Published in final edited form as:

Public Health Nurs. 2019 May ; 36(3): 401–410. doi:10.1111/phn.12583.

Developing educational modules to enhance care of aged and dying inmates: Set-up phase

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The United States has the highest rate of incarceration in the world (Wagner & Sawyer, 2018). With “get tough on crime” legislation (i.e., life sentence without parole, longer sentencing), aging of the Baby Boom generation (Human Rights Watch, 2012), and older adults entering prison due to committing more serious crimes (Marquart, Merianos, & Doucet, 2000), the demographics of the inmate population are shifting. Men and women age 55 years or older accounted for most of the growth (106%) in the prison population from 2003 to 2013 and the number of older adults in jail grew 278% between 1996–2008 (Carson & Sabol, 2016; Beck & Berzofsky 2010; Darrell & Beck 1997). Older adult or aged inmates are typically defined as individuals who are either 50 (National Association of Area Agencies on Aging, 2017) or 55 years of age or older (Aday, 2017). This leads to an estimated 500,000 older adults passing through jails each year (Snyder, 2012). Prison inmates have been convicted of or pleaded guilty to their crimes, been sentenced, and are serving sentences that are typically two years or longer. Many older adults are serving extended sentences and thusly will age and die in place—making geriatric and end-of-life care essential educational foci for prison staff. In contrast, jail inmates are often still in the criminal justice adjudication process or serving sentences of one year (two years maximum) or fewer and therefore are detained in jail for far shorter periods of time than are prison

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inmates. As such, contact with older inmates in jail settings provides a prime opportunity to engage this subgroup of inmates about their health. The criminal justice system faces growing demands to provide care for aged, chronically ill, and dying inmates. On average, aged inmates will have at least three chronic conditions that impair their functioning (Ahalt, Trestman, Rich, Greifinger, & Williams, 2013). Health disparities experienced by older inmates, taken together with an often, lifelong history of limited access to health care services and substance abuse can result in considerable health care needs for this population (Ahalt et al., 2013). Older inmates are the most expensive subset of inmates when considering healthcare costs. Estimates have been reported that the cost of care for older inmates is 3.5 times larger than for younger inmates (Williams, Goodwin, Bailargeon, Ahalt, & Walter, 2012). Resources to adequately prepare staff to meet this mounting problem are needed.

The purpose of this article is to elucidate the strategies used to “Set-up” the *Enhancing Care for the Aged and Dying in Prisons* (ECAD-P) educational modules. “Set-up” is the first of four phases in the Institute for Healthcare Improvement (IHI) Framework for Going to Full Scale, which served as the conceptual framework for this study (Barker, Reid, & Schall, 2016). Although the title of our group of educational modules includes the word “prison” and the work reported in this manuscript has focused exclusively in state prisons, we will take steps in later phases of this research to include jails. In addition, we have worked to ensure that the content of our educational modules hold relevance to caring for and managing aged and dying inmates in either prisons or jails. The set of interactive learning modules in our study are focused on educating multidisciplinary staff who care for or manage aged and dying inmates in priority areas of need (i.e., general aging, aging process, geriatric syndromes, signs and symptoms of chronic disease). Each endeavor of the Set-up process will be explained including the methods used to: reformat and extend an established comprehensive, content-driven end-of-life (EOL) educational program (i.e., *Toolkit for Enhancing End-of-Life Care in Prisons*; RO1 NR011874) (Loeb et al., 2018); identify and integrate geriatric content; and conduct in-person usability testing of module prototypes with prison multidisciplinary staff (e.g., security, unit managers, chaplains, and healthcare staff; R41AG049570). Usability testing evaluates the user interface, ease of use, and perceived barriers, as well as determines how to further understand and optimize knowledge gained by the research team about the organizational and environmental culture of corrections. All of the aforementioned efforts are deemed essential in facilitating future implementation of the computer-based educational modules.

