

The Challenges of Aging Inmates

NCCHC Updates in Correctional Health Care
Orlando, May 7, 2007

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Aging and long-term care topics

- Greying within prisons
- Importance of functional assessments
 - Value of correctional officer observations
- Findings of 2005-2006 survey
 - Levels of care
 - Case management
 - Recommendations
- Next steps



Aging Inmates: Challenges for Healthcare and Custody

A Report for the
California Department of Corrections and Rehabilitation

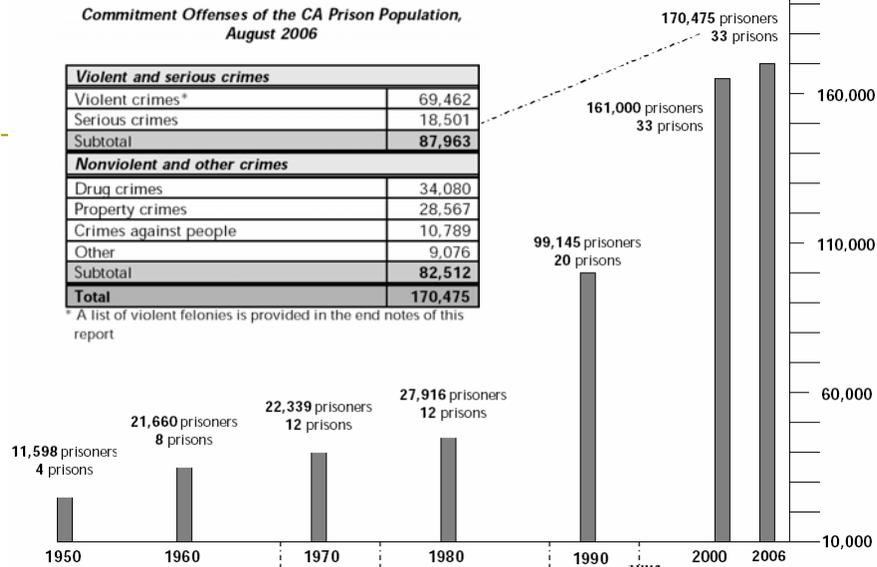
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**Commitment Offenses of the CA Prison Population,
August 2006**

Violent and serious crimes	
Violent crimes*	69,462
Serious crimes	18,501
Subtotal	87,963
Nonviolent and other crimes	
Drug crimes	34,080
Property crimes	28,567
Crimes against people	10,789
Other	9,076
Subtotal	82,512
Total	170,475

* A list of violent felonies is provided in the end notes of this report



Little Hoover Commission, 2007

Voters approved the sale of \$817 million in general obligation bonds for the construction of youth and adult correctional facilities to relieve overcrowding.

California prison demographics, 2006

	Prison Population	California Adult Population
Total Population	172,508	27,648,604
Gender		
Male	93%	50%
Female	7	50
Ethnicity		
Black	29%	6%
Hispanic	38	29
White	28	51
Other	6	14
Age		
18-19	1%	4%
20-29	31	19
30-39	31	20
40-49	26	21
50-59	9	16
60 and older	2	20

