A Survey of Family Medicine Residency Programs in Washington: Evaluating the Current State of Correctional Health Training and Future Recommendations

Cynthia J. Au

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Committee:

Jennifer Jones-Vanderleest

Jenna Van Draanen

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Abstract

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Cynthia J. Au

Chair of the Supervisory Committee:
Jennifer Jones-Vanderleest
Department of Health Services and Population Health

Background: There are more than 2.2 million people in the US under correctional control, exceeding corresponding population growth and crime rates. (Nowotny, 2021). Correctional control is a term used to refer to individuals who are under some form of correctional supervision, including those who are incarcerated in jails or prisons, as well as those who are on probation or parole. These individuals are subject to various forms of monitoring and restrictions, which can have a significant impact on health and well-being (Massoglia & Remster, 2019a). People experiencing incarceration are often highly historically marginalized. African American and Latino, as well as low income individuals and communities are disproportionately affected (Whitehorn, 2021).

Incarceration exacerbates disparities in health care access, quality of care, and overall quality of life (Minkler, 2020). The delivery of healthcare within the criminal-legal system is often unpredictable, leading to episodic, poorly coordinated acute, chronic, and preventative

care. Unfortunately, undergraduate and graduate medical education training programs often do not recognize the importance of learning to care for currently or formerly incarcerated people. Due to the unique healthcare needs of these underserved populations, it is important for physicians to have training in correctional health care.

Methods: A cross-sectional survey was developed and sent to the program directors for all 21 Family Medicine residency programs in Washington State. In addition to demographic questions such as program structure and number of residents in the program, key survey topics included questions about dedicated training in correctional health, barriers in establishing correctional health curriculum, and interest in implementing or expanding these curricula. Descriptive statistics were summarized in each area in regard to demographics, content, attitudes, and open ended responses.

Results: A response rate of 80% was achieved, with n=17 responses. The majority of respondents were from either a community-based and university-affiliated program. The majority of programs do not currently care for incarcerated people receiving medical care outside of the jail/prison/juvenile detention setting (n=10, 59%). Of those who do currently care for incarcerated people, the majority of the time was in an inpatient rotation or outpatient setting. Also from those who currently care for incarcerated people, all included some didactic learning component (n=6, 100%). Common barriers to expanding correctional medicine in curriculum were time constraints and difficulty scheduling, faculty bandwidth, paperwork, and lack of partnership with correctional facilities.

Conclusion: This study highlights the need to address correctional health in family medicine residency training programs, as the majority do not currently provide dedicated correctional medicine training. The findings emphasize the need for increased educational awareness and

cross-sector partnerships to better prepare future family medicine physicians for the unique health challenges faced by incarcerated individuals. Furthermore, by recognizing that incarcerated individuals are integral to community health, improvements can be made for individuals transitioning out of incarceration and reducing health disparities among this disadvantaged population. Overcoming these barriers will ensure comprehensive medical training, ultimately fostering health equity

Introduction

Over the last 40 years, there has been a 500% increase in the number of incarcerated individuals in the United States. (Massoglia & Remster, 2019b). Today, the US incarcerates more than 2.2 million people, far exceeding corresponding population growth and crime rates, and making it the leader in incarcerating its residents at a higher rate than any other country (Nowotny et al., 2021; Wildeman & Wang, 2017). The criminal-legal system encompasses a spectrum from policing to incarceration. Correctional systems include prison, jail, and juvenile detention facilities. Jails are typically shorter-term detention facilities operated by local governments to hold individuals serving sentences less than one year, or awaiting trial. In contrast, prisons are long-term correctional facilities operated by state or federal government, that house individuals convicted of more serious offenses.

The incarcerated population is disproportionately made up of African American and Latino individuals. In fact, African American individuals are incarcerated at a rate more than five times that of the White population (Whitehorn, 2021). This overrepresentation of racial and ethnic minorities in the criminal-legal system is a result of systemic and structural racism, such as discriminatory policing practices like Stop and Frisk, or policies such as mandatory sentencing minimums for some drugs but not others during the War on Drugs (Williams, 2005).

Health Needs of People Experiencing Incarceration

People experiencing incarceration have disproportionately higher rates of medical, substance use, and mental health disorders compared to the general population (Binswanger et al., 2009). Washington state in particular has one of the highest jail mortality rates in the US, and little is known about the root causes of this disparity (Brownstone, 2023).

The health needs of incarcerated individuals in the US are complex and often under-prioritized. Incarcerated individuals face a higher burden of chronic health conditions such as hypertension, asthma, diabetes, as well as infectious diseases such as HIV and Hepatitis C (Dumont et al., 2013). These health needs are exacerbated by correctional facility living conditions, which often include overcrowding, lack of access to healthy food and physical activity, as well as under-resourced and understaffed medical and mental health care (Smith, n.d.). Additionally, incarceration can exacerbate pre-existing disparities in health care access, quality of care, and overall quality of life (Greene-Moton & Minkler, 2020).

Post-Incarceration

As over 95% of incarcerated people in the U.S. will eventually be released, the care of currently and formerly incarcerated should be considered both a public health and community clinical health care priority. Post-incarceration health is an under-prioritized area of concern as individuals return to their communities. In fact, formerly incarcerated individuals have a higher risk of developing chronic mental health and medical conditions compared to the general population (Fox et al., 2014).