Provision of education on how to best care for aged and dying prisoners is an essential first step. Such educational programs must be tailored for the environment of correctional settings, including: 1) focusing on priority target population health needs; 2) being contextually accurate; and 3) being usable considering environmental constraints. There are many benefits to quality educational programs for staff who are responsible for the care and management of inmates. Correctional employees who are appropriately educated react more confidently and are better prepared to deal with the stressful nature of corrections (Ridley-Turner, 2002). Providing relevant education to employees encourages staff to act responsibly and better achieve adequate preparation for managing current situations and future issues faced in their work environment (Hill, 2002)—this is as essential in the correctional

environment as it is in the broader community outside of prisons and jails. An educational program that is relevant to staff members' job functions has also shown to reflect positively upon morale (Garland, 2002). The Delphi approach is a technique that can be used to identify and prioritize what education is needed. Employees who are motivated to advance their knowledge on issues faced as a regular part of their job may experience less boredom and demonstrate more interest and involvement in the correctional environment (Garland, 2002). Overall, valuable education helps correctional systems and their employees ensure that custody and control for those in their charge are maintained, as well as simultaneously provide adequately for inmates' care. In addition, providing education for all staff on the needs of aged and dying prisoners holds potential for contributing to positive change in corrections environments.

Background

Best-Practices in Managing Geriatric and EOL Care

Best practices for managing geriatric and EOL care have not been consistently integrated into corrections settings. Nevertheless, over the past three decades there have been several noteworthy efforts (Table 1). Of recent significance is the National Commission on Correctional Health Care's (NCCHC) inclusion of compliance indicators, which state the need for inmate patients to be cared for by individuals (e.g., staff and peer caregivers) with education in palliative care (NCCHC 2018a; 2018b). No specific compliance indicators are provided regarding geriatric care.

New Scale-Up Idea

Researchers in a previous study collaborated with prison insiders [e.g., nurses, chaplains, corrections officers, unit managers and psychology support staff (Penrod, Loeb, Ladonne, & Martin, 2016)] to develop, infuse, and evaluate the *Toolkit* (Loeb et al., 2018). Although these collaborative partners reported significant advances in enhancing EOL care, the educational process (i.e., the research team inviting prison staff to the University, delivering educational sessions, and then the prison staff going back to their correctional settings and delivering the training to peers) was both time and labor intensive. In addition, the format of the *Toolkit* (a rolling file box of learning modules) was cumbersome, was stored in varied locations across the state prisons, and was not always easily accessed by multidisciplinary team members. These challenges inhibited sustainability in some prisons. Information becomes obsolete as new evidence emerges and the lack of technological capabilities (i.e., the prison system did not accept zipped files and USB port memory sticks were prohibited) made updating the *Toolkit* a challenge. It was clear that a contextually-sensitive, standardized, technology accessible version of the *Toolkit* was essential for scale up.

The decision was made to reformat The *Toolkit* based upon the prevailing need for delivering effective education programs in corrections that focus on care of aged and dying inmates. Reformatting the comprehensive education program would mean standardizing the modules to streamline the educational process and to convert content-driven modules into a media-rich computer-based format that permits large scale dissemination. Therefore, to launch this new idea, the IHI's Framework for Going to Full Scale was applied (Barker et

al., 2016) as the guiding approach for transforming and further developing our computer-based educational modules that are now geared not only toward promoting enhanced EOL care, but also improved care for incarcerated older adults.

Framework

The goal of adopting the IHI Framework for Going to Full Scale was to guide the systematic approach to developing and disseminating a commercial product. The Framework for this project addresses the phases of going to full scale (i.e., Set-up, Develop the Scalable Unit, Test of Scale-up, and Go to Full Scale), the adoption mechanisms, and support systems needed to achieve large-scale programming (Barker et al., 2016). The Set-Up phase is the focus of this manuscript.