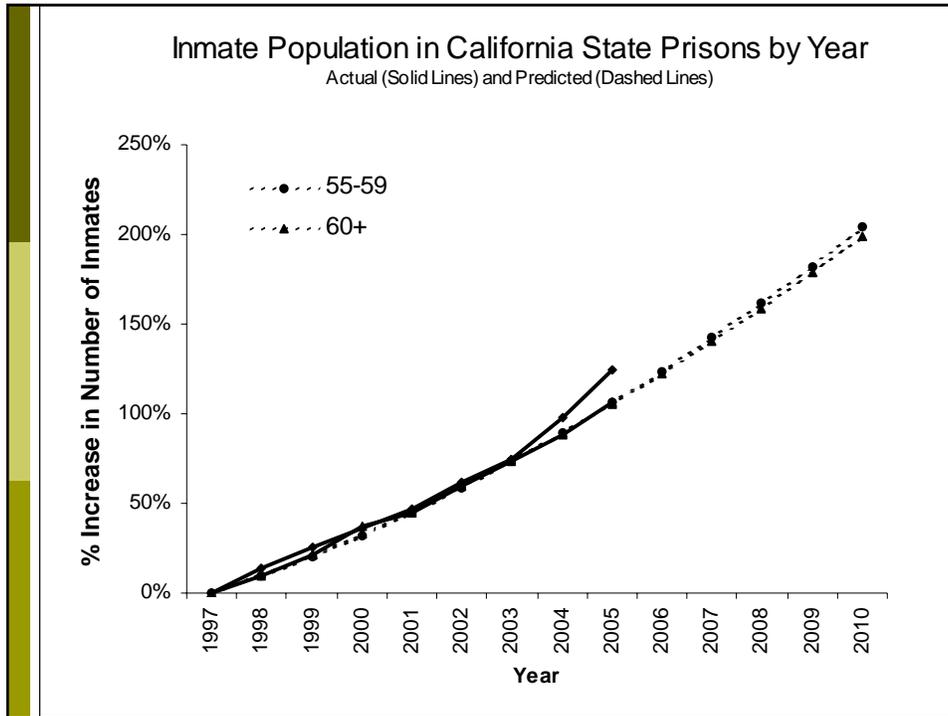
CA Legislative Analyst's Office, January 2007

Demographic and economic imperatives

	1997	1998	1999	2000	2001	2002	2003	2004	2005
55 - 59	2,143	2,428	2,692	2,909	3,140	3,462	3,735	4,232	4,811
60 +	1,781	1,951	2,177	2,445	2,581	2,855	3,097	3,373	3,699

- Numbers of older California prison inmates doubled in 8 years
- 5% of population => 22.4% of offsite costs

Age	% of Population	Total Hospital Costs	% of Total Costs	Cost/ Admission
<55	95%	\$266,425,758	77.6%	19,834
55+	5%	\$ 76,851,731	22.4%	26,747



It sounds simple

1. Identify inmate needs
 - Diagnoses, physical and cognitive functioning, medical/nursing needs and treatments
2. Match needs to resources

Custody classification and healthcare must coordinate

ADLs, IADLs: basic & instrumental activities of daily living

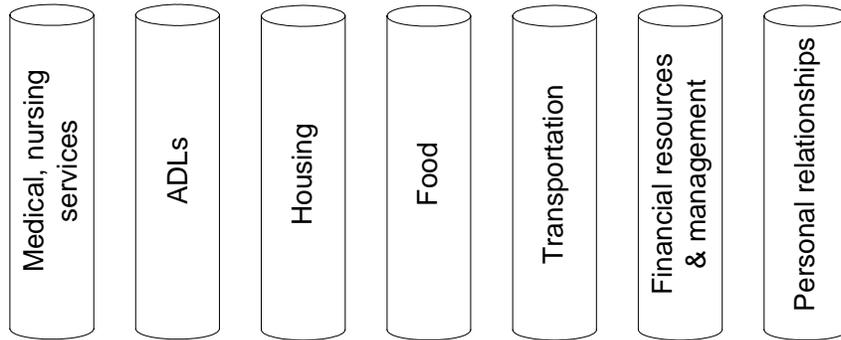
- **ADLs** = basic activities for self-care or care by others
 - Surveys often use 6
 - Bathing, eating, dressing, toileting, transferring in/out of bed or chairs, and walking
 - MDS (Minimum Data Set) includes 9
 - Bathing, eating, dressing, toileting, transferring, bed mobility, walk in room, walk in corridor, and personal hygiene
 - Scoring can focus on ability or on assistance needed , e.g.,
 - Independent, difficult, and dependent.
 - Independent, supervision, limited assist, extensive assist, total dependence
 - We described inmates as impaired if they required supervision
 - In prison, supervision usually requires presence of paid staff
- **IADLs** = higher-level activities for living in the community, e.g.,
 - Shopping, housework, accounting/finances, food preparation, transportation

