# A PROPOSAL TO THE D.O.C.

# FOR A MALE SUB ACUTE/ACUTE/HOSPICE CARE PRISON

This is a general proposal to convert Bay State Correctional Center into a sub-acute care center and Hospice Program with a Dialysis Specialty Clinic. This will equip the D.O.C. and its medical provider with the space/housing to accommodate the fastest growing segment of the prison population - the mushrooming aged in prison. The current capacity of the Skilled Nursing Facility (SNF) at MCI Shirley (29 beds[1]) and the Assisted Daily Living (ADL) Units at Shirley and Norfolk (29 total beds[2]) is woefully short of the current demand for such care of the male population. Further, the dialysis specialty clinics at Shirley and the Treatment Center (7 stations[3]) are maximized and will soon fall short of demand.

Of all the state prisons Bay State Correctional Center has a very unique structure most amenable to become an advanced elderly care center for the growing elder population in corrections. None of the present facilities meet standards for elderly care, also the operational schedules and rules are not conducive for the elderly and handicapped population. In a study by the D.O.C. evaluating how to handle its growing elderly population they said that it is important to provide older inmates both a "protected" environment as well as mainstream housing to offer the maximum degree of flexibility in their classification and assignment.[4]

Bay State offers two floors in the main building that are available for handicapped or elderly as there is an elevator. It is a self contained unit where all functions/activities are indoors and therefore would be accessible. The third floor could be housing for companion, hospice and cadre workers so they would be readily on-hand to assist and care for the patients. A two tier annex housing building, close to the main building could also be used, possibly with a focus for aged veterans in prison. It is wheelchair accessible to the main building through a very short outdoor path. The 2nd floor of that building could be for the ambulatory aged vets as well as for companion, hospice and cadre workers who could be tasked with the labor operations that the elderly cannot do. Bay State is small enough to allow elders to get around without worry of overexerting in a short amount of time allowed in a mainstream prison.

The present housing for elderly in the D.O.C. is in dire need. None of the present hospital housing will handle the influx of need. This is confirmed in the 2011 Corrections Master Plan, concerning "medical" where they have stated, "[t]he most pressing need for medical population is the estimated **635** prisoners suffering from long term, chronic illness requiring sub-acute care."[5] This means that currently, there are elderly individuals in population suffering in many ways trying to do their day-to-day activities. The D.O.C. also states that an in-depth needs assessment study that focuses on Medical Services Delivery in the Correctional System should be implemented;[6] that it is the medical vendor who is charged in the short term with, "determine[ing] needs for Prisoner population in a manner to minimize the overall costs to the DOC for transportation and security coverage as well as proposing alternatives that may be more cost effective from the current system concerning specialty clinics."[7] It is my hope that this proposal will help toward that end.

It is clear that the disparity between the estimated 635 prisoners who will soon need sub-acute care and the 58 beds currently available to meet that need is dramatic. It is also clear that the two facilities which have the 58 beds (MCI Norfolk and MCI Shirley Medium) have minimal ability to expand and keep it all in one building. Lastly, the Commonwealth's application of its discretionary criminal justice policies contributes to an ever increasing elderly prison population.

The lack of a viable compassionate release law, just one commutation granted since 1988, and the 2011 restructure of the parole board resulting in a lifer parole rate of less than 10% all contribute to the over 50 year old demographic increasing at a 5% annual rate.

Baystate and Old Colony are the only two prisons that are both: 1) all indoors/self contained and, 2) handicap accessible for half the population. Of the two, Bay State is the closest prison to Lemuel Shattuck Hospital which is an important consideration for a prison population that would be in more need of specialty medical services requiring transportation to the Jamaica Plain hospital. The facility count at Baystate is 327 as of January 2013, 20% over its design capacity of 266 as apposed to Old Colony Medium with a count of 781, 57% over its design capacity.[8] Although Old Colony's capacity is closer to the Corrections Master Plan estimated demand for prisoners suffering from long term, chronic illness, it is already established to focus on mental health care combined with its closeness to Bridgewater State Hospital. Between 1998 and 2006, the number of mentally ill people incarcerated in federal, state, and local prisons and jails more than quadrupled.[9] This was the cause of the DOC taking steps to change Old Colony to meet that growing need – a need which continues to this day and Old Colony is addressing. Further, the physical design of OCCC is better for a mental health facility; it is geared for higher security levels enabling the prison to section off at certain 'choke points' in case of emergencies.

This leaves Baystate as the only other handicapped accessible, indoor/self contained prison. This is a critical criteria for effective hospice care that is currently not addressed or provided at MCI Shirley. The reason for stressing handicapped accessible is self evident in meeting needs of the many non-ambulatory, wheelchair bound patients. The reason for stressing a self contained indoor physical structure is to allow for all of the nine criteria for hospice care future needs requested by the DOC of their medical vendor to be met.[i] The current Skilled Nursing facility at MCI Shirley does not allow for "patient directed holistic care." When a patient is having a good day and would like to go to church, library, or a program, or may want to talk to a close friend they have known for decades who is another prisoner in the facility – they are not allowed at MCI Shirley. In an indoor/self contained facility the infirmed could easily go to church, library, etc. locations. This would meet another unmet goal of the nine listed hospice care objectives: "emotional and spiritual support." Further, in a <u>whole</u> prison focused on hospice care, volunteers would be better treated and informed.[ii]

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[i] Request for Response: Comprehensive Health Services to Massachusetts Prison Population, RFR# 14-DOC-9004 – Prison Health Services, December 12, 2012, section 2.11.2 Medical Services Future Needs: Hospice Care. Where the DOC states …

a proposal for a hospice care program that meets the following criteria:

1). Interdiscipline, **patient directed holistic care**
2). Pain management
**3). Emotional and spiritual support**
4). Palliative, comfort oriented care
5). Hospice care team made up of physicians, nurses, chaplains, social workers, dieticians, and volunteers
6). Family support
7). Well trained prisoner volunteers
8). Bereavement care for survivors/staff/volunteers [ii]
9). Linkage to Community Hospice

[ii] Recently, following the death of prisoner M. "Jack" Balkin (W94723) who was in ADL at Shirley before being moved to SNF when his condition worsened, a volunteer who always talked to him came and was looking for him when another prisoner said he was dead. The elderly volunteer was quite surprised and began crying in the awkward moment. This should not happen.