During the Set-up phase the following objectives are achieved: establishing an approach for infusing the intervention into the target system; identifying the product that needs scaling-up; and determining what will be accomplished in the full-scale phase. In addition, buy-in for the program within the given context and identification of the test sites, as well as, support by early adopters are essential.

Methods

Expert Advisory Board (EAB)

Our design approach was three-fold and included an environmental scan, a modified Delphi study, and a usability study. The modified Delphi study is a variant of the Delphi method typical in health research where the content of the education is prioritized (Fletcher & Marchildon, 2014). Institutional Review Board approval was obtained prior to engaging in any aspect of the study. No participant incentives were provided.

An EAB provided essential consultation throughout the Set-up Phase of the project and was instrumental in the development of the product. Members included three nurses and one physician, each of whom had over 10 years of experience in one or more of the following areas: palliative care, geriatrics, and corrections health. Both a physician and a nurse had experience in corrections. Recommendations on recruitment strategies for the environmental scan and reviews of findings (Loeb et al., 2017) were provided by the EAB members. They also were instrumental in the recruitment of participants for the Delphi Survey and in reviewing the content of the prototype modules prior to the research team embarking on the initial round of usability testing.

Reformatting Modules and the Environmental Scan

An environmental scan provided a foundational understanding of the complex, contextual factors that impact correctional settings in the US. Specifically, the environmental scan of diverse correctional settings helped to determine current educational approaches, education and learning preferences of personnel, and the technological capacity to deliver computer-based educational modules (Loeb et al., 2017). For a more detailed description of the environmental scan methods and results see Loeb et al. (2017). Gaining the aforementioned knowledge was essential for the development of computer-based educational modules that

are tailored to address the health needs of the growing numbers of older inmates, many of whom will remain incarcerated through EOL.

Identifying and Integrating Geriatric Content Via a Delphi Survey

The Delphi process uses iterative group facilitation to gain reliable consensus on the opinion of experts through a series of structured questionnaires or rounds (Keeney, Hasson & McKenna, 2010). The goal is securing expert judgement based on experience. A Delphi Survey was conducted early in the *Set-Up* phase (i.e., 2015) to identify essential geriatric content for integration into the new prototypic modules. Two EAB members assisted with the recruitment of clinical experts. Participants had expertise in geriatrics (n=6) and corrections healthcare (n=1) and had worked “in the trenches.” All participants had advanced degrees (i.e., either Master’s or Doctorate) and were non-Hispanic, white females who were 51 years of age or older. In addition, all had greater than 16 years of experience in their field and all but one worked full time. Participants completed an informed consent that was embedded in an on-line Qualtrics Survey. Over three months, these experts independently and confidentially completed three Qualtrics surveys (Table 2) following the Delphi technique (Waltz, Strickland, & Lenz, 2016). The number of participants who took part in the Delphi survey varied slightly across the rounds of surveys.

The process was iterative. Analysis was conducted by the research team at the end of each round to generate the subsequent survey. The initial Qualtrics survey was emailed to potential participants identified by our EAB, six people responded. Each participant completed a demographic questionnaire and generated a comprehensive list of general care issues or special concerns related to older inmate care (Round 1: Brainstorming). The researchers reviewed the six independent lists and generated one comprehensive list of issues faced in caring for aged inmates. Researchers distributed a second online Qualtrics survey whereby participants (n=5) were asked to examine a list generated in round 1 and rate the content topic as essential/nonessential using a 5-point Likert scale (essential, high priority, medium priority, low priority, not a priority) (Round 2: Narrowing). Items that received essential or high priority by at least three out of five participants (60%) were retained for round three. Finally, in Round 3 (Ranking) forced ordering of the top 10 topics was used. Here participants (n=7) rank ordered the content areas by perceived importance. The outcome was a reliable consensus on essential geriatric content for inclusion into the newly rebranded *ECAD-P* computer-based educational modules. The EAB reviewed the findings and validated the results.