PADLs: prison activities of daily living

- Prison-specific functional activities include:
 - Dropping to the floor for alarms
 - Standing for head count
 - Climbing on and off the top bunk
 - Getting to the dining hall for meals
 - Hearing orders from staff
- PADL impairments predict adverse outcomes
 - Falls, depression, abuse

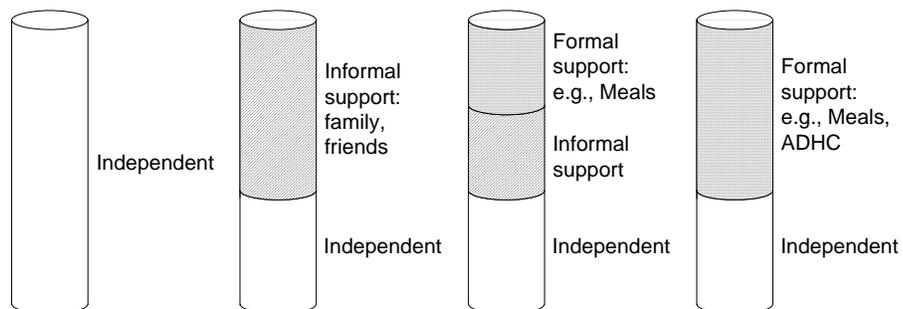
Williams BA, et al. Being old and doing time.
J Am Geriatr Soc. 2006;54:702-7

Functional assessment addresses needs and resources



- ❑ Functional domains overlap and interact
- ❑ Functional impairments often raise personal safety issues and lead to loss of independence

Variations in support



- ❑ Losses of independence can be compensated by:
 - Formal support (paid help and agencies)
 - Informal support (unpaid family, friends)
- ❑ In free world, most needs are managed by informal support (unpaid family, friends)

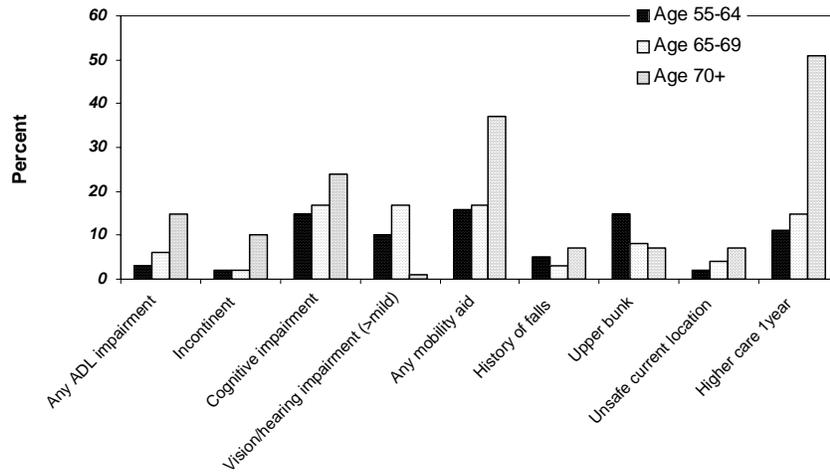
Correctional officers provide support for inmates

- Impaired inmates have no family for informal support
 - Must rely on other inmates, correctional officers, or healthcare staff
- COs often find themselves in caregiver-like roles
 - Arranging housing, meals, and transportation for all
 - More basic support for those with physical or cognitive impairments
 - Assisting those with wheelchairs, reminding them what to do, etc
 - Because they are paid, this support is technically formal
 - And yet the COs are not trained as caregivers
 - Their support is more similar to informal support than formal support from paid agencies