Care re-engagement upon release is influenced by stigma and mistrust of the health care delivery systems, and community based health systems are impacted by and face obstacles in care engagement due to stigma and mistrust (Wohl, 2016). Thus, this population should be prioritized in a larger public health context, considering the extreme marginalization and significant health disparities. After incarceration, access to healthcare is often extremely limited for those who have just been released from correctional facilities. There are a variety of factors contributing to this, from lack of insurance, limited transportation options, housing instability, social stigma, and limited support networks (Porter, 2014). As a result, many individuals

post-incarceration do not receive the care they need to manage their health conditions and stay healthy. These challenges can lead to increased rates of morbidity and mortality, poor health outcomes, and a cycle of recidivism (Rosen et al., 2020).

Furthermore, the experience of being under criminal-legal control itself for any amount of time can be extremely stressful, and can have lasting effects on mental and physical health. For example, exposure to overcrowded and unsanitary conditions, trauma, and violence in correctional facilities can add to a range of negative health outcomes for individuals after their incarceration (Anderson et al., 2016). Thus, prioritizing the health needs of formerly incarcerated individuals is an urgent public health concern that demands attention.

Effects of Incarceration on Families and Communities

The downstream effects of incarceration go beyond the individual who is incarcerated, but also can affect their families and communities. In the U..S, an estimated one in ten African American students has a parent who is or has been incarcerated (Morsy, n.d.). Families separating due to incarceration can have long-lasting and significant effects on the children left behind. Children with parents affected by incarceration are more likely to experience housing and financial insecurity, along with disrupted family relationships (Muentner, 2019). These barriers can lead to higher likelihood of experiencing adverse childhood events and illnesses, which have been linked to incarceration later in life, continuing the cycle of incarceration across generations (Reavis et al., 2013).

The effects of incarceration have ripple effects beyond the individual and impact the larger community, particularly regarding racial disparities. Neighborhoods with high rates of incarceration are more likely to experience social and economic uncertainty such as financial hardships or the disruption of families, along with a disturbance of social networks and

community cohesion (Clear, 2008). There is significant research examining disproportionate effects on communities of color from the correctional system, with African Americans being incarcerated at nearly six times the rate of whites (Whitehorn, 2014). This over-representation of African Americans in the criminal-legal system is rooted in historical and ongoing systemic racism, which has resulted in a disproportionate concentration of lack of access to quality healthcare and education, poverty, and other socioeconomic barriers in minoritized groups (Taylor, 2019; Dumont et al., 2013; Nowotny et al., 2021).

Physicians and Correctional Health

In 2022, the American Council on Graduate Medical Education (ACGME) recognized correctional medicine as a subspecialty (ACGME, n.d.), While this may help define and legitimize an effort to prepare a physician workforce that is competent to provide healthcare to incarcerated populations. Fellowship training, while validating correctional medicine as a defined body of work, is not necessary to deliver quality care to incarcerated populations and people upon community reentry.

Family medicine physicians are well positioned to care for people during and after incarceration, as they are trained to provide comprehensive healthcare for the individuals and families. Family physicians also deliver the majority of care to underserved rural and urban populations (AAFP, n.d.). Family medicine residency programs provide an ideal opportunity for exposure to and training in correctional medicine.

The limited research that has been conducted suggests that medical trainees, including residents lack adequate knowledge and training in correctional medicine, which can negatively impact their ability to provide high-quality care to incarcerated individuals (Min et al., 2012). In fact, the majority of medical students are unaware correctional medicine is a defined area of

clinical practice (Conger et al., 2022). Across a wide array of medical specialties such as primary care and speciality programs, a nationwide survey of 1,205 residency directors found that less than 15% of residency programs offer lectures on the care of incarcerated persons, and over 60% of programs do not offer a clinical opportunity to work in a correctional institutional setting (Kraus et al., 2001). Institutions that offer instruction in correctional medicine are more likely to agree that their graduates believe incarceration to be a social determinant of health, and that their graduates are prepared to care for incarcerated patients than those with no correctional medicine instruction (Simon & Tobey, 2019).

Methods

The aim of the study was to gather and analyze data from Washington (WA) state family medicine residency directors to increase understanding of the current state of correctional health training and residency director attitudes on correctional health, and make recommendations for curriculum development for future training. To achieve these aims, a cross-sectional questionnaire was developed and administered in a collaboration with the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) Region Family Medicine Residency Network (FMRN).

Participants

Participants were recruited from the FMRN contact list of family medicine residency programs in the state of Washington. In January of 2023, an email was sent to all family medicine residency directors in Washington State (n=21), inviting them to complete the questionnaire. A response rate of 80% was achieved, with n=17 responses.

Measures

The questionnaire consisted of 12 questions covering three main areas: program demographics, curricular content, and barriers to implementing or expanding correctional health curricula.

Demographics

The first section of the survey collected program and residency director demographics using the following questions: 1) What is your program type (University based; Community based; University affiliated; Community based, Non affiliated; Teaching Health Center; Other, please describe)? 2) Number of residents in your program (Small (<19 residents); Medium (19-31 residents); Large (>31 residents))? 3) What size community does your program serve (<30,000; 30,000-74,999; 75,000-149,999; 150,000-499,999; 500,000-1 million; >1 million)? 4) Total years as program director (<3 years; 4-6 years; 7-9 years; 10+ years)?

