox et al., 2015	"Buprenorphine Maintenance after Release"—*Addiction, Science & Clinical Practice*	Lack of early reentry services for opioid addiction leads to cycle of incarceration, release, relapse, criminal activity and re-incarceration (p.7).
Teixeira et al., 2015	"Health Outcomes for HIV-infection after Release"—*American Journal of Public Health*	Research documents HIV-infected people released from a New York jail who accepted a transitional care plan during incarceration had improved outcomes 6-months after release (p. 351).
Chodos et al., 2014	"Older Inmates and Community Acute Care Use"—*American Journal of Public Health*	Cross-sectional study evaluated jail inmates 55 years or older and anticipated post-release acute care use (p.1728). Subjects most likely to use acute care after release were likely to have congestive heart failure, poor or fair self-reported health, and falls (p.1730).

Haley et al., 2014	"Engagement in HIV Care after Release"—*Public Health*	Social cognitive theory and the HIV stigma framework may help in reducing the stigma of engagement for HIV-infected persons post-release (p.13).
Fox et al., 2014	"Health Outcomes and Retention in Care after Release"—*Journal of Health Care Poor Underserved*	Retrospective cohort study of care delivery and health outcomes for recently-released inmates found that < 50% of patients were retained in care at 6 months and many failed to achieve optimal outcomes (p.1145).
Jordan et al., 2013	"Transitional Care Coordination for HIV-infection"—*AIDS Behavior*	Documented a population approach to identify HIV-infected inmates and initiate discharge planning on admission (p.S212). The number of people leaving jail with linkage to a primary care upon release increased (p.S217).
Althoff et al., 2012	"Correlates of Retention in HIV Care after Release"—*AIDS Behavior*	HIV care post-release is important to maintain health and linkage to HIV treatment through community-services may improve the health of the person and the community (p. S168).
Wang et al., 2012	"Engaging Individuals in Primary Care after Release"—*Research and Practice*	Hypothesized that connecting inmates with primary care early after release would improve health outcomes due to health care access. Both groups had similar rates of primary care utilization but the transitional care clinic participants had fewer emergency department visits (p.e22).
Baillargeon et al., 2009	"Psychiatric Disorders and Release"—*American Journal of Psychiatry*	Found that inmates with a major psychiatric disorder were more likely to have been incarcerated previously (p.103). Mentioned benefits using a continuity of care reentry program to help mentally ill inmates access community reduce recidivism (p.103).
Draine & Herman, 2007	"Critical Time Intervention for Mentally Ill after Release"—*Psychiatric Services*	This interventional model had the promise to provide support for persons with mental illness released from prisons or jail (p.1577). Best results occurred with assertive community treatment (p.1580).
Binswanger et al., 2007	"High Risk of Death after Release"—*New England Journal of Medicine*	Study documented that over a period of 2–3 years, morality risk for released inmates increased by a factor of 3.5 compared with the general population (p.161).

Table 2 Brief Biographies of Expert Panelists

Emily Wang, MD, **MAS,** Associate Professor at the Yale School of Medicine and Co-founder of the Transitions Clinic Network. Research focuses on promoting health equity for vulnerable populations, especially individuals with a history of incarceration, through both prison and community-based interventions.
Cheryl Dennison Himmelfarb, PhD, RN, ANP, AAN, FAAN, FAHA, FPCNA, Associate Dean Research, Office of Science and Innovation, Sarah E. Allison Professor for Research and Self-Care, Johns Hopkins School of Nursing.
Marc Stern, MD, MPH, Affiliate Assistant Professor, Health Services at the University of Washington, School of Public Health. Previously served as Assistant Secretary for Health Services for the Washington State Department of Corrections.
Aaron Fox, MD, Associate Professor of Medicine and a Clinician-Investigator in the Division of General Internal Medicine at Albert Einstein College of Medicine, Montefiore Medical Center.
Anthony M. Sturgess, RN, MSN, Chief, Medical and Behavioral Health Services, Montgomery County Department of Correction and Rehabilitation.
Kendra Jochum, **LCSW-C,** Oversight of Reentry Services and Program Development for Pretrial and Sentenced Inmate Populations at Montgomery County Correctional Facility, Montgomery County, MD.
Meg Lindberg, **LCSW-C,** Supervisory Therapist coordinating transitional services for a segment of the inmate population at Montgomery County Department of Corrections and Montgomery County Correctional Facility, Montgomery County, MD.
Melissa George, **LCSW-C,** Clinical Reentry Social Worker coordinating reentry services and programs at Montgomery County Correctional Facility, Montgomery County, MD.
Asa Briggs, **RN, MSN,** DNP Student Yale University, Psychiatric Mental Health Nurse Practitioner/Director of Psychiatry at Unity Health Care, Inc., for the DC Jails, White House Advisor for President Obama's My Brother's Keeper Initiative.