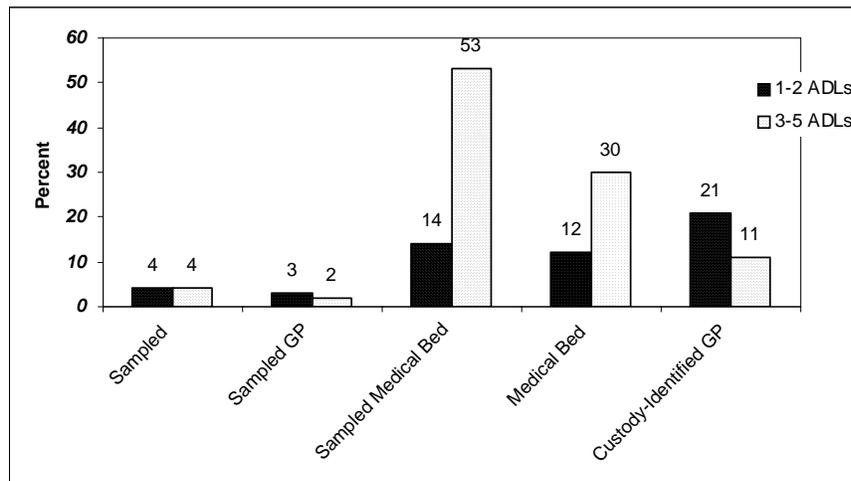
Survey of older inmates and long-term care

- Surveyed 10% of the 55+ inmates at 11 of California's 33 prisons (N = 431)
- Also all inmates in "medical beds" (N = 196)
 - General Acute Care Hospital (GACH)
 - Correctional Treatment Center (CTC)
 - Outpatient Housing Unit (OHU)
 - Skilled Nursing Facility (SNF)
 - Hospice
- Got diagnoses, function, and needs from:
 - Charts
 - Nurse proxies
 - Correctional officer proxies

Characteristics of sampled GP inmates by age



ADL impairments by setting



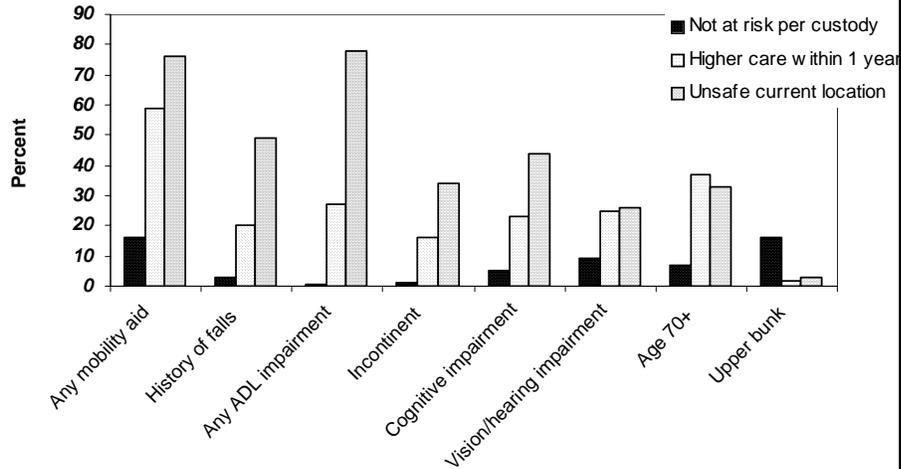
Small sample of women (N = 38)

- More likely to need assist with mobility and bathing
- Far more likely
 - to use a wheelchair
 - to be incontinent
- More likely to have diabetes, thyroid disorder, congestive heart failure, hypertension, arthritis, CVA, depression, COPD/asthma, anemia, hyperlipidemia
- Less likely to have cancer or hearing loss

Assessment of risk by correctional officers

- Do you feel the inmate is physically or medically unsafe in his/her current location?
- Do you feel the inmate will need to move to a higher-care location within the next year?