Curricular Content

The next section addressed the types and scope of residency educational activities related to correctional medicine training using the questions: 1) Do your residents care for currently incarcerated people receiving medical care outside of the jail/prison/juvenile detention setting (Yes; No; Do not know)? 2) If yes, on what rotations (Outpatient; Inpatient; N/A; other (please list))? 3) Does your residency program provide dedicated training in correctional health care (Didactic learning: lecture, grand rounds, etc; Required rotation/clinical time in correctional facility; Elective rotation/clinical time in correctional facility; N/A; Other (please list))? This set of questions used multiple choices and select all that apply response options.

Residency Director Attitudes and Interest

The final segment of questions focused on attitudes and interest of the residency director in correctional health and included: 1) If your program does NOT have residents training in correctional facilities, please indicate why; 2) Please indicate your interest in implementing

and/or expanding your correctional medicine curriculum; 3) What concerns would you have about implementing and/or expanding your correctional medicine curriculum?; 4) How do you think learning about correctional medicine could be of value to your residents while in training and in post-graduate practice?; 5) Feel free to add any other comments here. This concluding section aimed to gauge barriers, interest, and perceived value pertaining to implementing or expanding correctional health curricula at their institution. Questions included a mix of select all that apply, multiple choice, and free response. Variables were nominal and ordinal categories.

Data Collection Procedures

An initial outreach email was sent via the FMRN contact list in January 2023 inviting participants to complete the questionnaire using an online survey tool (RedCap). Two reminder emails were sent approximately one and two weeks after the initial outreach, in an effort to increase the response rate.

This study was approved by the Institutional Review Board at the University of Washington. Participation was voluntary and participants were informed of the purpose and provided their consent to participate at the beginning of the questionnaire. The consent form included information that they could withdraw from the study at any time, and provided both researcher and FMRN contact information for any participant inquiries.

Analysis

To assure data quality, a review of responses was conducted to assess completeness and accuracy and data cleaning was performed where needed. The data analysis employed descriptive statistics to summarize the data. This involved calculating the proportions of responses in each response option for the ordinal and nominal categorical variables. Open-ended responses were organized by theme and are presented in a summary table.

The variables analyzed were program type, number of learners, size of community the program serves, program director duration, whether learners currently care for incarcerated individuals or provide dedicated training in correctional healthcare, barriers to establishing curriculum, attitudes, interest, and perceived value of correctional health education.

Results

Out of 21 Washington state family medicine residency directors who were sent the survey, 17 responded which resulted in a response rate of 81%.

Demographics

The majority of respondents were from either a community based and university affiliated (n=9, 53%), teaching health center (n=3, 18%), or community based and non affiliated (n=3, 18%) residency program. The remaining answered university based (n=1, 6%) or other (n=1, 6%). See Appendix A1 for more information. Most programs serve a population of 150,000-499,999 (n=6, 35%) or 30,000-74,999 (n=4, 23%) residents in their community. Tied for third was <30,000, 75,000-149,999, or 500,000-1 million residents (n= 2, 12%). There was one response with a population over 1 million (n=1, 5%). See Appendix A2 for more information. The majority of responding programs were small (<19) (n=7, 41%) or medium (19-31 residents) (n=7, 41%), sized according to the CAFM Education Research Alliance (CERA) definition (STFM, n.d.). The lowest percentage responded large (>31 residents) (n=3, 18%). See Appendix A3 for more information.The years of work experience as program director were <3 years (n=6, 35%), 4-6 years (n=5, 30%), 7-9 years (n=1, 6%), 10+ years (n=5, 29%).

Content

The majority of responding programs do not currently care for incarcerated people receiving medical care outside of the jail/prison/juvenile detention setting (n=10, 59%). Some programs (n=6, 35%) have residents who care for currently incarcerated people receiving care outside of the jail/prison/juvenile detention setting (e.g. in the emergency room, labor and delivery). There was one response for I don't know (n=1, 6%). See Appendix A4 for more information. Of those who answered yes to caring for currently incarcerated people, the majority of the time was in an inpatient rotation (n=6, 100%) or outpatient setting (n=3, 50%). Also from those who currently care for incarcerated people, all included some didactic learning component (n=6, 100%). Other responses included offering elective rotation/clinical time in correctional facilities (n=4, 67%), or required rotation/clinical time in correctional facilities (n=1, 17%). The majority of all programs surveyed do not provide dedicated training in correctional health care (n=10, 58%).

Attitudes and Interest

The majority of the responding family medicine residency programs in Washington do not currently offer medical training related to correctional health (n=10, 58%). Among these programs, the concerns of program directors in establishing or expanding correctional health curricula varied. The proportion of barriers listed were the following: Do not know how to begin (n=9, 90%) low prioritization (n=7, 70%), no room in schedule (n=4, 40%), distance or transportation issues (n=4, 40%), no funding (n=2, 20%), no interest (n=1, 10%), safety concerns (n=1, 10%), or poor learning environment (n=1, 10%). See Appendix A5 for more information.

All respondents indicated some level of interest in expanding or implementing correctional medicine curriculum. The majority of responses had moderate or slight interest

(n=14, 82%), while the remaining respondents answered either extremely or very interested (n=3, 17%).