Table 3 Valid Domains and Content

Domain	Relevant	Important	Content	Relevant	Important
Cognitive Impairment	100%	100%	Type of release Pattern of release Access to services Personal readiness for reentry	75% 72% 96% 83%	72% 67% 96% 94%
Chronic Disease	100%	100%	Type of release Pattern of release Access to services Personal readiness for reentry	83% 67% 85% 83%	83% 67% 85% 75%
Acute Illness/care	89%	89%	Type of release Pattern of release Access to services Personal readiness for reentry	72% 61% 74% 79%	67% 61% 74% 67%
Medication Management	100%	100%	Type of release Pattern of release Access to services Personal readiness for reentry	61% 72% 71% 64%	58% 72% 78% 72%

Note. A standard of .78 (78%) positive response to the ratings of each domain or content item and .90 for total scores reflects an agreement that is greater than chance; total scores were calculated by averaging results across items (Polit & Beck, 2008).

Table 4 Focus Group Themes

Transition Concerns - Lack of communication between the correctional system staff and community health system staff regarding the health of the person and connecting them with a primary care clinic - Primary care appointment wait time is approximately 6 months, possibly due to lack of benefits or reinstatement of benefits - Correctional system built around security or public safety and not the health of the person incarcerated
Medication Complexities - Health and medication literacy problems - Food insecurity prohibiting ingestion of some medications
Change in Environment - Transition to an unstructured environment - Medication self-management skills lacking (e.g., reminders, refills) - Lack of housing after reentry contributing to loss of or theft of medications or medication vouchers (homeless shelter, homeless living on the streets)

Figure 1: Evidence-based, Adaptive Transitional Care Tool for Planned Release of Older Incarcerated Persons

Patient Details:
Name of Person Being Released:
Date of Birth:
Gender:
Duration of Recent Incarceration:
Facility Name:
Facility Address:

Contact Person Completing the Tool (Name and Number):

Release Details:
Contact Person (family, friend, parole officer, primary care provider):

Planned Date of Release:
Planned Release Location (home, shelter, nondisclosed):
Need for Hospitalization/Urgent Treatment: YES ☐ NO ☐
Details:

Access to Community Services Needed (e.g., transportation, food, housing, primary care, etc.): YES ☐ NO ☐
If Yes, which services are needed (list all that apply)?

Diagnoses at Release (Chronic illnesses: e.g., hypertension, diabetes, asthma, substance use disorder, infectious disease, etc.):
1.
2.
3.
4.

Other Health/Social History:
1.
2.
3.
4.

Physical Ability and Cognitive Function at Release:
NO ISSUES ☐
Physical:

Cognitive:

Cognitive Testing Done: YES ☐ NO ☐

Other:

Medication List and Reason for Medications: NONE ☐

1. Med Name:	Reason:
2. Med Name:	Reason:
3. Med Name:	Reason:
4. Med Name:	Reason:
5. Med Name:	Reason:
6. Med Name:	Reason:

Able to Access Medications: YES ☐ NO ☐

Recommendations: YES ☐ NO ☐

Able to Manage Medications: YES ☐ NO ☐

Recommendations: YES ☐ NO ☐

Relevant Legal Information (e.g., released on probation or parole, diminished mental capacity, etc.): YES ☐ NO ☐

Behavioral Issues (e.g., if diabetic, becomes aggressive with low blood glucose level, triggers including restraints, etc.):
YES ☐ NO ☐
If YES, describe in detail:

Benefits (e.g., Medicaid or Medicare, other): YES ☐ NO ☐
If NO, Plans to Obtain Benefits: