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the State of Louisiana**

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CARING FOR THE INCARCERATED PATIENT: PROVIDER PERCEPTIONS OF QUALITY OF CARE IN THE STATE OF LOUISIANA

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Background: As of December 2023, there were roughly 28,000 people held in state custody in Louisiana. Prior research and litigation have documented challenges with healthcare service delivery within prisons, but less is known about the higher acuity care incarcerated people receive at state-contracted hospitals.

Methods: Between November 2020 and January 2021, authors conducted semi-structured interviews with a convenience sample of Louisiana healthcare professionals about their experiences of providing incarcerated people care at hospitals. Interviews were audio-recorded and transcribed verbatim. Authors used applied thematic analysis techniques to synthesize qualitative data and identify themes.

Results: Nine health professionals with diverse roles and specialties participated. Eight of nine providers expressed concerns that prisons do not provide adequate care to individuals in their charge, seven reported that incarcerated patients present to the hospital with late diagnoses or in terminal states of illness, and eight identified policy and systems barriers having a negative effect on care delivery.

Discussion: Findings in this study are consistent with previous research demonstrating that incarcerated people in Louisiana receive inadequate healthcare. Providers at state-contracted hospitals may be unaware of how to improve care for incarcerated people. Educational campaigns and organizational support to enhance coordination between prisons and external hospitals and clinics may improve the quality of care incarcerated people receive.

Conclusions: Healthcare providers perceive incarcerated people to receive inadequate quality of care, and there are steps organizations can take to improve this care.

KEYWORDS: incarceration, health care, provider, quality of care



BACKGROUND

As of December 2023, Louisiana had the highest rate of incarceration in the United States, with a rate of 1,067 people per 100,000, almost double that of the U.S. rate of 614 per 100,000.¹ In 2021-2023, roughly 50,000 people were held in over 100 prisons, jails, detention centers, juvenile facilities throughout Louisiana. Roughly 28,000 of these individuals were in custody of the Louisiana Department of Public Safety and Corrections (DPSC) and housed in a variety of state prisons, as well as local jails.² There are notable racial disparities in incarceration in Louisiana. Roughly 12% of the state's overall population is Black, yet Black people comprise about half of Louisiana's prison population.^{3, 4}

Incarcerated people have significant medical and mental health needs.⁵ Roughly half of people incarcerated in state or federal facilities in the U.S. report having a chronic condition such as hypertension or cancer, and 17% report having had an infectious condition such as tuberculosis or HIV.⁶ In one national sample, approximately one quarter of people in state facilities were found to have a prior diagnosis of any mental health condition including but not limited to major depressive disorder, bipolar disorder, schizophrenia, and post-traumatic stress disorder.⁷ A recent Louisiana estimate suggests the number of incarcerated people with a mental health conditions may be as high as four in 10.⁸ Carceral facilities are required to provide healthcare to incarcerated individuals under the U.S. Constitution. Care must also be equivalent to the care provided in community settings, as established in *Estelle v. Gamble* and *Farmer v. Brennan*.^{9, 10} Failure to provide appropriate care for people in custody post-conviction may be considered "cruel and unusual punishment" under the 8th Amendment to the Constitution.¹⁰

Nationally, the mean annual healthcare cost for an individual incarcerated in a state system is roughly

\$5,700, but DPSC spends just under \$2,200 per individual per year.¹² These costs include hiring providers to work at onsite prison-based health facilities, as well as contracts with external hospitals and clinics to provide emergency and/or specialized services. Contrary to the standards issued by the National Commission on Correctional Health Care, DPSC has conceded to hiring physicians whose licenses are restricted.¹³ These providers may not have the same level of training or supervision as providers practicing in community settings and may have a restricted license due to misconduct.