Open-Ended Responses

The free responses provided further clarity regarding concerns residency directors have with expanding correctional health curricula. Common themes that emerged were time constraints and difficulty scheduling, faculty bandwidth, paperwork, and lack of partnership with correctional facilities. See Appendix B1 for free text responses organized by theme.

As for how correctional health might add value to their program, every respondent answered that correctional health would be valuable to their program. Themes included learning about the impact of living in correctional settings and health effects and improving health justice. Additionally, a few stated the potential value of intersection with addiction medicine training, mental health care training as well as social awareness and advocacy training. See Appendix B2 for free responses organized by theme.

Discussion

The findings of this study amplify the need for more comprehensive training in family medicine residency programs. Despite a high jail mortality rate in Washington State, and the broad spectrum of family medicine being an ideal setting for managing the complexities of correctional health, the majority of family medicine residency programs in Washington state do not offer any dedicated correctional health curriculum. It is clear that there is a lack of exposure to this patient population. This lack of training could lead to gaps in care for incarcerated individuals, further exacerbating existing health disparities.

Increasing Educational Awareness

It is crucial to include incarcerated populations in community systems of care, through acknowledgement that incarcerated individuals are part of the local healthcare continuum. Family medicine residency programs can play a crucial role in this regard, by providing training that emphasizes continuity of care, both during and after incarceration. This will require a shift in mindset from viewing correctional healthcare as a separate entity to recognizing it as part of caring for community health, and an essential component of family medicine.

One approach is to develop didactic components that discuss correctional health, and there are several places where these can be included. For example, seminars and lectures on the healthcare needs of underserved populations could incorporate elements on correctional health. Furthermore, family medicine residency programs could offer electives or rotations in correctional facilities to provide experiential learning opportunities with this population. This would not only increase educational awareness, but also provide pathways for residents to develop clinical skills and gain a deeper understanding of the complex challenges this population faces.

In academic medicine, there is a focus for providers and institutions to support medically underserved individuals. The Accreditation Council for Graduate Medical Education, along with the Medically Underserved Areas/Populations (MUA/P) Advisory Group, emphasize a mission to enhance physician workforce development in communities that face physician shortages (ACGME, n.d.). Incarcerated individuals are a prime example of this population, and this poses an opportunity for improvement for family medicine and other training programs.

Patient advocacy should be a key pillar of any medical training program, and this includes advocating for the healthcare needs of incarcerated individuals. Family medicine residency

programs should aim to create a culture of inclusivity and patient-centered care that prioritizes the importance of serving all members of the community, regardless of their circumstances.

Cross-Sector Partnerships

Collaborations between correctional institutions and educational institutions are essential in addressing the complex healthcare needs of incarcerated populations. Cross-sector partnerships can facilitate use of best practices and information exchange which can ultimately improve the quality of care provided to people experiencing incarceration. Cross-sector partnerships can also provide a continuum of care that extends beyond the walls of the correctional facility and into the community. These partnerships have the potential to increase access to substance abuse and mental health treatment, housing assistance, and other resources that are critical to successful reentry and lowering recidivism rates (Ducharme et al., 2021). Ideally, through increased exposure to correctional healthcare/medicine increased interest in providing healthcare to the incarcerated population (Simon et al., 2019).

Limitations

The present study has several limitations. The sample size was relatively small and specific only to Washington state, which limits generalizability of the findings. Future research should focus on including more diverse, larger samples to increase external validity. Secondly, the methods relied on self-reported data from residency directors, which may be subject to biases such as overestimating or underestimating their knowledge or experience with correctional medicine. Future research should incorporate additional measures to assess reliability and validity of self-reported data. Lastly, this study utilized a cross-sectional design, which provides a snapshot in time, limiting the ability to draw conclusions about change in knowledge, attitudes,

or curriculum over time. Future research could focus on longitudinal design methods to track changes over time.

Conclusion

This research study sheds light on the current state of correctional health training in family medicine residency programs in Washington state, and provides valuable insights into the perspectives of program directors. The findings indicate a need for increased educational awareness and integration of correctional medicine concepts into residency curricula. There are potential benefits of such training, including increased understanding of the unique health needs of incarcerated individuals, increased awareness of social determinants of health, and health disparities.

The results underscore the importance of bridging gaps between academic medicine and the incarcerated population, and cross-sector partnerships between residency programs and correctional facilities in facilitating educational opportunities and promoting the continuity of care for individuals reentering the community post-incarceration. The barriers identified relating to implementing or expanding correctional health training should be addressed through collaborative efforts, and an honest effort to include the incarcerated population in the creation of a physician workforce well-equipped to treat this disadvantaged population.

