Improving Delivery of Care to Hospitalized Incarcerated Patients

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Background

- Hospitalization of incarcerated persons brings added expenses, i.e. secure transportation and guarding.
- If imprisonment trends continue, the cost of providing care for this group can be expected to rise.
- Educating community hospital providers on practices that can improve the care of this population may help reduce their healthcare costs and safely increase healthcare value.

Objectives

- Develop an educational curriculum for hospital clinicians on the care of hospitalized incarcerated patients with a goal to
  - improve clinician's ability to identify areas related to treating hospitalized incarcerated patients that can be improved
  - implement strategies to improve transitions of care to and from correctional facilities when hospitalized in a community hospital

Methods

- A literature review was performed using Pubmed.
- Meetings were had with stakeholders, including hospitalists, obstetrician-gynecologists, addiction medicine specialists, prison medicine physicians, lawyers and legal/risk management specialists, RNs, CM/SW, public safety/security, and private and public correctional medical directors.
- Data and policies related to hospitalized incarcerated patients were summarized. Based on key findings from the above, improvement strategies were proposed and a lecture series was developed to disseminate this information.

Results

Clinical Care and Outcomes

- Early aging phenomenon: 2-year decline in life expectancy for each year served in prison.
- 10% are serving a life sentence; at some point, they will likely require hospitalization
- Harms related to shackling:
  - proactive injury to patients, damage to underlying structures leading to skin breakdown, compressive neuropathies, and fractures of the small bones of the hand, and influence on provider bias.
  - predisposition to falls, deconditioning, and elevated risk of VTE
  - They can impede exam maneuvers, delay positioning during seizures, predispose to falls, promote deconditioning, and elevate risk of venous thrombosis.

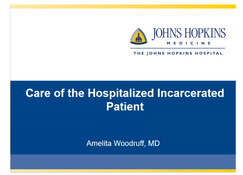
State and Federal Policies Summary

- 4 types of correctional health care delivery systems: direct, contracted, state university, and hybrid models. The type influences hospital care and subsequently costs.
- Hospital care accounted for about 20% of health spending in 10 states between 2007 and 2011. More recent data revealed that New York spent 23% and Virginia 27% on hospital care.
- Prison health care isn't insurance-based, but copay or fee based.
- As of February 2022, all federal prisons and 40 states charge incarcerated people a copay when they initiate medical care. The average cost falls around $2
- In some states, not everything is covered by copay, i.e. medications and additional treatment
- Incarcerated people aren't allowed to keep basic over-the-counter resources like NSAIDs or cold medication. Reports suggest this influences patients to wait until symptoms are severe to seek care.

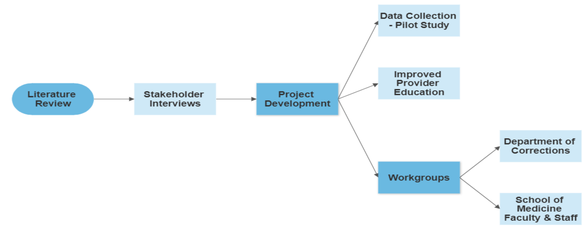
Successful Interventions

- California: algorithm to i.d. patients at risk for readmission RN follow-up after discharge. Over two years, the hospital readmission rate decreased from 9.3 to 2.4 %
- L.A. County built an urgent care center at its jail. ~ five fewer patients a day sent to a hospital. After six months, the jail had saved over $1 million in transportation costs and a nearly identical amount from fewer visits
- On site prison hospitals built in Texas
- "Locked" units in community hospitals
- Massachusetts: $3 copay cannot be collected for dx and tx of contagious diseases & all mental health care.
- Medicaid expansion
- Buprenorphine X- waiver
- Telemedicine!

Lecture/Course Development



Creation of Health System Work Group



Conclusion

- 3 important themes i.d.'d to provider understanding and education could lead to the implementation of interventions that can safely increase healthcare value for this population.
  - Improved communication with the prison system
  - Optimized care while in the hospital, such as temporary removal of shackles, initiation of MOUD or infectious disease therapy, and end-of-life care
  - Expanding programs such as telemedicine and mobile services. A lecture series for hospital providers was developed highlighting the above findings and outlined recommendations on how to implement some of these changes.
- Future: replication of established programs in other states to avert some off-site care.

References

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I have nothing to disclose.