Developing the Prototype Modules and Usability Testing

The research team collaborated to prototype three media-rich, interactive computer-based modules designed for the context of corrections. Team members were two nurse scientists with expertise in EOL care and corrections, a psychologist with expertise in dissemination and implementation research, and an instructional designer with expertise in online learning. The content was based on the original paper and electronic file *Toolkit* (Loeb et al., 2017). However, throughout the development process, content was modified, updated, and refined by the research team. The modules were: Raising Awareness; Introduction to Supportive Care; and Introduction to Loss and Grief. The Raising Awareness module introduces

correctional personnel to the concept of the need for enhanced care of aged, and dying inmates including the shift in demographics in correctional settings. The Introduction to Supportive Care module provides information to non-medical correctional personnel on the specific needs of aged and dying inmates. Supportive care is defined, core values are identified, and strategies are recommended in this module. Finally, the Introduction to Loss and Grief module provides information on how to deal with loss (e.g., including, but not limited to death) and grief. Screenshots of the three prototypical modules can be seen in Figure 1. The EAB reviewed and endorsed all three modules prior to usability testing.

As the team planned for and developed the Usability Study protocols, the EAB corrections experts suggested that an informational meeting at the State Department of Corrections be held. Nine central office administrators representing training, research, health services, and the Secretary's office attended the session with the principal and co-investigator nurse scientists. Outcomes of this meeting included: state correctional institutions (SCIs) to target for usability testing; space for testing at SCIs; and permission to bring a laptop computer into SCIs where the testing would take place.

The prototype, containing the three aforementioned modules, was built within the program software, Axure. The prototype was self-contained on a laptop computer. Each module had learning objectives, content delivered through multiple interactive features (e.g., drag and drop, hover, click and reveal, video), and ended with a comprehension check quiz. Usability and acceptability were assessed following an established protocol to identify problems and rate their severity. Testing was conducted at two SCIs in one Mid-Atlantic state (n=16 participants). Four participants were female (25%), one participant was Hispanic, two participants were Black or African American, one participant was Asian, and 13 were White. Prior to engaging any participants, verbal explanations of the usability study were provided and signed informed consent was obtained. The focus of the usability testing was to examine: navigability; detect problems; observe time spent solving problems; identify problem severity; and develop recovery strategies. During the completion of the three modules, participants' actions, eye movements, utterances, and barriers to use were observed. In addition, follow up questions were posed after participants completed the three modules. Severity in usability concerns/errors were categorized into levels: Level 1 being the most severe and representing tasks or programming issues that make it impossible to use the program or finish the task; Level 2 are programming issues that do not function ideally or are difficult for the user to navigate, but do not impede them from finishing the task; and Level 3 are programming issues or tasks that are problematic, but do not cause a high level of concern or distraction. Finally, after usability testing, the participants completed the System Usability Scale (SUS; Brooke, 1996; System Usability Scale, 2018), a validated tool for assessing the usability and acceptability of technology-based products (Bangor, Kortum, & Miller, 2008; 2009; System Usability Scale, 2018). A SUS score of 68 is considered above average (Brooke, 1996; System Usability Scale, 2018).

Results

Modified Delphi Study

The Delphi Survey generated a list of essential content in rank order of priority. Thirty-seven content areas resulted from the brainstorming session (Round 1; Table 3). After round 2, the 37-item list was narrowed down to 23 items, which were deemed essential or a high priority by at least 60% of the participants. Twenty-three items were retained for round three (Table 3). A final list of eight prioritized content areas resulted from round 3, which involved ranking (Table 3). Two items tied for the ranking of seven.

At the conclusion of this process, the modified Delphi study resulted in the identification of essential geriatric content (aging process/normal aging versus disease states; signs and symptoms of chronic diseases/symptom management; geriatric syndromes; and health promotion) for specification in the comprehensive learning system. As findings were discussed with the EAB, additional insights were generated. Cultural competence in the context of correctional settings was deemed by the EAB to be essential because products must be sensitive to the unique demands faced by aging inmates and staff.