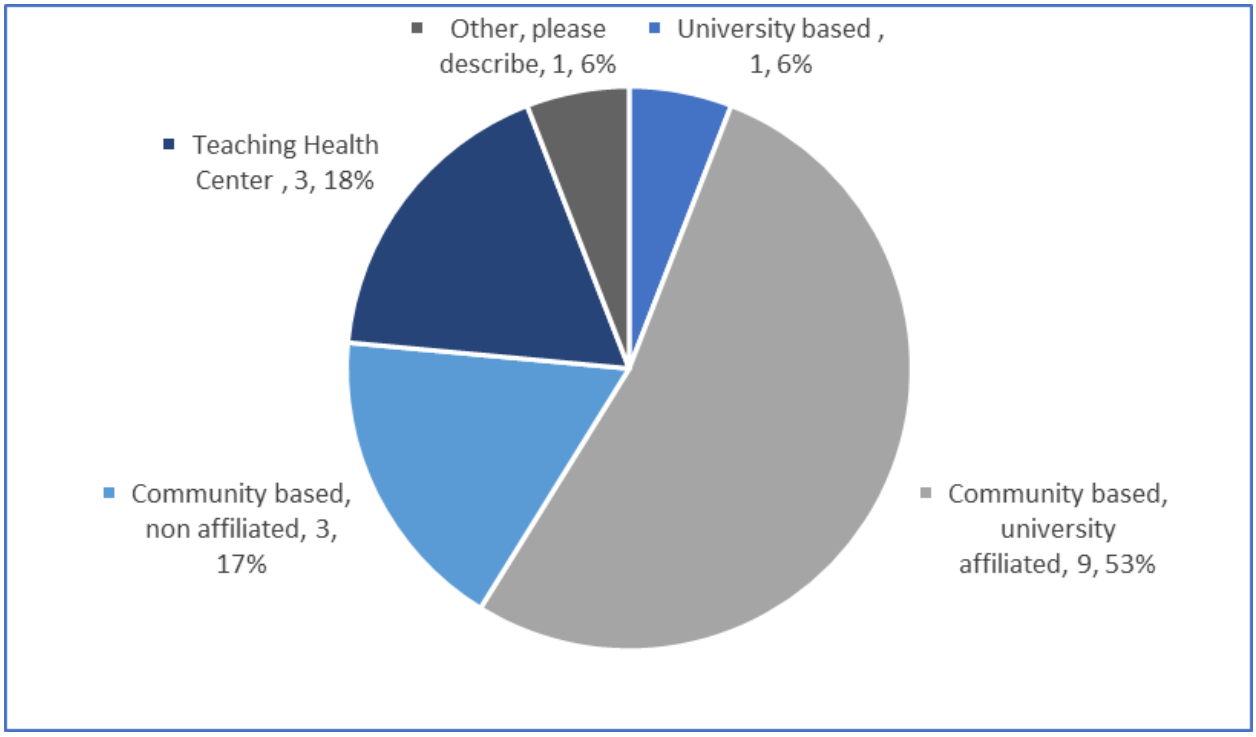
Equipping future family medicine physicians with the knowledge, skills, and empathy necessary to address the health needs of individuals involved in the criminal-legal system promotes health justice and helps to ensure equitable care for all. This research study sheds light on the need for greater attention to correctional medicine within family medicine residency programs. The findings underscore the often overlooked nature of this field. However, recognizing that correctional medicine is an essential component of healthcare provision and

health equity efforts is crucial. As one participant aptly stated, “"I believe that correctional medicine is often overlooked since the population is not part of society”. By incorporating dedicated correctional training components, fostering cross-sector partnerships, and advocating for improved healthcare quality for incarcerated populations, we can work towards a more inclusive healthcare system that acknowledges the value of providing comprehensive care to all members of society, including those affected by incarceration.

