Care for Aging Patients in the Correctional Setting

Position Statement

The National Commission on Correctional Health Care recognizes the importance of effectively caring for the growing population of aging patients who reside in carceral settings.

This position statement does not address the provision of inpatient care of aging people in the correctional setting such as that provided in skilled nursing, palliative care, and hospice units.

Correctional health care systems should adopt policies and procedures that specifically address the delivery of health care to aging patients. Health care policies should be informed by input from knowledgeable stakeholders such as health care professionals with expertise in geriatric care and community advocacy organizations.

Older adults in the carceral setting should be evaluated and treated for health care conditions in accordance with evidence-based guidance. Key clinical care considerations should include the following:

1. Older adults should receive preventive health care services in accordance with age-based recommendations of the U.S. Preventive Services Task Force[1].
2. Older adults should receive immunizations in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, including provision of recombinant zoster vaccine and respiratory syncytial virus vaccine.
3. Older adult patients should not ordinarily be prescribed medications that are considered inappropriate for use in older adults as defined by evidence-based geriatrics recommendations. Medication reconciliation should be conducted regularly to confirm that the patients' treatment regimens are being administered as prescribed without omissions, duplications, dosing errors, or concerning drug interactions.
4. Older adults should be screened for cognitive impairment using a validated tool. Screening should be conducted when clinically indicated and preventively during periodic health assessments in accordance with protocols approved by the clinical authority.
5. Older adults should be screened for depression using a validated tool. Screening should be conducted when clinically indicated and preventively during periodic health assessments in accordance with protocols approved by the clinical authority.
6. Older adults should be assessed during periodic health assessments for sensory deficits, fall risk potential, sleep disturbances, dietary intake, weight status, dentition issues, skin integrity, incontinence, mobility concerns, and other functional impairments that may impact instrumental activities of living and participation in correctional programs. Identified concerns should be addressed in the patient's treatment plan that may include, in part, recommendations for fall prevention, sleep hygiene, adaptive devices, interventions to address sensory deficits, therapeutic recreational activities, and housing accommodations.
7. Correctional health professionals should be attuned to the signs and symptoms of potential elder abuse during clinical encounters with older adults, provide medical and mental health care as clinically indicated, and advocate for correctional interventions to ensure patient safety.

Correctional health care systems should establish clear policies and procedures for discussing, documenting, and completing advance directives and medical orders for life-sustaining treatment (MOLST) for incarcerated people

in accordance with the recommendations in the NCCHC position statement on MOLST. Specific provisions should be included that address the needs of incarcerated people who lack decision-making capacity and may lack the support of family and friends to participate in end-of-life decisions.

Correctional health professionals should advocate for older adults who are candidates for compassionate or medical release by providing timely and well-documented diagnostic evaluations and comprehensive discharge plans for eligible patients in accordance with applicable state and federal policies.

Correctional health professionals should ensure that postrelease transitional health care plans address the cognitive, emotional, and physical health care needs that commonly affect older patients. Transition plans should be patient centered and initiated upon incarceration. As appropriate, they may include supporting patient health literacy to navigate continuity of care, facilitating access to health care benefits, anticipating the potential need for mental health care services, supporting reengagement with family and other social supports, providing accessible and safe housing accommodations, and assessing health care conditions that may affect compliance with parole and probation requirements.

Discussion

In 2021, adults aged 50 and older represented 20% of adults in state and federal prisons in the United States.[2] By 2030, it is anticipated that about one third of all U.S. incarcerated people will be over the age of 50, marking a growing proportion of older adults living in carceral settings and requiring comprehensive medical care with significant associated costs.[3-4] Incarcerated people may present as 10 to 15 years older than their chronological age due to cumulative effects of stress and violence during incarceration as well as risk factors for poor health over the life course.[5] Thus, state and federal prison policies have adopted a range of lower thresholds, from 50 to 65 years of age, for defining older adults.

Older incarcerated people have higher rates of chronic disease and mental health problems as well as higher utilization of health care resources compared to their younger counterparts and nonincarcerated older adults.[3,6-7] A 2016 survey indicated that disabilities were self-reported by 70% of prisoners 65 years of age or older compared to 35% of the U.S. adult population. The rates of different disabilities reported by state prisoners 65 years of age or older were ambulatory (46%), hearing (35%), cognitive (27%), and vision (24%).[8] Additionally, the physical and cognitive impairments faced by many older incarcerated people make them more vulnerable to elder abuse within the carceral setting.

Correctional health care systems should adopt policies and procedures and patient-centered treatment plans that adequately address the complex health care needs and vulnerabilities of aging patient populations during incarceration and upon transition to the community.[9-10] Comprehensive, age-friendly health care prioritizes the use of evidence-based tools to assess and act upon four key areas: mobility, mentation, medication, and what matters.[11-12] This model can be adapted to optimize care for aging adults in the carceral setting.