A federal judge recently found the healthcare offered at the largest DPSC facility, Louisiana State Penitentiary (LSP), is inadequate under constitutional standards.¹⁴ LSP, widely known as Angola, is located on a former plantation that was named after the homeland of the enslaved people who were forced to work its fields.¹⁵ Both men and women who have been incarcerated in Louisiana reported barriers to care including cost-prohibitive co-pays, lack of respect from providers, having health concerns ignored, and difficulty accessing off-site care for high-acuity needs.^{16, 17, 18}

In 2020, the Louisiana Legislature adopted House Concurrent Resolution 91 (HCR 91), which requested a multi-stakeholder study committee assess the adequacy of health services provided to people in Louisiana prisons, including services provided at contracted off-site facilities.¹⁹ As part of the HCR 91 study, the authors aimed to assess external providers' perspectives on the quality of care provided by DPSC, barriers and facilitators of providing care to incarcerated patients, and processes for coordinating care between DPSC facilities and external hospitals and clinics.

METHODS

The authors conducted semi-structured interviews of Louisiana health professionals from a convenience sample

about their experiences with providing services for incarcerated people at external (non-DPSC) hospitals and clinics. Study team members collaborated to develop a semi-structured interview guide. Topics included professional background, general experiences with serving currently and formerly incarcerated patients, common reasons for patient presentation at a hospital or clinic, protocols for follow-up care and communication, and general impressions of care provided in prisons.

Study team members recruited potential interviewees through faculty meetings at Louisiana universities, listservs of faculty and clinicians at academic institutions, and word of mouth. No attempt was made to include specific specialties or representation of different care providers in the recruitment process. Eligibility criteria included: being age 18 or older, speaking English, and being a member of a health care team at a non-DPSC facility that provides health care services to incarcerated people in Louisiana.

Potential participants who expressed interest and scheduled an interview received a link to a password-protected online meeting room. A study team member confirmed eligibility and obtained verbal consent to participate and record the interview. Participants provided basic demographic information including race, ethnicity, gender, and level of education. All interviews occurred between November 2020 and January 2021. One team member led each discussion, and another took notes. Interviews were audio-recorded and transcribed verbatim by a professional transcription service.

The qualitative data were analyzed using thematic analysis techniques. One researcher independently reviewed all transcripts and developed an initial codebook based on the transcripts and the interview guide. Two researchers then independently coded interviews, then met

to review and resolve discrepancies in coding. They used codes to identify major themes and subthemes and exemplar quotations. A threshold of at least two thirds of participants (6) expressing a similar viewpoint was considered a theme. Subthemes were identified when at least three providers discussed a topic related to one of the main themes.

Research procedures were approved by the Institutional Review Board at LSU Health New Orleans (#694).

RESULTS

Nine health professionals agreed to participate in an interview. Seven were physicians who worked at a total of three different Louisiana hospitals that serve currently incarcerated individuals. Physicians' specialties included internal medicine, surgery, and emergency medicine. One physician had experience working in prisons. Study team members also interviewed two community health workers who provided health system navigation and health education for formerly incarcerated individuals. Table 1 contains a summary of participant demographics.

Three main themes were identified within the data. First, eight of the nine providers expressed a belief that healthcare for incarcerated people in Louisiana is inadequate. Provider 2 stated, "*I think it's definitely a substandard system. There's the healthcare that everybody else gets, and then there's the healthcare that incarcerated people get...the standard of care is not met.*" There were concerns about access to preventive care, with one health professional saying, "*It doesn't sound like they have access to preventive care... the overwhelming story that we get from people is that just doesn't exist.*" Seven providers expressed concerns that patients were not "*offered treatment*" for some conditions such as Hepatitis C., "*...and so then the Hepatitis C...has been allowed to just run*

Table 1. Interviewee demographics (n=9)

	Mean (SD)	Range
Age	48.2 (12.7)	31-69
Race	n	%
Asian American	1	11
African American/Black	3	33
White	4	44
More than one race	1	11
Ethnicity		
Hispanic or Latino	1	11
Not Hispanic or Latino	8	89
Education		
High school or GED	1	11
Some college	1	11
Professional Degree	7	78
Gender		
Woman	7	78
Man	2	22
Services Provided		
Currently provide services to incarcerated people	7	78
Currently provide services to formerly incarcerated people	2	22

indolently for years or decades and then has advanced to hepatocellular carcinoma.”