Appendix

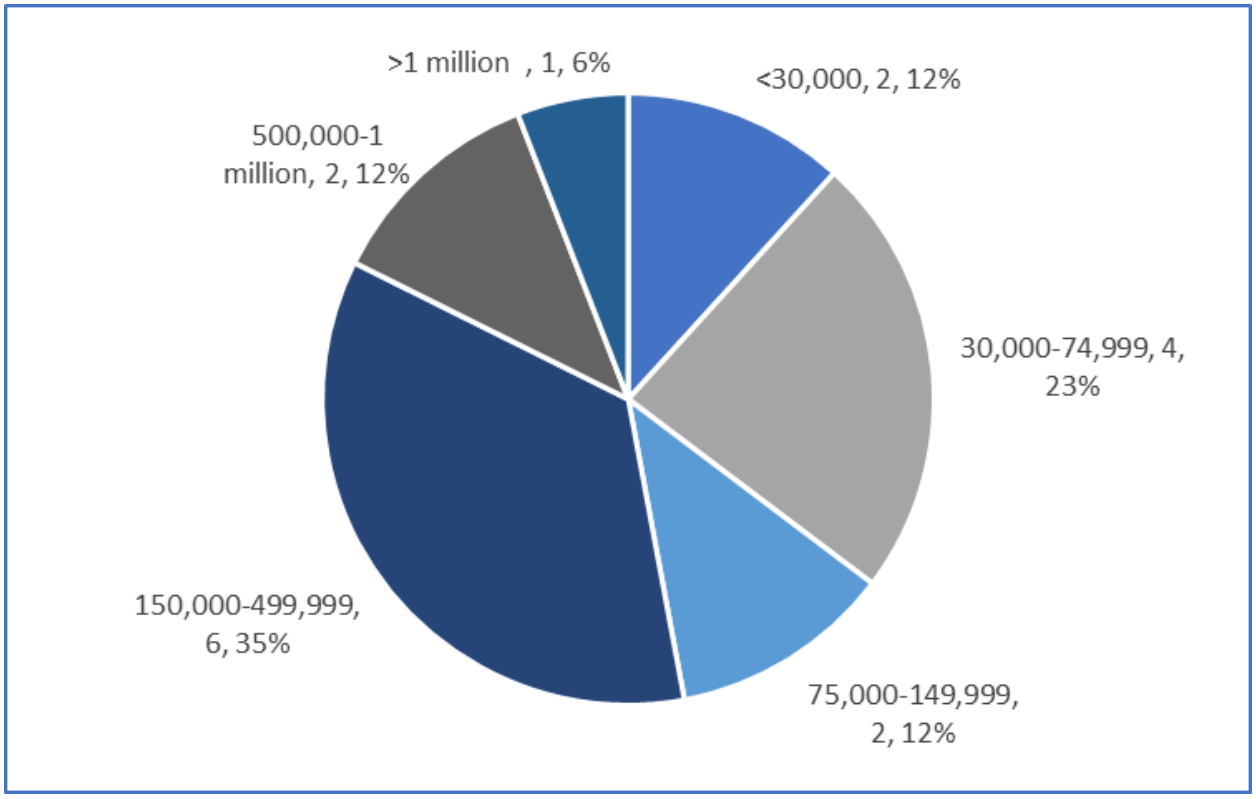
Appendix A1

Distribution of Family Medicine Residency Program Types in Washington State



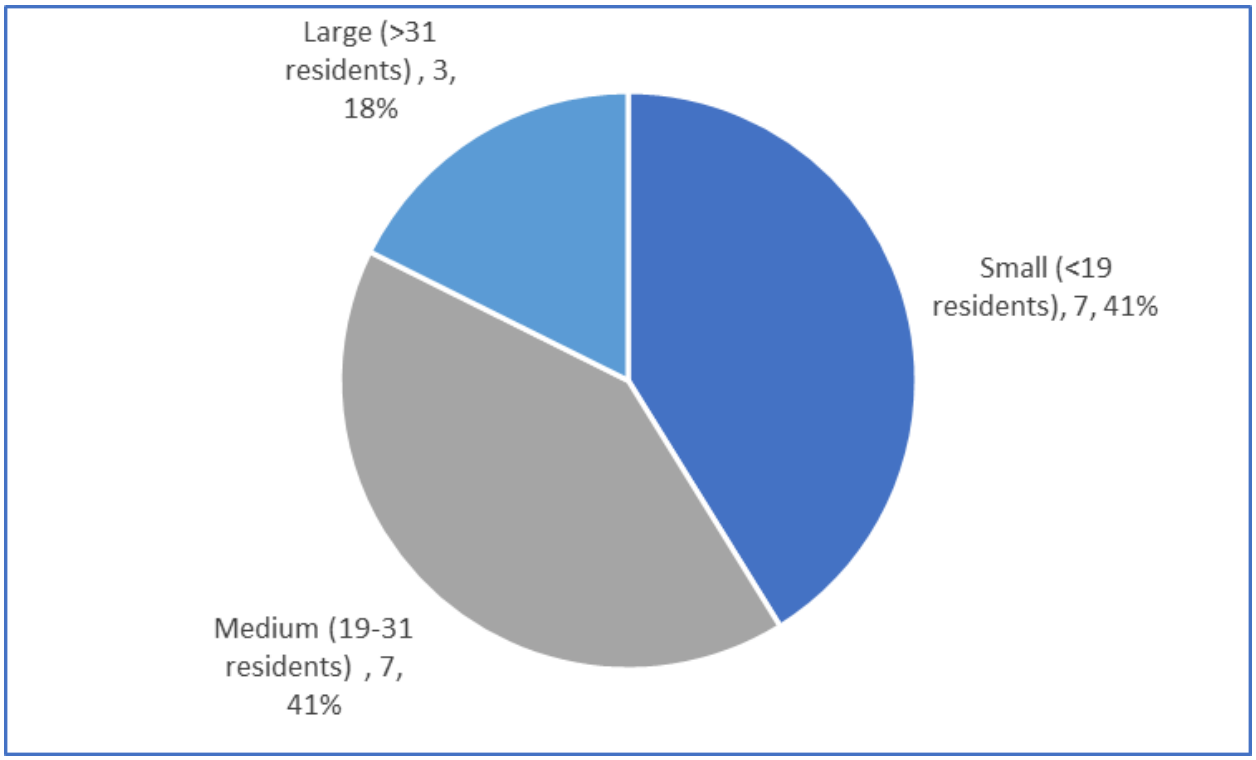
Appendix A2

Distribution of Size of Community Served by Family Medicine Residency Programs