Bay State would more than triple the current capacity of 58 beds mentioned in the opening paragraph. It would also allow for more mobility of those in sub acute/acute/hospice care to get around. A hospice center would also expand the already established companion program for the incarcerated, and with outside hospice support could have a part two qualification for hospice care attendants.

In providing a sub-acute and acute care facility at Baystate, the specialty clinic for dialysis could/should also be moved there. The need for more dialysis capability is upon the DOC now. The dialysis room in Shirley is at capacity with six crowded stations[10] (one typically only used for Segregation Management Unit residents). There are two 3-4 hour sessions, six days a week which allows a capacity of 72 total sessions (if all six were used each session). Sessions are three to four hours for each patient who has dialysis three days a week. There are currently twenty-four (24) prisoners utilizing dialysis; at 3 days a week that uses 72 total sessions – the currently scheduled maximum. Dialysis patients are from ADL, SNF, and population and they are mixed together for sessions. This is interesting as prisoners are not allowed to visit their long-time friends in the SNF for reasons of "not wanting to introduce germs from population," yet this practice is employed in the dialysis specialty clinic. The total number of prisoners on dialysis/pre-dialysis diets at MCI Shirley is 26. So it is clear that to keep the cost of dialysis treatments minimized by not having to transport prisoners to an outside facility will require a larger dialysis capacity. There is a much larger room that could be used for a dialysis specialty clinic at Bay State rendering a more comfortable, more sanitary, and a medically rewarding environment than the present room at MCI Shirley which is cramped, overcrowded, and taxing on the medical provider.

One particular concern for dialysis patients is for prisoners who come from a minimum security setting losing their minimum security status because of a medical condition. That is why having Bay State classified as pre-minimum would be advantageous. Because of the perimeter structure at Bay State, it could be a medium/minimum facility for the sake of those patients who qualify for minimum but need dialysis. Even though early release would be the better solution for this situation, the current sentiment of the state's criminal justice policy is not conducive for someone who is quite ill to be released earlier and allow for care in a better environment.

With the long-identified need for ADL and SNF sub-acute and acute care bed space expansion that cannot be met at MCI Shirley and the need for a more dignified dying process with hospice care, a radical move needs to be made just as it was to convert OCCC into a mental health geared facility. Bay State can address this need and allow Shirley to continue to operate. As far as medical staffing goes, the medical provider is bound to meet the demand of medical services required. Bay State could have a Nurse Practitioner or Doctor's Assistant 24 hours a day with a doctor on call as it is in Shirley Medium. A certified Nurses Aid could supervise the companions/cadres/ hospice care inmates and their training.

It is encouraging to know the DOC and medical provider are consulting with Fleet Maul who established the federal prison hospice program and founded the National Prison Hospice Association. As Mr. Maul has stated, "hospice restores humanity by giving guards and inmates permission to care. They begin to feel 'We are a community that takes care of ourselves. We don't just let our guys die with nobody taking care of them.' "[11] Prison culture (prisoners and even more-so staff) is very difficult to change. In order to create an environment as Fleet Maul speaks about would require a dedicated facility to establish its own culture. Bay State can be that facility!

endnotes

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[1] Request for Response: Comprehensive Health Services to Massachusetts Prison Population, RFR# 14-DOC-9004 – Prison Health Services, December 12, 2012 section 5.11 Infirmary and Skilled Nursing Care

[2] Ibid, section 5.12 Activities of Daily Living Units

[3] Ibid, section 5.19 Dialysis Services

[4] Narative Report of the Committee prepared by the D.O.C. (Robert Hughes, John Noonan, Robert Pouliot, James Ranaghan, Diane Silva, Michael Thompson) and Office of Elder Affairs (Naren Dhamodharan) as mandated in §286 Ch 43, Acts of 1997

[5] The Corrections Master Plan, DOC 0801st1 – Final report, December 2011 by Division of Capital Asset Management; Chapter 5 – Medical Population, p114

[6] Ibid, p114

[7] Request for Response: Comprehensive Health Services to Massachusetts Prison Population, RFR# 14-DOC-9004 – Prison Health Services, December 12, 2012, section 2.10.1 Medical Services Short Term Objectives: Specialty Clinics, p.24

[8] MA DOC Prisoner Management System, as compiled by the Research and Planning Division, as of January 1, 2013

[9] Schizophrenic killer, my cousin, Mother Jones Magazine, May/June 2013, p.25, sources: motherjones.com/mental-health-sources

[10] It should be noted that there is one addition dialysis station for male prisoners located at the Treatment Center in Bridgewater.

[11] National Prison Hospice Association Website, an interview with Fleet Maul

This report was written by Ken Seguin, a prisoner at MCI Shirley who has first hand exposure to the Skilled Nursing facility and Assisted Daily Living Unit as the patients' law clerk and library assistant. Several others contributed to this with our hope being that someone from the D.O.C. and its medical provider would use the information to advance the work being done to meet the need for more capacity for SNF, ADL and to begin a hospice care.

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