Usability Study

The usability study was conducted to evaluate CBL module prototypes. Results from the in-person usability testing yielded a specifications document. Issues were organized by severity of type (Level 1–3). No Level 1 severities were experienced. Seven Level 2 issues and 10 Level 3 issues were raised. All of the Level 2 and 3 issues can be easily addressed in future iterations of ECAD-P development. For example, some Level 2 problems included delayed feedback on a quiz result page; high scroll-factor (i.e., having to scroll down further than anticipated); click area was unclear (i.e., either not visible or too small); and unnecessary buttons causing confusion. An example of a Level 3 issue was “unclear objectives with acronyms.” One user noted he thought feedback inconsistency was good, because it kept his interest, but this was an individual opinion and was not a theme across participants. In addition, a limited number of static images in the program were included to provide accurate and realistic portrayals of inmates in the program. Some participants suggested that photos should be added that reflect inmates’ racial and ethnic diversity as well as accurately portray corrections environments. Another suggestion was to add photos in places they were entirely absent, especially on pages that were not highly interactive.

Most testers reported acceptability of visual design, functionality, and content. Overall, users reported the program would be helpful in their continuing education. The total SUS score for the program was 87.8 suggesting a very high level of acceptability and usability. Fisher’s exact and Wilcoxon Mann-Whitney tests were conducted to assess whether there were any differences in usability outcomes between the two SCI facilities. Analyses revealed no significant differences ($p>.05$) between usability testers based upon their SCI affiliation.

Discussion

The Set-up phase of *ECAD-P* [R41AG049570] demonstrated the potential for refining and implementing cutting edge, media rich learning modules focused on the care of aged and

dying inmates. The Set-up established proof of concept, three prototype modules, and a specifications document to guide future programming. In addition, a Technology Niche Analyses® (TNA®) was provided by Foresight. This independent market insight analysis was funded by the National Institutes of Health and provided a preliminary commercialization plan (Small Business Innovation Research and Small Business Technology Transfer [STTR], n.d.). TNA® is designed to help small businesses with their commercialization efforts. The TNA® supported the commercial feasibility of the program and the need for continued research for the *Developing the Scalable Unit* and STTR Phase II study [R42AG049570]. Finally, the Set-up phase also demonstrated the utility of the IHI Framework for Going to Full Scale (Barker et al., 2016).

The Set-up phase of our study has been instrumental in exposing the available infrastructure for dissemination of an educational product within correctional settings. The team has a greater understanding of the range of available technology and learning management systems in correctional settings across the US. There is an emergent trend in corrections: technology and access to web-based learning is improving. Use of computer-based educational modules have become commonplace; however, many products are “home grown” without innovative, interactive features (Loeb et al., 2017). The prototype modules are an example of how care can be infused given the restrictive environment of corrections. The culture in corrections is markedly different than in the free world. Custody and control seem adversarial to the notion of care, and corrections personnel struggle to prioritize the competing demands of each responsibility (Burles, Peterneilj-Taylor, & Hotslander, 2016). These educational modules are a first step in demonstrating the potential of what can be done by corrections staff to provide care for the growing numbers of older inmates living with and dying from advanced chronic illnesses while continuing to maintain custody and control (Williams & Abraldes, 2007). The technologies applied were selected to meet the constraints of corrections settings (e.g., restricted access to smart devices, the internet, and other technologies). The environment is not technology-rich; however, corrections administrators and staff are accustomed to and receptive of computer-based education (a frequently used delivery platform for mandatory education sessions). Therefore, the technological innovation proposed for this project is well-suited to the targeted market.

Limitations.

There are three limitations of this study that warrant mentioning. First, there was an imbalance between the number of experts in geriatrics (i.e., six) and the number of experts in corrections health (i.e., one) for the modified Delphi survey. This limitation was at least in part mitigated by the strong representation of corrections health by the physician and nurse/chaplain on the EAB. The second limitation is that Delphi study participants were homogeneous in regard to gender, race, and ethnicity. Finally, one participant failed to complete round one and two participants failed to complete round two of the Delphi survey; however, all seven participants took part in round three of the surveys.