Behavioral health conditions were also perceived to be undertreated. Provider 4 stated, *“A lot of them, they have mental health issues and they come in here and they never got treated on the inside,”* while Provider 6 was, *“suspicious that psychiatric concerns are undertreated within the system on a whole.”* Provider 1 was particularly concerned about treatment for opioid use disorder, saying, *“it's wildly mismanaged in terms of nobody being offered medication assisted treatment and just sort of put into withdrawal with no symptom management at all, which can in and of itself be life-threatening.”*

Six providers perceived that incarcerated patients were treated poorly by prison staff. For example, when patients requested care, *“nothing was done.”* Provider 3 said, *“From what the patients tell me, it's that they've been complaining... for many months to years and have been dismissed.... they'll come in because, ‘they couldn't ignore the fact that I can't*

walk anymore.” There was a general sense that incarcerated people are treated with disrespect, with Provider 8 noting, *“it'd be nice if these patients were treated as people.”* Three interviewees also commented on how such disrespect may create a barrier to their ability to provide care. Provider 5 stated *“...[patients] come out of a traumatic environment in prison...they don't really have that trust for doctors, you know?”* Another health professional explained the need to establish rapport with patients *“because you're asking questions, and then they want to know, well, ‘why are you asking me all these questions?’”*

Interviewees highlighted several other important barriers to care during incarceration, including a concern that prisons *“don't have the capacity or the equipment or the manpower to fulfill that mission of adequately meeting the needs of the people coming into the prison.”* Health professionals noted that incarcerated people need to *“get approval from the overseer before they actually get to see a physician. And it's based on his*

Table 2: Theme 1: Care provided to incarcerated individuals is inadequate

Theme	Illustrative quotes	N*
Substandard care	<i>"I think it's definitely a substandard system. There's the healthcare that everybody else gets, and then there's the healthcare that incarcerated people get. I think there's very clear and specific instances in which the standard of care is not met... the most egregious which is age-appropriate cancer screening. It's clearly mandated. It's one of the clearest public health guidelines in this country and that is not happening on a sustainable basis as far as I can tell with people who are incarcerated."</i> – P2	8
Lack of preventive care, including screenings	<i>"It doesn't sound like they have access to preventive care... the overwhelming story that we get from people is that just doesn't exist."</i> -P2 <i>"And I'm not sure that at the facilities that they were doing regular health checkups... Like colonoscopies, there's no way that every 50-year-old was getting sent to us for a colonoscopy."</i> -P8	3
Treatment for curable or manageable conditions not offered	<i>"So, people that haven't been tested for Hep C or if they have been tested, have not been offered treatment. And so, then the hepatitis C...has been allowed to just run indolently for years or decades and then has advanced to hepatocellular carcinoma."</i> -P1 <i>"They have told the guards or whoever's in charge of medical personnel that they weren't feeling better, or they weren't getting better, and nothing was done."</i> -P7 <i>"From what the patients tell me, it's that they've been complaining... for many months to years and have been dismissed....they'll come in because, 'they couldn't ignore the fact that I can't walk anymore.'" – P3</i>	7
Limited mental health treatment	<i>"A lot of them they have mental health issues and they come in here and they never got treated on the inside."</i> -P4 <i>"And I also am suspicious that psychiatric concerns are undertreated within the system on the whole."</i> - P6	4
Challenges obtaining necessary medications	<i>"Opioid use disorder... it's wildly mismanaged in terms of nobody being offered medication assisted treatment and just sort of put into withdrawal with no symptom management at all, which can in and of itself be life-threatening from seizures and severe dehydration. And is not the standard of care and is not even the national standard of care in department of corrections across the country. So, we're quite behind on that."</i> - P1	6
Concerns ignored	<i>"They have told the guards or whoever's in charge of medical personnel that they weren't feeling better, or they weren't getting better, and nothing was done."</i> -P7 <i>"From what the patients tell me, it's that they've been complaining... for many months to years and have been dismissed....they'll come in because, 'they couldn't ignore the fact that I can't walk anymore.'" – P3</i>	4
Patients lack trust in the medical system due to substandard care	<i>"You know, I think the biggest barrier is doubt... [patients] come out of a traumatic environment in prison, especially people who've been down 30 and 40 years. They have been through such a traumatic experience that they don't really have that trust for doctors, you know...They been in prison, so they don't really trust doctors."</i> - P5 <i>"I think that's important because a lot of times people from prison, don't really trust just regular providers. And sometimes I even have to break the ice with them before they even open up to communicate with me because you're asking questions, and then they want to know, well, why are you asking me all these questions?"</i> -P4	3
Inadequate staff	<i>"They don't have enough staff for the number of prisoners there. [Prisons] don't have the capacity or the equipment or the manpower to fulfill that mission of adequately meeting the needs of the people coming into the prison because they're coming in so fast. - P5</i>	4
Non-medical staff determine who will be seen by a physician	<i>"They have to get approval from the overseer before they actually get to see a physician. And it's based on his opinion of them basically. If he's a person that probably don't cause any trouble, maybe he'll get seen."</i> - P4 <i>"...the EMT...they go direct to security and get his opinion... And then that would determine whether [the patient would] get adequate treatment or not. It's always security first..."</i> - P5 <i>"Well, it depends on where it's at. If you're in the general population, you'll get a thorough checkup from time to time. If you was in cell blocks at Camp J was maximum security area where they feel like, 'Why are you there? You in there, you're a troublemaker,' so you didn't get the same attention."</i> -P5	6

