

Geriatrics and Palliative Care in the Correctional Health Setting

*Taking Care of Older and Seriously Ill Patients on
Rikers Island*

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Who counts as “older”?

- In the community: 65 and older
- In correctional settings: US Bureau of Justice Statistics uses 55 and older
- Phenomenon of **“Accelerated Aging”**:
 - Theory that incarcerated patients may seem 10-15 years older than their chronological age
 - Takes into account high prevalence of risk factors for poor health in this population: e.g. Substance use, TBI, low socioeconomic status
 - Recognizes early onset in this population of disability and serious sequelae of chronic disease

1. Ron H. Aday, *Aging Prisoners: Crisis in American Corrections*, Praeger, Westport, CT, 2003.

2. Brie A. Williams, James S. Goodwin, Jacques Baillargeon, Cyrus Ahalt and Louise C. Walter, “Addressing the Aging Crisis in U.S. Criminal Justice Health Care”, *Journal of the American Geriatric Society*, Vol. 60, No. 6, 2012.



Older Patients in the NYC Jails: In the Literature

- From 2001-2009, admissions of people in the 55-64 year old age group at Rikers increased by 88% and admissions of individuals >65 years increased by 34%
- An analysis of mortality trends over the same period found that the death rate/100,000 inmates amongst patients 55-64 years old was double the death rate for patients 45-54 years old

Brittain J, Axelrod G, Venters H. Deaths in new York City Jails, 2001-2009. Am J Public Health. 2013; 103:638-640.

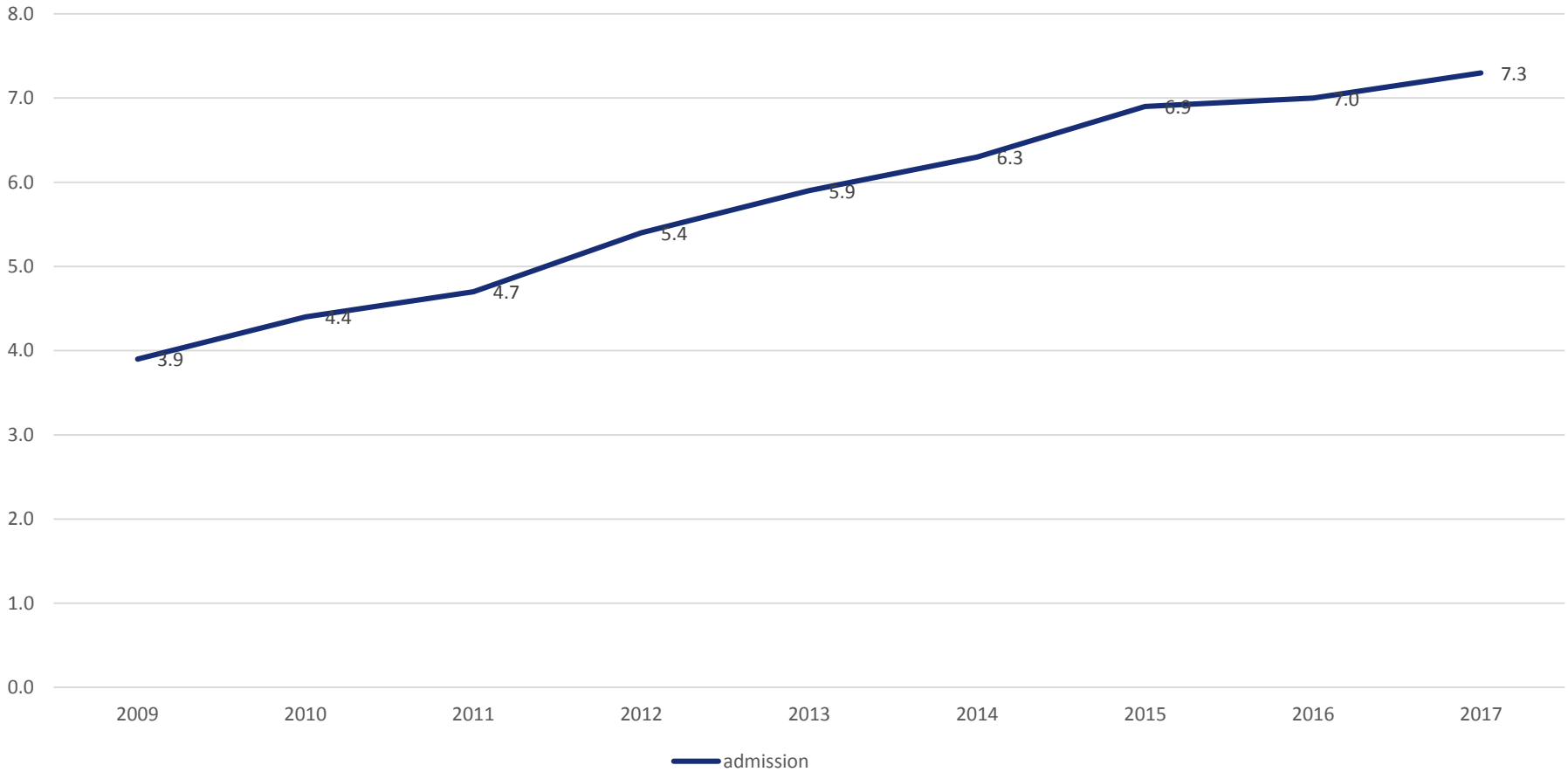
- In an analysis of the Rikers Island “Hot Spotters”, the most frequently incarcerated individuals in 2013, 14.5% of the frequently-incarcerated cohort was over 50

MacDonald R, Kaba F, Rosner Z, et al. The Rikers Island Hot Spotters: Defining the Needs of the Most Frequently Incarcerated. American Journal of Public Health. 2015;105(11):2262-2268.