Appendix A3

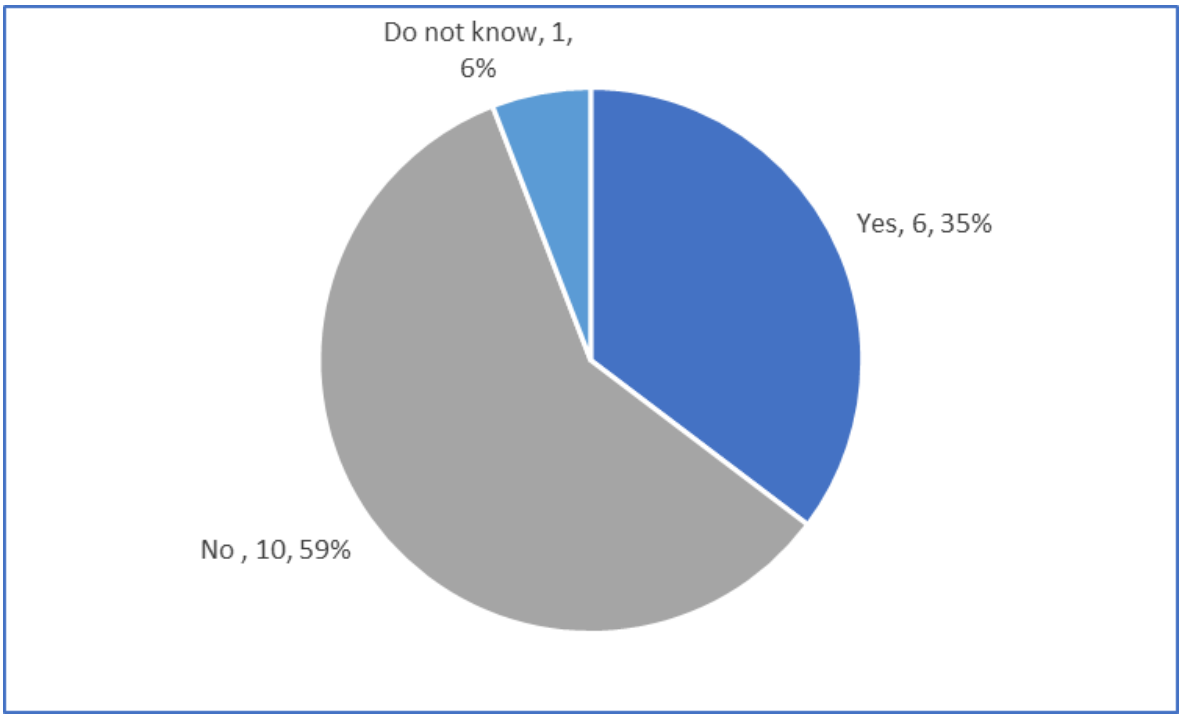
Distribution of Size of Washington State Family Medicine Residency Program Learners



Appendix A4

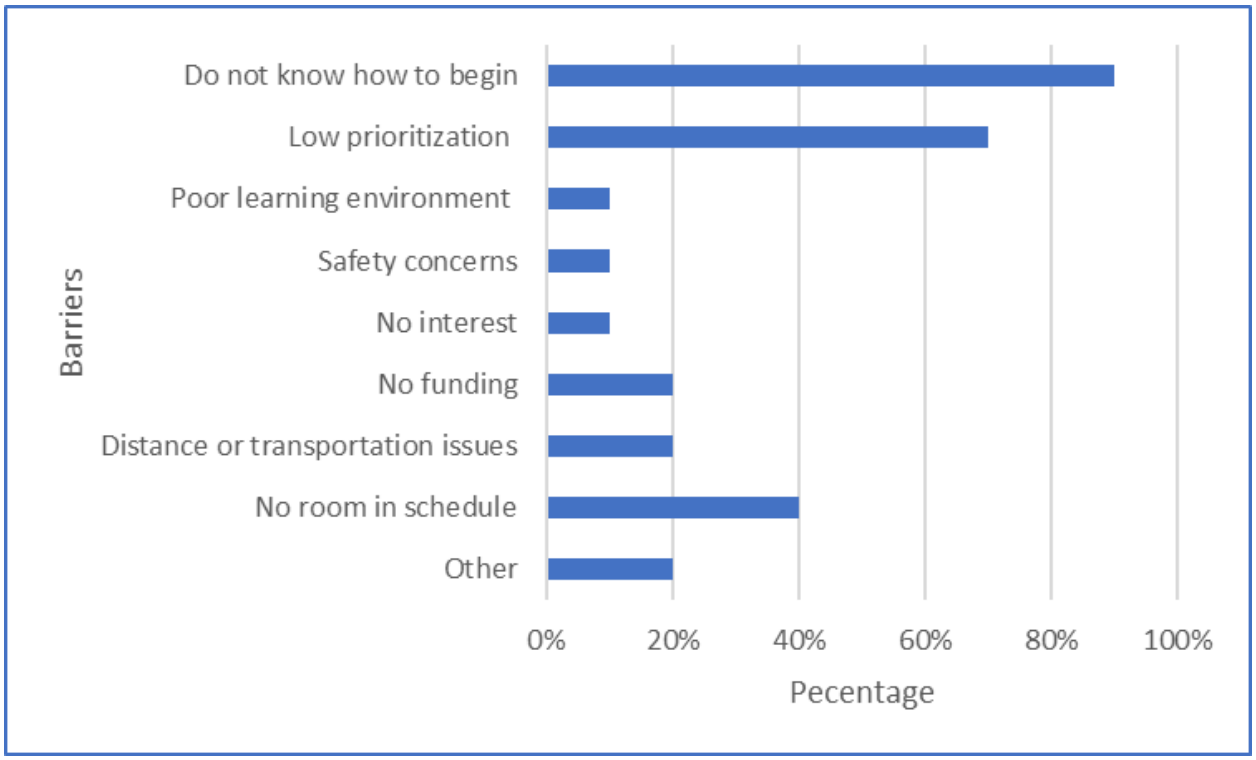
Distribution of Involvement of Family Medicine Residents in Medical Care for Incarcerated