*number of providers who commented

opinion of them basically. If he's a person that probably don't cause any trouble, maybe he'll get seen." Provider 5 explained that incarcerated people are initially evaluated by "the EMT" who are trained security officers. One health professional explained that access to care may differ by level of custody by saying, "If you're in the general population, you'll get a thorough checkup from time to time," but in the "maximum security area...you didn't get the same attention." Table 2 provides a summary of the themes related to the providers' perceptions that care provided to incarcerated patients is inadequate.

The second major theme was related to concerns about patient presentation at the hospital, with a total of seven participants commenting on the issue. Seven participants shared the viewpoint of provider 3, who indicated, "There's a greater percentage of the incarcerated population that comes in with later disease." Provider 7 concurred, saying, "Usually when they're coming in, it's the end of their disease." Their providers mentioned patients having late stage cancer, with one saying prisons "never told them [patients] that they had cancer. And next thing you know it's at stage four." Another explained, "People are presenting very late in the process to palliative care when they could have had access to cancer modifying treatment earlier... Colon and prostate are two major ones that are getting missed." Provider 2 shared:

I've seen way more cases of obvious, advanced cancer than I think anyone should see with this... It's not something that you would have had happen if the person was not incarcerated. Horrible stories of young people with end-stage cancer that could have been treated. People with things like colon cancer and lung cancer which are incredibly treatable, by the time they come to us it's metastatic, everywhere, so they need to be on hospice.

Four interviewees mentioned that patients experience injuries due to violence. For example, Provider 2 told the story of an incarcerated patient who "...had just gotten

completely beat-up by a guard." Another provider said, "...it seems like 70% of them are trauma related, whether it's a broken bone or a head injury." Table 3 summarizes the findings related to patient presentation to hospital as perceived by the interviewees.

Finally, healthcare providers described some policy and system-level barriers to providing hospital-based care for incarcerated patients. One issue that five providers mentioned was that patients are required to be restrained to their beds. Provider 8 explained, "I think one of the mainstays of post-operative recovery is getting people up and walking and we can't do that. So, I do think that care is elongated, that they are at risk for post-operative blood clots and pneumonias." Another healthcare professional explained, "So, we're giving them medications to clear their bowels, but they can't make it to the bathroom in time because they have to call a guard to uncuff them from the bed."

Five providers agreed that there were issues with patient privacy due to guards being present during visits. One mentioned "times where the guards want to go in and are asking personal questions about somebody's medical condition." When asked about discharge paperwork, another provider stated, "I believe that the guard gets it. I don't think they [patients] actually get their own paperwork." Providers believed requirements for supervision of incarcerated patients led to delays in care. One professional explained, "They could be delayed by two hours, could be delayed by a couple of days. Just depends on when the guards are available."

Three providers raised concerns about the perceived lack of ability to obtain informed consent. Provider 1 shared:

So, the result is we had a patient who had brain surgery craniotomy, where they open up brain and all the notes said, 'Emergency consents obtained by two doctors.' No family was contacted...So, this person had a consenting relative who should have been called legally by Louisiana law and was not.