Older Patients in the New York City Jails: Unpublished Data from 2009-2017

Percentage of Admissions to NYC Jails of Age >55



Older Patients in the New York City Jails: Unpublished Data from 2015-2017

	All Patients	Under 55	55-64	65 +
Total population	158, 693 (100%)	147, 611 (93%)	9,950 (6.2%)	1,231 (0.8%)
Female	9.1%	9.3%	7.0%	6.0%
Non-Hispanic White	14.3%	14.2%	14.7%	22.1%
Non-Hispanic Black	55.2%	54.9%	61.8%	48.9%
Hispanic	25.5%	25.9%	19.4%	23.2%
Other/Unknown	5.0%	5.0%	4.2%	5.8%



Older Patients in the New York City Jails: Unpublished Data from 2015-2017

	All Patients	Under 55	55-64	65 +
Length of Stay (mean)	66.9	67.3	59.9	75.3
Self-reported homelessness	10.8%	10.5%	14.5%	13.2%
Medicaid	83.8%	83.7%	85.8%	73.8%
M- status (Mental Health diagnosis)	44.7%	44.6%	47.4%	37.4%
Serious Mental Illness (SMI)	6.7%	6.4%	10.5%	11.7%



Older Patients in the New York City Jails: Unpublished Data from 2015-2017

	All Patients	Under 55	55-64	65 +
Number of Diagnoses (mean)	2.5	2.4	3.6	3.35
Number of hospitalizations per admission (mean)	0.03	0.03	0.07	0.15
Number of medications (mean)	4.16	3.99	6.34	6.91
Total # of medical, specialty and mental health encounters (mean)	11.18	10.9	13.67	25.54
HIV/AIDS	3.3%	3.0%	8.8%	5.7%
Hep C	4.6%	3.9%	14.4%	15.0%



Older Patients in the New York City Jails: Unpublished Data from 2015-2017

	All Patients	Under 55	55-64	65 +
Hypertension	10.1%	8.1%	35.7%	46.1%
Diabetes, type II	4.6%	3.7%	16.4%	18.8%
Cancer	0.8%	0.6%	3.1%	5.8%
Coronary Artery Disease	0.5%	0.3%	2.6%	5.8%
Congestive heart failure	0.3%	0.2%	1.0%	3.0%
COPD	0.6%	0.4%	3.0%	6.2%
Self-report, any opiate use	41.6%	14.1%	21.8%	12.3%
Self-report, cocaine use	21.4%	20.5%	35%	19.3%



Challenges in Caring for the Older Population: Geriatric Syndromes

Geriatric syndromes:

Multifactorial clinical conditions that do not fit into discrete disease categories

In older adults, these conditions are:

- Prevalent
- Impact quality of life and function
- Often involve multiple organ systems
- Have heterogeneous presentations
- More common in **frail elderly**



Geriatric Syndromes: Jail-related Risk Factors

Geriatric syndromes:

- Urinary incontinence → Embarrassment; victimization
- Weight loss, frailty → Diet; poor dentition; isolation
- Pain → Prevalence of chronic pain in pop; limited PT
- Sensory impairment → Easily lose hearing aids, glasses
- Cognitive impairment → Isolation; victimization; legal issues
- Delirium → isolation; new environment; lack of sleep
- Constipation → Diet; limited exercise; med effects
- Polypharmacy → Discontinuity of care; anticholinergics
- Falls → Limited assist devices, shackles, built environment

Challenges in Caring for the Older Population: Treating Serious Illness in Jails and Prisons

Fundamental disconnect between incarceration and providing community-standard-of-care palliative care:

- *Barriers between patients and families*
- *Lack of control exacerbated by custody*
- *Lack of privacy*
- *Limitations on use of pain and anxiety medications*
- *Negative feelings associated with incarceration – shame, depression, regret, anger, trauma – complicated by illness, and vice versa*



CHS Geriatrics and Complex Care Services in 2017

- To our knowledge, Dr. Bedard is the first dedicated jail-based geriatrician and palliative care physician

Services provided:

- Geriatric assessments
- Palliative care/complex care assessments
- Ongoing management of geriatric syndromes, complex decision-making, symptoms as needed
- Advanced care planning
- Intra-facility care coordination and coordination with hospital services
- Coordination with court liaisons
- Discharge planning



CHS Geriatrics and Complex Care Services in 2017

- 120 unique patients
- Patients identified by referral and EMR report based on age, illness
- Coordination with legal services on behalf of 35 patients to expedite appropriate discharge plans for patients with serious illness
- 26 patients eventually returned to the community
- 6 patients deceased since return
- 15 patients placed at Coler nursing home since transition to H+H