Mobility

Age-associated physical changes can impact the ability of older adults to move safely and function independently. In the broader U.S. population, falls are the primary cause of injury-related visits to emergency departments and are the leading cause of accidental deaths in individuals over 65.[13] This problem is exacerbated among older adults with mobility issues or functional impairments, who are five times more likely to be

admitted to long-term care facilities and three times more likely to be hospitalized than their peers without mobility issues.[14] Fall risk can be heightened considerably in the correctional setting due to myriad potential physical and environmental constraints. Challenges may include navigating overcrowded conditions, climbing on and off one's assigned bunk, walking long distances to the dining hall or health care unit, maintaining stability when coping with security restraints, responding to alarms, and avoiding safety hazards.

Correctional health professionals can play a pivotal role in fall prevention for their aging patients by conducting fall screenings during periodic health assessments usings sources such as the CDC STEADI toolkit[14-15] and by prescribing evidence-based treatments aimed at maintaining strength, balance, and flexibility. Such interventions will improve patient well-being and reduce health care costs.[16-18]

Mentation and Sensory Deficits

Undetected or poorly managed changes to mental activity can critically impact older adults.[19] In the United States, 12% to 18% of adults over 60 are living with mild cognitive impairment (MCI), and 10% to 15% of them will develop dementia.[20] Additional risk factors for dementia include poor diet and lack of physical activity, high levels of stress, low education levels, traumatic brain injuries, and reduced access to preventive health care, which are more likely experienced by incarcerated older adults compared to the community-dwelling older population.[10] Relying on patient self-reports of cognitive impairment may significantly underestimate its prevalence in the carceral setting. In screening studies, 40% to 78% of incarcerated older adults show signs of mild cognitive impairment.[21-22]

Incarcerated people with cognitive and sensory impairments face considerable challenges navigating day-to-day living in highly regimented correctional settings. Challenges may include effectively engaging in correctional programs, hearing and obeying orders from public safety officials, visually navigating safety hazards, and being misunderstood by their peers and correctional staff. Of notable concern, cognitively impaired people may be subject to unjust disciplinary action and victimization from other residents.[23] Additionally, older adults may experience profound isolation during incarceration and disengagement with their families. They are at higher risk for depression, suicidal ideation, and suicide than their younger peers.[24-27]

Correctional health professionals should assess older adults for cognitive impairments, depression, and sensory deficits during periodic health assessments. The Mini-Cog screen for cognitive impairment is a validated tool that allows for staging and monitoring for disease progression.[28-29] The Montreal Cognitive Assessment (MoCA) and Saint Louis University Mental Status (SLUMS) exam are other validated assessment and staging tools.[30-31] Asking patients about any vision and hearing loss during periodic health assessments can be a simple initial assessment for sensory deficits. The early detection of cognitive and sensory impairments in aging patients allows for timely treatment interventions, ongoing assessments for further declines, and the provision of accommodations to facilitate institutional living.

Medication Management

Aging incarcerated patients often require treatment with complex medication regimens for highly prevalent medical and mental health concerns. Optimizing medication management should be a priority for these patients and considered a potential risk management concern. Adults metabolize drugs differently as they age, increasing their susceptibility to adverse drug events. It has been estimated that up to 30% of hospital admissions for older adults are related to adverse drug reactions.[32] Correctional settings can also present challenges for effective

medication management that can include frequent staff turnover, suboptimal information technology, and public safety constraints.[33]

Correctional health professionals should receive training on optimizing medication management for their older patients. A valuable guide is the American Geriatrics Society Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults,[34] a regularly updated, evidence-based reference tool that provides important guidance for safely prescribing medications to older patients. Additionally, medication regimens for older patients should be regularly assessed and reconciled at least annually to identify medication omissions, duplications, dosing errors, potential adverse drug interactions, and benefit versus risk of prescribed medications.[35]

What Matters

Asking patients "What matters to you?" is central to achieving patient-centered care and shared decision-making.[36] An age-friendly approach includes aligning care with the older adult's specific health outcomes, preferences, and goals, and often includes advance care planning and end-of-life care.[11-12] Although limited, research in the correctional setting has identified many barriers and constraints on individual-driven decisions to advance care planning and palliative and end-of-life care.[37-38] Additionally, although medical/compassionate release is an option for certain aging patients with disabling or life-limiting illnesses, multiple barriers exist in many correctional systems that limit this option.[39]

Correctional health care administrators can support "what matters" to aging patients by (a) training their correctional health care workforce to identify patient preferences and goals as well as carry out advance care planning discussions,[40] (b) training their interdisciplinary health care teams to provide evidence-based palliative care, and (c) providing administrative oversight to maximize efficiencies in the evaluation and review of medical/compassionate release requests.

Correctional health professionals can support "what matters" to their aging patients by (a) discussing advance care preferences with their patients upon incarceration and annually thereafter and documenting these preferences in the patient's medical record, (b) providing palliative and compassionate end-of-life care that values patient preferences, and (c) providing timely and thorough diagnostic evaluations and reentry plans that facilitate medical/compassionate release for potentially eligible patients.

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