So that is completely beyond the standard of care.

Finally, six interview participants talked about the challenges with coordinating care between hospitals and prisons because there are no standard communication protocols or bi-directional access to medical records. Provider 1 mentioned calling medical directors at multiple facilities and said, “*They [prison providers] say they can read our record. I think they can. We can't read theirs. So, the issue though, is that there's so much turnover with these doctors. It's just a constant endeavor to try to figure out who to reach out to.*” Six providers commented on challenges related to follow-up care. As Provider 3 stated, “*You can make whatever recommendations for medications you want, because when they go back, they're just going to get whatever they get anyway.*” Another provider explained, “*The ongoing assumption is really among all the doctors is that pretty much no follow-up appointment will happen, and no follow-up care will happen...*” Provider 6 also highlighted the difficulties of ensuring patients receive follow-up care, saying, “*...we can't make appointments for them. They're not, for safety reasons, not allowed to have a clinical appointment given to them at discharge.*” Finally, provider 6 mentioned that patients often do not show up for follow-up visits, saying, “*I'm sure it's not because the patient didn't want to come and see an oncologist... I think there's some system-level barrier that is preventing them from being able to do that.*” Table 4 summarizes the key findings related to systemic barriers to providing care to the incarcerated population in Louisiana.

It is important to note that one healthcare provider, a physician, (Provider 9) who had worked in prisons offered a different view of several of these issues. This provider stated that incarcerated people have access to “*whatever the standard recommendations are*” for care including pap smears, colonoscopies, mammograms,

dental care, eye care, and an annual physical exam. Provider 9 said that incarcerated people who do not receive preventive services have chosen not to engage in such services. This provider believed that there was adequate care coordination between hospitals and prisons, stating, “*we just write whatever they need in the discharge summary. Follow up in 1 week, 2 weeks. Whatever we write down goes.*” This provider noted that medication formularies in prisons are reviewed regularly and that if there is a medication that an incarcerated person needs that is not on the formulary, “*they can get it.*” The provider spoke highly of the experience of treating incarcerated patients, noting that they are the “*Most appreciative people I take care of. Not even close. The thing is they have no choice. Not like 'I don't like Dr. X.' No, they are stuck. They can't doctor shop. We are all aware of that. They don't have a choice.*”

DISCUSSION

The study team conducted interviews with a convenience sample of healthcare providers who care for incarcerated people at state-contracted health facilities outside of Louisiana prisons. Overall, eight out of nine providers believed that incarcerated individuals in Louisiana do not have access to adequate healthcare. They reported that patients present at the hospital with late stages of disease and largely agreed that coordination of care between prisons and hospitals is poor. This research aligns with findings of litigation, prior research on formerly incarcerated individuals' perceptions of prison health care.^{14, 15, 16, 17} Furthermore, an 2019-2020 American Correctional Academy (ACA) audit of LSP noted that LSP did not complete approximately 50% of ordered specialty consults, consistent with the perceptions related to difficulties obtaining follow-up care noted by the providers in this study.^{20, 21}

