

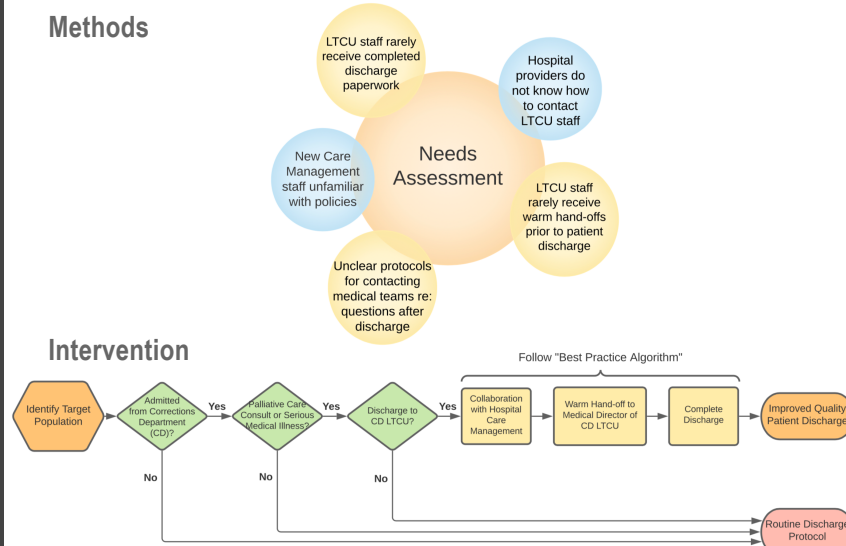
Background

- Prisons are constitutionally required to provide health care
- Incarcerated persons are often sicker than the general population and have more medical comorbidities¹
- The number of state and federal prisoners 55 years of age or older was estimated to increase by 234% between 1999 and 2013.² With this aging population comes more palliative care needs.
- Care Transition** (def): movement of a patient from one setting of care to another
 - Transitions increase risk for adverse events due to potential miscommunication during transfers
 - Safe and effective transfer of patient medical care relies on effective provider communication³

Project Aims

- Identify unique challenges related to care transitions of persons who are incarcerated, specifically those with complex medical needs
- Create an educational intervention for inpatient clinical staff to identify patients with palliative care needs, and encourage use of a best practice algorithm when discharging these patients to Corrections Department (CD) Long-Term Care Unit (LTCU) facilities
- Establish relationships between the inpatient Palliative Medicine Consultation Service and Corrections Department LTCU staff to improve care coordination and communication about shared patients during and after hospital discharge

Methods



Quality Improvement Pilot Project

Target Population: Patients

- Incarcerated patients
- Palliative care needs or serious medical illness
- Planned discharge to CD LTCU

Target Population: Intervention:

- Internal Medicine Residents and Attendings
- Family Medicine Residents
- Hospital Care Management Team
- Palliative Care Consult Service

Pilot Timeline:

- February – April, 2017

* Intervention delayed due to Covid-19 surge

Educational Intervention

Introduction to vulnerabilities related to care of incarcerated persons, particularly around care transitions (i.e., hospital discharge)

Introduction to New Mexico Corrections Department structure and medical capacity at LTCU

Creation of a "Best Practice Algorithm"

For reference by:

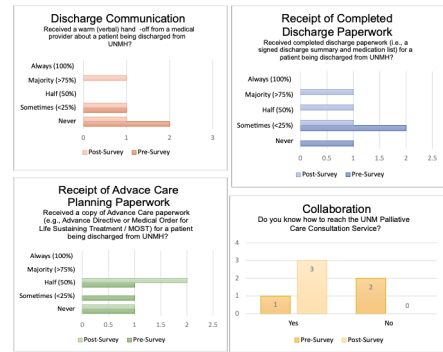
- Internal Medicine Department
- Family Medicine Department
- Hospital Care Management

Protocol:

- Warm (verbal) handoff to Medical Director of Corrections Dept LTCU
- Discuss hospital diagnoses, treatments
- Review discharge medication plan
- Update on status of Compassionate Release application (if in process)
- Provide contact info for primary medical team if follow up questions arise

Measures

Surveys of NM CD LTCU staff:
 Within the past 3 months, how many times have you . . .



"We had a really good interaction with [medical director of the LTCU] a week or so ago concerning a shared patient we had by virtue of your project. Having his contact and knowing he was available to discuss a transitions element for our patient led to us initiating a plan of care we otherwise would not have known would work at the LTC."
 – UNMH hospitalist

Discussion / Next Steps

- Hospital discharge is a high-risk transition for any patient, particularly those who are already vulnerable (e.g., incarcerated, with complex medical needs including palliative or end-of-life care needs)
- This quality improvement pilot demonstrated improved communication and collaboration; we hope to expand use of this process to other hospital and outpatient departments

References

¹ Linder J and Meyers F. Palliative Care for Prison Inmates. "Don't Let Me Die in Prison". JAMA. 2007; 298(8): 894-901.
² Pew Charitable Trusts. 2014. Prison Population Continues to Age. Oct. 3. <https://www.pewtrusts.org/en/research-and-analysis/articles/2014/10/03/prison-population-continues-to-age> (Last accessed 01/02/2021)
³ Agency for Healthcare Quality and Research: Chartbook on Care Coordination. <https://www.ahrq.gov/research/findings/hqdr/chartbooks/carecoordination/measure1.html> (Last accessed 01/02/2021)