

Providers Offer Ailing Prisoners A Helping Hand



The aging of the country's prison population is bringing higher rates of disabling conditions, with many needing long term/post-acute care services.

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The incidence of providing health care to current or former offenders is increasing among health care providers generally, and long term and post-acute care (LT/PAC) providers are no exception.

The unique role that LT/PAC providers play in caring for aging individuals is becoming even more critical as the United States experiences unprecedented numbers of aged current and former offenders who enter the community to receive care or to live following completion of their sentences. For care providers, these individuals bring with them both familiar and distinct health conditions and realities.

THE AGING OFFENDER POPULATION

Much like any other setting in the United States, prisons are coming to grips with the aging baby boomer population. According to a 2014 report from The Urban Institute titled, "Aging Behind Bars: Trends and Implications of Graying Prisoners in the Federal Prison Population," individuals aged 50 and over currently make up the fastest growing age group in the federal prison population.

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Between 1994 and 2011, the number of prisoners aged 50 and above grew from 9,000 to 30,000—an increase of 330 percent. In addition, the proportion of federal prisoners aged 50 and above has increased from 12 percent of the total prison population in 1994 to 17 percent in 2011. In 2019, the proportion is projected to be 28 percent. In addition, in 2011, there were approximately 5,000 prisoners aged 65 and older, and that number is projected to triple by 2019.

ACCELERATED AGING BRINGS CHALLENGES

The rise in the aged incarcerated population has implications for state and federal budgets, since this population requires more health care than that of the young incarcerated population. According to current estimates, the annual cost of incarcerating an individual aged 50 or over is more than \$68,000, which is double the cost of a young offender.

Different factors may contribute to the high cost, including a greater incidence of disease and more health needs due to prisoners who originally come from low socioeconomic backgrounds, along with the experience of incarceration.

Brie Williams, MD, professor of medicine in the Division of Geriatrics at the University of California San Francisco, agrees. She is among the very few palliative care and geriatrics physicians with professional experience in correc-

tional settings and has trained criminal justice professionals in geriatrics and palliative care.

"Growing evidence suggests that, when comparing younger prisoners with older adults in the community, older prisoners often experience a high burden of chronic medical conditions, cognitive impairment, and disability," she says.

According to Williams, these conditions contribute to accelerated aging of the offender. This involves higher rates of chronic medical and disabling conditions at relatively earlier ages than in those who are not incarcerated.

"This phenomenon is generally connected to a lifetime of exposure to stressful risk factors such as low socioeconomic status, poor access to health care prior to incarceration, disproportionate diagnoses of mental health disorders, and low educational attainment," she says. "As a result, many older adults in prison have medical conditions and a degree of disability that would be expected for older adults 10 to 15 years their senior."

A VARIETY OF CARE ARRANGEMENTS

One way that states are grappling with the high cost of caring for older prisoners is through attempted agreements between state departments of corrections and the provider community to take care of them. In the past several years, state legislation to parole some of-

fenders with infirmities in private nursing care centers has appeared in states like Connecticut and Kentucky. While not always successful and generally unpopular among consumer advocates, they represent just one of the ways that LT/PAC settings may interface with this population.

Another way that aged offenders may enter the health care system is via compassionate release. According to the U.S. Federal Bureau of Prisons (BOP), compassionate release was adopted by Congress as part of the Sentencing Reform Act of 1984 and is a process by which some seriously ill prisoners are eligible for immediate early release from their sentence in order to die outside of prison.

Several states across the country have compassionate release agreements with BOP, but few offenders have actually been released annually. That began to change in 2013, according to the Inspector General of the U.S. Department of Justice, with the number of individuals released on the rise since 2013.

FORMER OFFENDERS RE-ENTER

Distinct from current aging offenders, former offenders who have served their time are typically released back to the community through their state's department of correction re-entry program



Williams

if in existence, or they may re-enter via a halfway house, which provides transition services that include training, health care, and housing for a specified period of time.

Williams says these individuals face physical and social challenges from the start.

"When these individuals are released from prison, they may have multiple chronic and serious medical conditions that they must contend with, which can be further complicated by social risk factors such as homelessness, joblessness, and poor social support," she says.

KEEPING IN LINE WITH RESIDENT RIGHTS

In May 2016, the Centers for Medicare & Medicaid Services (CMS) published updated guidance for state survey agency directors clarifying federal guidance for providing services to "justice-involved individuals" in nursing care centers, skilled nursing facilities, and other settings. These include inmates of a public institution, individuals under the care of law enforcement, and individuals under community supervision.

According to the memo, skilled nursing facilities must meet Medicare and Medicaid eligibility requirements related to the level of care required in that setting. Regardless of the payer source, the facility must assess all individuals' needs and be able to maintain compliance with Requirements for Participation for all residents.