Individuals Outside Correctional Facilities



Appendix A5

Distribution of Reasons for Not Having Residents Training in Correctional Facilities



Appendix B1

Perspectives on Concerns with Implementing and/or Expanding Correctional Medicine

Curriculum by Theme

Theme	Quote
Curriculum Placement	Mostly it is a time issue.
	Mostly a matter of time/ curricular priority.
	Time constraints; no faculty bandwidth; low resources.
	Difficulty with scheduling
	Time in an already packed curriculum.
Administrative Work	Need to make the paperwork barrier smoother, also need assistance with scheduling variety as we have minimal support staff/admin help at our program
	I am not sure where to start and who to contact. I have a general idea but I need to know who to contact and what the need at the correctional facility is?
	Preparation (information) for the rotation; what to stop doing to make room for this.
	Not enough bandwidth for faculty and opportunities in the area.
Supervising Faculty	Faculty lead- I have no one currently
	Who will be supervising the resident? ARNP, PA, MD/DO?
	Ensuring adequate supervision

	Push back from residency oversight

Appendix B2

Perspectives on the Value of Learning about Correctional Medicine for Family Medicine Residency Training

Theme	Quote
Curriculum Intersectionality	Could be valuable for addiction medicine training, mental health care training as well as social awareness and advocacy training.
	Incredible value for the residents to learn more about the impact of living in correctional setting and health effects - both short and long term - as well as effect on family members.
Importance of working with vulnerable populations	I believe you will learn the most vulnerable population in this country and who needs tremendous support.
	Correctional medicine patients are a highly vulnerable population. When medical intervention is supportive, holistic, strong it has the potential to change outcomes and improve health justice." and "I believe that correctional medicine is often overlooked since the population is not part of society. We need to reach the population in these facilities and try to provide the same standard of care as we do the rest of the population.
Relevance to patients or program	Somewhat unclear at this time since only two of 182 graduates (that we know of) have chosen to have this as part of their clinical profile.
	Might depend a lot on the program/resident; I do think some of my residents could provide care in Correctional facilities in the future so I would consider making it a required experience; but it may be great as an elective.
	It's pertinent to many if not a majority of our patients

Appendix C

Survey Introduction and Questionnaire

Introduction

Thank you for your interest in participating in this research study! The purpose is to evaluate the current state of correctional health training in Washington Family Medicine residencies and make curricular/further research recommendations based on the data.Your contact information was obtained through the WWAMI-Region Family Medicine Residency Network and their data use request process.

This survey will cover topics such as residency program size and setting, as well as attitudes and interest in correctional medicine. You can skip the questions you don't want to answer, and all of your responses to the questions will be confidential and anonymous. **This survey will take 2-3 minutes to complete.**

This study is being conducted through the University of Washington School of Public Health, and is a part of my thesis project. My name is Cindy Au and I am a second year Master's in Public Health student. Please reach out to cyn1998@uw.edu if you have any questions. For WWAMI-Region Family Medicine Residency Network related questions, please contact Amanda Weidner at aweidner@uw.edu.

By clicking the button below, you agree to the collection and use of your survey answers and email address. We value participant privacy and your answers to this survey will only be used for study related procedures. We will collect and use your data in accordance with our University of Washington Institutional Review Board (IRB) guidelines.

Demographic Questions

What is your program type?

- University based
- Community based, university affiliated
- Community based, non affiliated
- Teaching Health Center
- Other, please describe

Number of residents in your program (total) ?

- Small (<19 residents)
- Medium (19-31 residents)
- Large (>31 residents)

What size community does your program serve?

- <30,000
- 30,000-74,999
- 75,000-149,999

- 150,000-499,999
- 500,000-1 million
- >1 million

Total years as program director:

- <3 years
- 4-6 years
- 7-9 years
- 10+ years

Content

Do your residents care for currently incarcerated people receiving medical care outside of the jail/prison/juvenile detention setting (e.g. in the emergency room, labor and delivery)?

- Yes
- No
- Do not know

If yes, on what rotations? (select all that apply)

- Outpatient (please list)
- Inpatient (please list)
- N/A or other _____

Does your residency program provide dedicated training in correctional health care? (select all that apply).

- Didactic learning: lecture, grand rounds, etc
- Required rotation/clinical time in correctional facility
- Elective rotation/clinical time in correctional facility
- N/A
- Other _____

Attitudes and Interest

If your program does NOT have residents training in correctional facilities, please indicate why (select all that apply).

- No room in schedule
- Distance or transportation issues
- No funding
- No interest
- Safety concerns

- Poor learning environment
- Low prioritization
- Do not know how to begin
- Other _____

Please indicate your interest in implementing and/or expanding your correctional medicine curriculum:

- Extremely interested
- Very interested
- Moderately interested
- Slightly interested
- Not at all interested

(free response) What concerns would you have about implementing and/or expanding your correctional medicine curriculum?

(free response) How do you think learning about correctional medicine could be of value to your residents while in training and in post-graduate practice?

(free response) Feel free to add any other comments here.

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