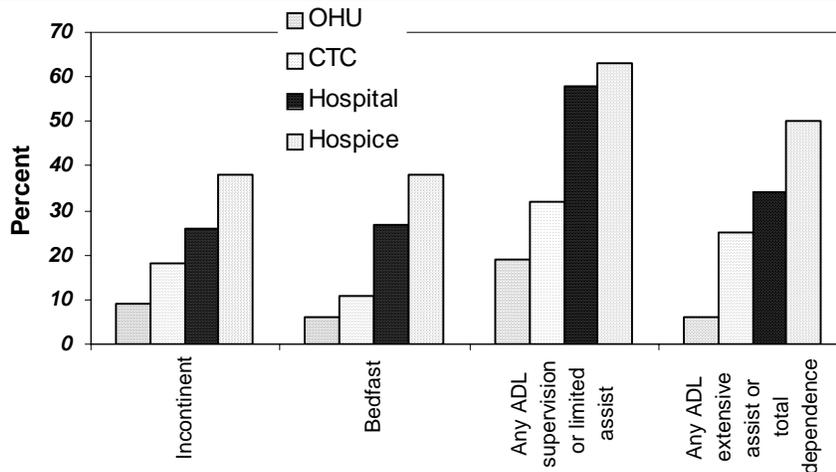
Correctional officer risk assessments reflect impairments



Diagnoses in medical beds

	HIV	Cancer	ESRD	ESLD	CVA	Cognitive impairment
OHU	9%	0%	0%	13%	22%	19%
CTC	0%	5%	11%	2%	7%	14%
GACH	10%	13%	12%	10%	13%	26%
Hospice	25%	63%	0%	13%	0%	0%
SNF (women)	5%	20%	20%	0%	0%	5%

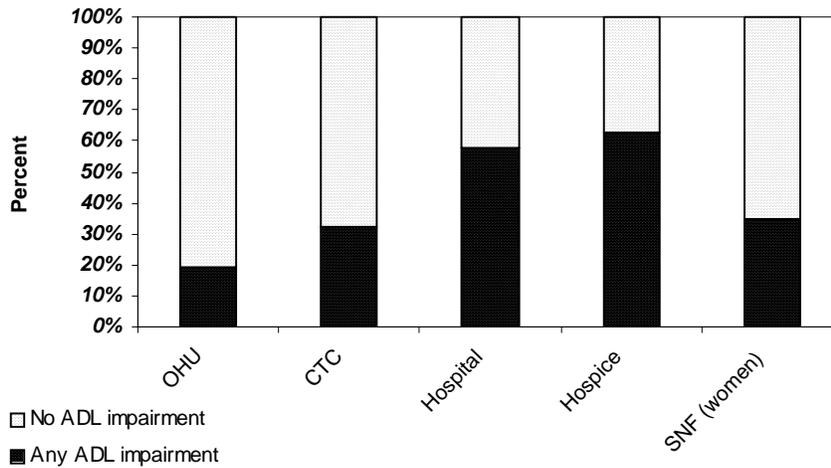
Increasing impairments in OHU, CTC, hospital, and hospice



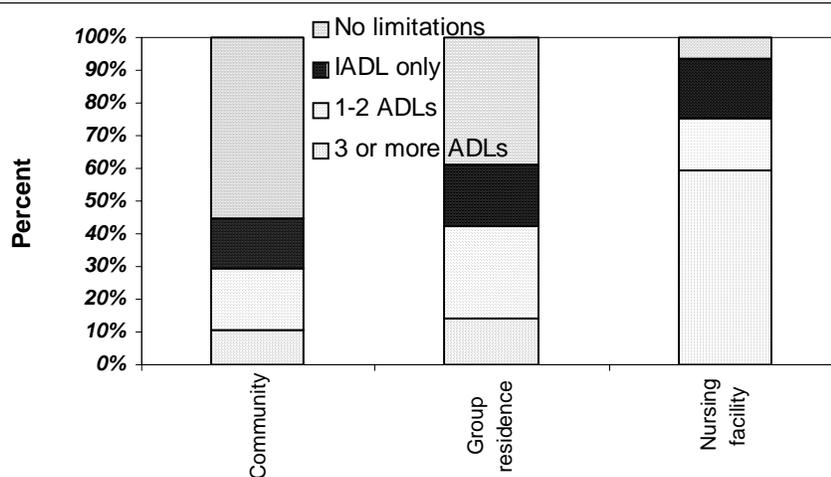
Less-than-compelling reasons for being in medical bed