Further, the memo details that some department of corrections or law enforcements terms may conflict with CMS requirements, if the terms affect the care provided by the nursing facility or if the facility is violating an individual's rights by enforcing the terms.

IN PRACTICE: CARING FOR OFFENDERS WITH URGENT NEEDS

Janine Finck-Boyle is a former administrator and chief executive officer of a Washington, D.C.-based skilled nursing center and long term acute care (LTAC)

hospital. During her tenure in the early 2000s, her organization accepted offenders needing long term or post-acute care. The center had 105 beds, with 45 in the LTAC hospital.

"We would occasionally accept individuals who had been incarcerated and then needed health care. They would go to the local hospital for emergency care or surgery," she says. "Depending on the outcome, we potentially get people coming to us to be cared for in long term care or the LTAC hospital."

For example, Finck-Boyle says, in the case of an acute care episode, patients would come to the LTAC hospital and go on the ventilator for a short-term stay.

If the person needed to come for intravenous therapy, antibiotics, or if they had a stage three wound, they would come to the nursing center and stay for a short time. If the case was a chronic disease, such as cancer or chronic obstructive pulmonary disease, they would come for long term care and stay until death.

Finck-Boyle's company participated in the Medicaid program and had a contract with the District of Columbia Healthcare Alliance, a locally funded program providing medical assistance to low-income individuals not eligible for Medicaid or Medicare.

"It would usually be a handful of people at any given time" from the prison system, says Finck-Boyle. "There was no guard at the door; these people were very sick. If there was a parole officer,

we would know about that because they would need to monitor the individual."

THE REFERRAL PROCESS

Finck-Boyle's center received information from the main hospital (which was also owned by the same company) through a referral process. "The hospital would provide information on the individual's medical and social background. They would send the referral, and we would look at it and decide whether or not we could care for them. Since we were owned by the same company, we would try to help as much as possible," she says.

"The social history would include anything about drugs, alcohol, tobacco, and sometimes what prison they would be coming from," she says. When considering the vulnerability of the other residents and staff in the building, the social history would be critical information.

"Of course if we were getting information about a violent offender, we would know that up front, and then we would have made a decision. This was rare," she says.

With such a diverse mix of residents and patients, Finck-Boyle says it was important for the administrator to always be considerate where the few offenders being cared for were placed within the center. "I had to be very mindful, especially if there was a shared room," she says. "We also had a lot of clients that were referred to us that were heavy drug abusers, and they were young. If

'When considering the vulnerability of the other residents and staff in the building, the social history would be critical information.'

I had an 88-year-old female we were caring for, I couldn't put her with someone who was 35 and had a history of substance abuse."

AFTER CARE

After receiving care, Finck-Boyle says that individuals rarely went back to prison; those receiving long term care would typically remain in the nursing center until they died. This was because the center would choose patients with the highest acuity, she says. "We would look at individuals that we could care for in long term care or in the LTAC hospital."

In the hospital, patients had a goal to improve. "We didn't want patients' health conditions to plateau. Those that didn't succeed in their goal of getting better may have then gone into the nursing center," she says.

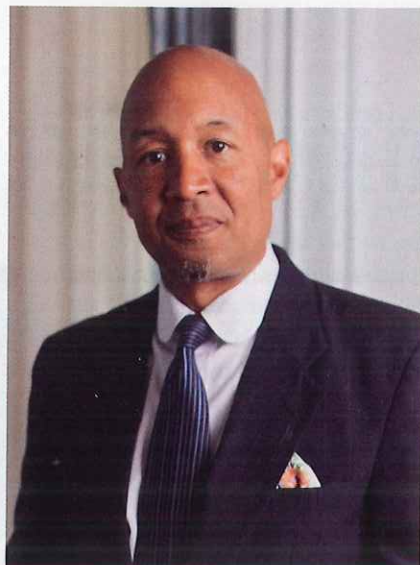
Finck-Boyle says that her staff approach for providing medical care was the same. "We didn't differentiate. We'd care for the individual as we'd care for anyone else that came to the center, regardless of background," she says.

When asked if others in the center ever raised opposition about providing care for the offenders, Finck-Boyle says no. "We never had an incident, everything just kind of moved along" like any one else's care.

CARING FOR FORMER OFFENDERS

Stoddard Baptist Home, a 64-bed skilled nursing center, and Stoddard Baptist Global Care, a 259-bed skilled nursing center, accept former offenders in the Washington, D.C., area. Stoddard has a long history of taking care of low-income populations in the city, beginning in 1902, says Steven Nash, president and chief executive officer.

"In Stoddard's earlier years, residents came via referrals from the Baptist churches in the area," he says. "We served all levels of the community, from ex-offenders, to preachers and school teachers—the door was open for all in need." In 1986 the center began partici-



Nash

pating in the Medicaid and Medicare system and because of regulations, accepted a fewer number of former offenders over the years. "We have still taken care of some individuals from the system, not as many as we did in the past," says Nash.