Table 3: Theme 2: Incarcerated patients' presentation to hospitals

Theme	Illustrative Quotation	N*
Advanced disease	<p><i>"There's a greater percentage of the incarcerated population that comes in with later disease." - P3</i></p> <p><i>"Usually when they're coming in, it's the end of their disease." - P7</i></p> <p><i>"I would say, the patients that are coming from certain of the prisons tend to be a great deal sicker" - P6</i></p>	7
Advanced cancer	<p><i>"I have heard stories...where they never told them that they had cancer. And next thing you know it's at stage four." - P4</i></p> <p><i>"People are presenting very late in the process to palliative care when they could have had access to cancer modifying treatment earlier. And they wouldn't have gotten to stage four cancer either ever or not as quickly. So, stage four lung cancer, where if you started treatment at stage one, which we do in the community, you could have given this person years... And same for really every type of cancer that we're seeing in the community. It gets picked up because people have colonoscopies, and they have proper prostate screening. Colon and prostate are two major ones that are getting missed." - P1</i></p> <p><i>"I think the most obvious and most alarming example of that is cancer. I've seen way more cases of obvious, advanced, cancer than I think anyone should see with this... It's not something that you would have had happen if the person was not incarcerated. Horrible stories of young people with end-stage cancer that could have been treated. People with things like colon cancer and lung cancer which are incredibly treatable, by the time they come to us it's metastatic, everywhere so they need to be on hospice." - P2</i></p>	3
Injury due to violence	<p><i>"And it seems like 70% of them are trauma related, whether it's a broken bone or a head injury, which oftentimes during the arrest or some sort of, if they're involved with something at the facility and you get pinned down. Oftentimes kids will end up with a concussion. So, they come for those reasons." - P8</i></p> <p><i>"He was in his early 20s, but I think he was five foot two and weighed maybe a hundred pounds and he had just gotten completely beat-up by a guard. We asked him, do you want us to do anything about this? And he was like, please don't, because that's going to put me at so much more risk." - P2</i></p>	3

*number of providers who commented

The findings presented here echo other research done in the area. A 2021 study of physicians, resident physicians, and RNs noted statistically significant knowledge deficits related to surrogate decision making, in-hospital shackling, and mandatory presence of guards/officers during care, indicating the need for additional training and discussion of hospital policies on caring for incarcerated patients.²² Shackling and presence of guards/officers was brought up by several providers in this study, with limited insight as to if it was a requirement or not. Another study that evaluated 20 years of medical decision making found that physicians lack

awareness of ethical principles and legal rights for incarcerated patients and often even documented confusion about their incarcerated patients' rights in the chart.²³ While this study did not examine provider awareness of these policies, several subthemes identified in this study reflect the issues presented in these papers, including concerns with lack of consent, guard presence, and the effects of shackling on patient care. Awareness campaigns of the rights of incarcerated patients have the opportunity to provide improved care to incarcerated patients, particularly as the providers interviewed for this study expressed related concerns.

Table 4: Theme 3: Policy and system barriers that affect care delivery for incarcerated patients

Theme	Illustrative Quote	N*
Restraints hinder care and recovery	<p><i>"I think one of the mainstays of post-operative recovery is getting people up and walking and we can't do that. So, I do think that care is elongated, that they are at risk for post-operative blood clots and pneumonias." - P8</i></p> <p><i>"...a lot of times we're getting people for procedures that might require them to clear their bowels. So, we're giving them medications to clear their bowels, but they can't make it to the bathroom in time because they have to call a guard to uncuff them from the bed. And so, they may have a bowel movement from the bed." - P3</i></p>	5
Patient privacy is compromised	<p><i>"I've definitely also had times where the guards want to go in and are asking personal questions about somebody's medical condition..." - P2</i></p> <p><i>"I believe that the guard gets it (discharge paperwork). I don't think they actually get their own paperwork." - P6</i></p>	4
Presence of guards presents challenges to care	<p><i>"The DOC requires that there are two guards with them that accompany them. So, if two guards are not available tests can get delayed. They could be delayed by two hours, could be delayed by a couple of days. Just depends on when the guards are available." - P3</i></p>	4
Lack of informed consent	<p><i>"So, the result is we had a patient who had brain surgery craniotomy, where they open up the brain and all the notes said, 'Emergency consents obtained by two doctors.' No family was contacted. And the patient at that time didn't have capacity. This patient had a cousin in (city), who was never involved until after the surgery...So this person had a consenting relative who should have been called legally by Louisiana law and was not. So that is completely beyond the standard of care." - P1</i></p>	3
Challenges with follow-up care	<p><i>"It kind of was a joke for a while. You can make whatever recommendations for medications you want, because when they go back, they're just going to get whatever they get anyway." - P3</i></p> <p><i>"The ongoing assumption is really among all the doctors is that pretty much no follow-up appointment will happen, and no follow-up care will happen and everything that we want to do, we have to get done in the hospital." - P1</i></p> <p><i>"They [prison providers] say they can read our record. I think they can. We can't read theirs. So, the issue though, is that there's so much turnover with these doctors. It's just a constant endeavor to try to figure out who to reach out to." - P1</i></p> <p><i>"Now, if I need them to follow up in the clinic for something, and this is where it gets really tricky, because we can't make appointments for them. They're not, for safety reasons, not allowed to have a clinical appointment given to them at discharge. So that some of those specialty clinics that are hard to get into, that normally would require a phone call from us, we can't make that phone call. Because even if we ask them, they can't make the appointment." - P6</i></p> <p><i>"Sometimes it falls through the cracks... they just won't come. I'm sure it's not because the patient didn't want to come and see an oncologist... I think there's some system level barrier that is preventing them from being able to do that." - P2</i></p>	6