- ❑ Inability to store clean nephrostomy supplies
- ❑ Prohibition against having:
 - Portable oxygen
 - Nasal CPAP machine
 - Indwelling dialysis (Quinton) catheters
- ❑ Too much walking distance from yard to dining hall
- ❑ Need for assistance putting on socks and getting set up for bathing

Many inmates in medical beds have no ADL impairment



ADL impairments in free world levels of care



Mr. P, 74 years old with increasing dementia

- Incarcerated for some very bad behavior when he was *compos mentis*
- No longer able to participate in mental health groups, so can't be housed in special program yards
 - Now in isolated maximum security housing because of his behavior, e.g., spitting at people
 - Other inmates filing formal complaints because he doesn't bathe, and he stinks
 - Ornery old man

Level of care should depend on more than clinical characteristics

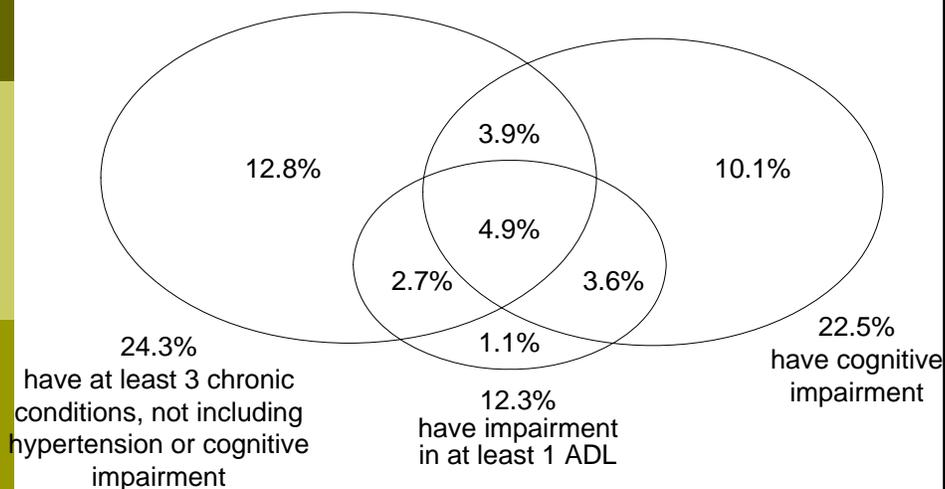
- In the free world, level of care depends on:
 - Clinical characteristics
 - Resources available
 - Preferences
- Trials of quantitative algorithms predicting levels of care have generally failed
 - Ex-presidents with Alzheimers don't go to nursing homes

“Medical” and “social” models are moving to population management

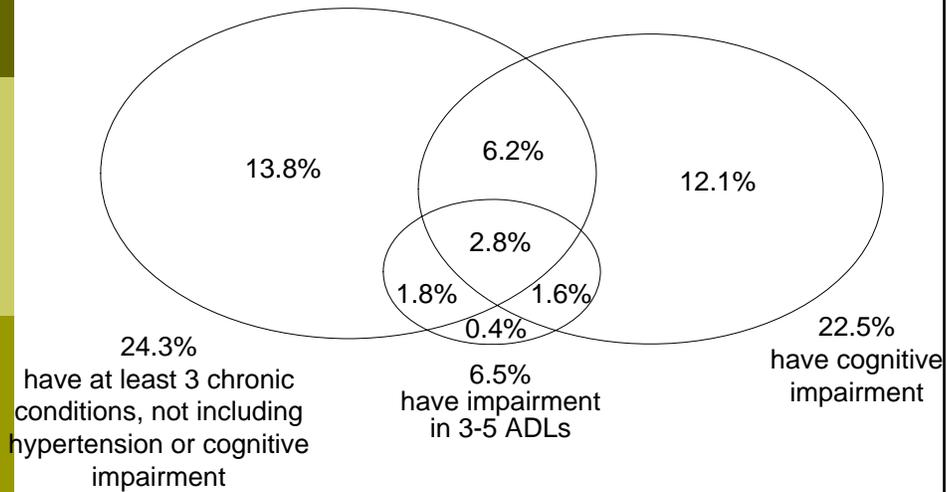
Both medical and social models focus on “high utilizers”