A CARE PIPELINE

The center accepts former offenders who have already served their time, are in the community, aged significantly, and are ready to be discharged from the hospital. There are potential situations where a person may be living in a halfway house, where they temporarily reside and receive programming to reintegrate into society. There, they may get sick and need significant care.

No formal agreement exists between Stoddard and the area hospital or halfway house to accept former offenders.

"Nine times out of 10 they are out of the prison system, and they have become ill and entered the hospital. Their information is put into the general system for all nursing homes to review," says Nash. All local nursing centers have a chance to review the person's total health condition provided by the hospital and decide whether or not to take on a case.

Like Finck-Boyle's center, Stoddard carefully decides if staff can care for patients based on their health profile.

"We can usually care for them medically, but if their needs require greater mental health resources than what is available, the individual could be better served elsewhere," says Nash. "We don't have psychiatrists or mental health staff on site every day."

Stoddard also sends nurses to assess the former offender in advance. "We want to make sure they are in a place where we can serve them well," says Nash.

He says that the former offenders may typically have the same medical care needs as a non-offender of the same age. "They may have some acute illnesses and those typical to the geriatric population," he says. Of course individuals may also have some health conditions related to their incarceration.

Nash says what makes caring for the former offender population different is their psychosocial needs, which are unique compared to other elderly resi- ➤

'All local nursing centers have a chance to review the person's total health condition provided by the hospital and decide whether or not to take on a case.'

dents. "It's very stressful to be in that prison system. Unfortunately, that may cause a lot of other issues for these people. It can have a significant effect on people's aging process and their illnesses."

LIKE EVERYONE ELSE

Similar to Finck-Boyle's approach, Nash says the center treats the former offender like everyone else. The individual goes through the sex offender background check, the same as other pending residents at Stoddard. All health information is kept confidential in accordance with the Health Insurance Portability and Accountability Act regulations. "We follow all the same rules and regulations for everybody," he says.

Former offenders may also have support from their parole officers. They may be required to stay in contact with the officer throughout their stay at any nursing care center; the officer may come to the center periodically to check on progress, says Nash.

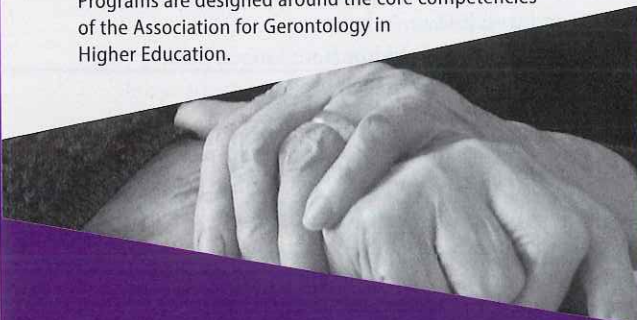
Nash recalls one former offender who had a serious offense and served significant years in the prison system. He came to Stoddard to receive care after his sentence was complete. "He had a parole officer while he was here that monitored his needs and made sure he stayed on the right track," says Nash.

Understanding Aging

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'Those who did their time need to go back in the community. They need to be in a place where they can succeed.'

"We worked with him and got him back in shape. He was able to successfully re-enter the community, and we found senior housing for him. That was a good success story for us." Such experiences are encouraging for Nash and his staff. "We'd like to have more of those down the road," he says.

After a successful stay at any nursing center, a typical former offender could go into a housing arrangement that could be seniors housing or affordable housing. Young former offenders also search for housing with help from the social worker staff, and they also seek employment.

"Those who did their time need to go back in the community," says Nash. "They need to be in a place where they can succeed."

For senior former offenders returning to the community, a social worker will handle the discharge planning as they would do for any resident. "They use the same resources that we have for other residents here being discharged," says Nash.

ADVICE FOR OTHER PROVIDERS

For providers caring for current or former offenders, Nash recommends sticking to the mission of their organization and learning from others already doing it. "It's important for providers to have resources so they feel comfortable if they haven't done this before," he says. "The geriatric population of ex-offenders will need some different levels of support. Just be sure you're able to take care of them and you're honest about it."

Finck-Boyle's advice for facilities with an interest is to be open. "It's difficult and can be very challenging, but there are very acutely ill individuals that need care services in prison," she says. For providers with no prior experience, she recommends cultural sensitivity training for staff and resources to help them increase their understanding.

It's also about attitude. "If someone crosses our door we look at that person holistically," says Nash. "If we can care for them, we do. I advise folks to take that attitude. You'll have to do some different things. You have people that want to come back in the community and live and change their lives, and we owe it to our society to look out for them and help them succeed." ■