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Addressing Complex Primary Care Needs for an Older Man Recently Released from Incarceration with Multiple Emergency Department Visits

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ABSTRACT

Purpose	Older prisoners being released into the community need to be placed in a system to help them transition from living in prison to living in a free society. They must adapt in order to find housing, community services, medical, dental, and psychiatric care. When the complex social needs of these persons are not fully met, the emergency department is used as a safety net.
Methods and Findings	This paper describes a patient who had multiple emergency department visits which were his routine method of seeking medical care.
Health Care Policy Implications	We believe that public health policy requiring a comprehensive geriatrics assessment with a focus on memory and abilities prior to release from prison for older inmates may optimize care. The emergency department, in this case, is in a unique position to provide geriatric appropriate assessments and hopefully halt the multiple emergency department visits. Changes in public health policy may be beneficial in the care of our patients. Clinicians may be able to advocate for changes in public policy through their health system public policy advocate or professional organizations. This change may positively impact unnecessary ED usage and reduce expenditure.

CASE PRESENTATION

A 72-year-old male with a history of long-standing incarceration for much of his adult life and alcohol and smoking dependence presented to the Emergency Department (ED) eight different times due to unmet housing and personal needs. He was typically brought by the police or an ambulance to the ED after being found intoxicated at night in a disheveled state. After a brief stay in the ED, he would be discharged to the community, having recovered from the drinking episode. Due to short ED stays which were mostly at night, he was not able to access resources, consult with social work, or see physical therapy. Cognitive testing was limited due to his intoxicated state. He was advised to follow up with primary care. A review of the medical chart did not reveal that he had accessed community resources.

Finally, the patient came to establish primary care in our clinic after being released from prison. He was homeless, wearing ripped prison clothes, and was missing his glasses. He had recently lost 13 pounds. He had a history of hypertension, hyperlipidemia, latent tuberculosis, prostate cancer, surgery for small bowel obstruction, inguinal hernia, chronic obstructive pulmonary disease, and decreased vision and hearing. He reported a fourth-grade education level and he had worked low-paying jobs. He had little contact with his only living sister and had no children. He had a parole officer; however, we were unable to contact him. He denied any psychiatric history. Unfortunately, shortly after seeing us in the primary care geriatrics clinic, the patient returned to jail.

DISCUSSION

We describe a 72-year-old male that had been in and out of prison since the 1980s, dealing with issues of alcohol, smoking, and homelessness. We learned that even though there are several programs available to help transition prisoners at the time of release into the community, there are no effective systems targeting older prisoners, leaving many homeless and without needed medical care.

There are 700,000 people released from prison yearly and seven million released from jail.[1] Older inmates, who constitute 8% of the prison population, need $67,000 per year for maintenance while younger inmates need $18,600 per year. This causes a strain on the system.[2] Older inmates commonly have functional impairments, hearing and vision loss, arthritis, and other major medical illnesses. Studies demonstrate that 47% of older inmates intend to use the ED after release, which can consist of over 250,000 people yearly causing unnecessary expenditure.[3] A fraction of this cost could properly be used to implement a system to help transition newly freed people to find a home and a job, therefore a more beneficial option for society as a whole. The limited resources to address substance use disorder for these individuals may not match the needs of older adults.[4]

Once released from prison it may be difficult to establish primary care due to an inability to find a stable place to live. The rates of depression for former prisoners are said to improve if they are able to find a home. These shortcomings make it almost impossible to establish primary care and ensure that they are taking their prescribed medications. Furthermore, undiagnosed and untreated geriatric syndromes may place them in a situation where they are unable to appropriately take part in the legal system or stay safe in jail. This could easily affect their health, place others in danger of criminal activity, and increase their chance of re-arrest. Given that there is a lack of knowledge about geriatric syndromes by legal experts, it may lead to an inability of the older adult to fully comprehend the situation and advocate for themselves.[5] The level of mental health needs and substance abuse among homeless former prisoners is very high compared to other community members, so there must be efforts to help the unmet needs of those inmates released.[6] This care for older patients with complex needs is vital to sustaining society, especially focusing on those leaving jails with fewer opportunities. There is a lack of social work education for older prisoners who are transitioning into the community. Younger prisoners released hold a greater priority in society and are offered more opportunities in comparison to older prisoners that suffer due to the lack of resources available.[7] There must be an initiative to educate legal professionals about age-related health.[4] This in turn could help us create a care plan for those incarcerated and will help the system run more efficiently.

For this patient, the behavioral and social health needs are tied to his medical needs. Therefore, the primary issue that must be addressed is the way we can help his transition back into society. This effort may decrease ED visits, substance use disorder, and multiple imprisonments.[4] The development of a care plan and collaboration with the ED and Department of Aging may help. A change in public health policy that requires a comprehensive geriatrics assessment, especially a cognitive screen, before being released to determine the ideal living situation and define his functional abilities would be optimal. The patient did not have primary care at the time of the ED visits, making it difficult to transition medical care into the community.

LESSONS LEARNED

This case illustrates shortfalls in the system leading to barriers in the optimal care by the clinician, especially lack of recovery programs focused on the needs of older adults, incomplete geriatrics assessment, and lack of involvement of decision makers. Three best practices for ED Clinicians:

1. Assess older patients who have been recently incarcerated for cognition and function as they are vulnerable individuals for unmet social and functional needs. When assessments are not available or not possible due to time constraints, recommend connecting the older patient to a geriatric clinic.

2. Consider assessing older patients who are vulnerable using an interdisciplinary team in the ED including social work, PT/OT, nursing, pharmacy, and ED clinicians. Ask the patient or family if they are at baseline function to ensure that they are able to return home.
3. Communicate and coordinate with the patient's primary care office and have them connect with the individual's parole officer for appropriate follow-up care before the individual leaves the ED. As health care professionals we may not be aware of our patients having a parole officer. The social worker could provide appropriate outreach to these individuals.

KEYWORDS

Incarcerated, older adults, prisoner health

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AUTHOR CONTRIBUTIONS

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CONFLICTS OF INTEREST

Michael L. Malone owns stock in Abbott Labs and Abbvie. All other authors have no conflicts to report.

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