- In Medicare, 25% of patients generate 85% of expenditures
- Chronic disease management
 - First tried single-disease focus, e.g., DM, CHF, asthma
 - But chronically ill patients tend to have multiple illnesses
 - Single-disease, formulaic approaches have limited impact
 - Kaiser’s chronic care model includes:
 - Care managers providing intensive direct patient care and education
 - Case managers providing care coordination for complex patients
- Community-based long-term care integration
 - Targets more complex patients with range of services
 - Prioritizes keeping people at the lowest possible level of care
 - E.g., Program of All-Inclusive Care for the Elderly (PACE)

Overlap of chronic conditions, cognitive impairment, and ≥ 1 ADL



Overlap of chronic conditions, cognitive impairment, and 3-5 ADLs



Medical beds mostly younger

Average age 49.8 years

Age	% medical bed inmates
<55	65 %
55-59	12 %
60-64	7 %
65-69	6 %
70+	10 %

Recommendation Topics

(2006 report)

Integrated care management, continuum of settings and services

- ❑ Frequent functional screening
- ❑ Coordinated case management, chronic care, disability, and mental health programs
 - Keep inmates at the lowest practicable level of care
- ❑ New special needs yards and assisted living units
- ❑ New inmate caregiver programs
- ❑ Adult day health programs
- ❑ Neurobehavioral units
- ❑ Cognitive assessments in the disciplinary process

Interdisciplinary teams and expertise

- ❑ Geriatric, physiatry and rehabilitation expertise
- ❑ Effective interdisciplinary teams
 - Individualized care plans
- ❑ Adequate equipment
 - E.g., “low-low” beds, fitted wheelchairs, Hoyer lifts
- ❑ Advance care planning programs
- ❑ Ethics expertise and resources
- ❑ Self-management of chronic illness
 - Peer-led education and groups

Environmental and program modifications

- ❑ Cell, shower, and toilet modifications
- ❑ Good lighting and signage
- ❑ Environmental temperature control
- ❑ Flat and even walking terrain
- ❑ Ground-level housing
- ❑ Lower bunk assignments
- ❑ Limited walking distance to dining hall, clinics, etc
- ❑ Sufficient time to complete activities
- ❑ Access to toilets during exercise and activities
- ❑ Modified requirements for standing, dropping to ground, etc
- ❑ Modified work programs
- ❑ Retirement program

New study will sample all ages

- Demographics
- Diagnoses
- Medical-nursing needs and treatments
- ADLs and PADLs
- Cognitive status

***DRAFT* new names for levels of care**

HIGH-ACUITY medical bed Inmates require:

- RN available 24 hr for assessment, monitoring &/or complex management
- IV hydration for more than 3 days
- Complex or high-risk medication regimen or blood transfusion
- Complex wound care regimen
- Extensive assistance with ADLs (or totally dependent)

LOW-ACUITY medical bed Inmates are unable to be at lower level of care because they require:

- RN available 8-16 hr for assessment, monitoring &/or management
- IV hydration for less than 3 days
- Straightforward IV antibiotics, e.g., for osteomyelitis
- Straightforward wound care regimen
- Supervision or limited assistance with ADLs

Specialized GP housing

Regular GP

Hospice

Specialized GP housing / sheltered housing

Inmates do not require continuous nursing care/medical bed, but

- would benefit from cohorted housing and services and/or
- cannot be in regular GP due to:
 - Vision, hearing, or mobility impairment preventing residence in regular GP
 - AIDS
 - Pregnancy
 - Frailty due to age or medical condition
 - Other_____

If need for supervision or limited assistance is inmate's only reason for not being in regular GP, then that inmate can be in sheltered housing with ADLs provided by cell mate, buddy system, or inmate helper program.