*number of providers who commented

Some of the challenges identified could be improved by making relatively simple updates to hospital policies and practices, and making standard protocols clear to providers, administrators, and prison staff who transport patients. Given

that care for incarcerated patients is offered in secure areas of hospitals, healthcare professionals should be allowed to remove (or simply not use) restraints, particularly for patients for whom ambulation is critical to recovery. Patient privacy could also be

improved by encouraging providers to conduct visits without guards in the exam room. For providers concerned about safety, a guard could be stationed outside of a windowed exam room to allow for observation, without compromising the ability of providers and patients to speak freely. Furthermore, seasoned providers, as well as students and trainees, would likely benefit from training in the importance of building trust with incarcerated patients who may have had their health concerns disregarded by prison staff.²⁴ Hospital-based providers should be informed about their rights to advocate for, and protect the privacy of, their patients, and hospital administrators should be willing to enforce patient-centered policies at the behest of the healthcare providers. Overall, simple policy adjustments and provider education could improve incarcerated patients' experience of receiving hospital-based care and providers' experience of caregiving.

In addition, reforms are needed to establish a system in which hospital-based providers can ensure continuity of care for their patients. State contracted hospitals and DPSC officials should collaborate to develop protocols for hospitals to make follow-up appointments for patients, view DPSC medical records, and communicate seamlessly with staff at carceral facilities. Care coordination should be a priority, as it is recommended by professional organizations such as the ACA and the American Academy of Family Physicians.²⁵ Care collaboration across disciplines and facilities is recommended by the World Health Organization, and it has proved beneficial for incarcerated patients.²⁶ For example, a state prisons in California implemented a learning collaborative strategy for managing chronic disease, resulting in success with patient outcomes, citing the chronic condition of asthma specifically.²⁷ Continuity can also be improved with shared medical records.

Kentucky recently implemented a health

exchange, which allows medical providers at jails to communicate with providers more easily at contracted facilities, connecting multiple stakeholders in the design of the system.^{28, 29}

Hospitals should also establish a clear process for hospitals to attain appropriate informed consent from family members or other surrogate decision makers. For example, incarcerated people could identify at intake a list of designated family to call, which could be included in that person's medical record or sent with the patient. Increased ability for care coordination could lead to increased completion of follow-up appointments and improved health outcomes.

There are several limitations of this study. First, the sample size was small, and the full range of perspectives of external health care providers was not represented and saturation was not able to be reached. Due to the small sample size, it is possible that over-interpretation could occur. In addition, it is possible that providers who were most concerned about the quality of health care provided in prisons opted to participate, leading to potential bias in the results. The providers interviewed did not specialize in behavioral health, so it is possible they did not have sufficient training to diagnose the mental health conditions discussed. Nonetheless, this is, to the knowledge of the authors, the first study to assess external providers' perspectives on the barriers and facilitators to providing care in Louisiana prisons. Findings may inform new policies for treating and coordinating care for incarcerated patients. Additionally, it is the hope of the authors that providers acknowledge the challenges they face while caring for incarcerated patients and continue to share their stories and advocate for protection for this population.

CONCLUSION

Eight of nine health professionals perceived that people incarcerated in Louisiana receive substandard care, expressed concern about patient presentation at hospitals, and identified policy and systems barriers to providing appropriate care. These findings align with previous research and recent litigation. Some possibilities for improving care include sharing medical records with carceral facilities; equipping trainees with the knowledge of patient rights; and reviewing hospital policy related to providing care to incarcerated individuals.

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