Implications for Public Health Nursing—The missions of public health nurses and correctional agencies are complementary to each other. However, many times public health nurses focus on health issues related to infectious disease, substance abuse, and

socioeconomic factors. As the inmate population ages across the nation, public health nurses who work either within or outside of corrections settings, have a prime opportunity to collaborate with multidisciplinary staff to provide enhanced care for chronically ill and dying inmates. Public health nurses can provide support to the corrections community. Free world public health concerns related to aging are like the issues faced inside corrections facilities; however, the contextual features of this environment create an additional layer of complexity when assessing and implementing strategies to enhance care. The rising demands for corrections health, limited resources to meet these demands, and other factors, such as, the marginalization of inmates in society contribute to a public health problem specific to corrections (Restum, 2005). Correctional facilities face many challenges in caring for older adults. Lack of health care utilization prior to entering the corrections setting and the prevalence of previous substance abuse of many inmates have contributed to accelerated aging—inmates with the health status of community living elders who are 10–15 years older (Loeb, Steffensmeier, & Lawrence, 2008). As older adults live in or move in and out prisons and jails, public health nurses have an opportunity to engage this particularly vulnerable group of older adults about their health concerns. The aging of the inmate population, alone, causes functional and safety concerns as corrections facilities were not designed to care for sick, frail, older inmates. Beyond usual activities of daily living, inmates are expected to attend roll call, drop to the floor for alarms, and access upper-level bunk beds (Williams & Abalades, 2007). In addition, effective management of chronic conditions, polypharmacy, mental health in aging, and geriatric syndromes (i.e., vision/hearing impairments, falls, incontinence, cognitive impairments, functional ability) is difficult in any setting, but when corrections staff are expected to meet these demands while simultaneously maintaining custody and control it is especially challenging. While corrections personnel may not prioritize healthcare over custody and control, public health nurses can work to advance a mission of social justice and equitable distribution of health resources. This mission can be accomplished through efforts that encourage evidence-based educational modules on aging, chronic illness, and end-of-life care for all those persons who are aging, living with chronic illness, and dying in the correctional environment. Learning about the needs of older and dying inmates and the feasibility of delivering computer-based educational modules within the restrictive environments of corrections settings is a first step for public health nurses. Armed with this knowledge, public health nurses can contribute to efforts aimed at ensuring inmates receive evidence-based care that parallels the care and treatment of aged, chronically ill, dying people in the community at large.

Culturally competent and appropriate care is critical to the health and well-being of inmates. Often, there is little to no education for corrections healthcare staff that is tailored toward maintaining the health and quality of life for aged and dying inmates. Beyond corrections health staff, corrections staff that interact with the older inmate population should have a baseline understanding of the need for enhanced care for this population. Education may be a first step in addressing the public health issues of aging (i.e., chronic disease, disability, and workforce demands needed to care this population). Computer-based educational modules such as ECAD-P can allow for widespread dissemination of knowledge about the care and management needs of the increasingly older and sicker population of inmates who are encountered across the corrections community and beyond, when their health care needs

exceed the capacity of infirmaries within corrections facilities. Although just the first step toward large-scale implementation has been made, ECAD-P holds potential to increase the promotion of health as well as the prevention of disease and disability among older inmates. In addition, lessening of suffering can also be achieved.

Future Research—As we progress into phase II of our research, the team will continue Scalable Unit development. Solutions will be implemented for addressing Level 2 usability concerns presented in the findings, including: ensuring users see their total score immediately on a quiz results page; delivering feedback for all answers (i.e., both correct and incorrect responses); fitting learning content in screen view; displaying visual indicators for all click areas; and removing unnecessary distractors from screen view. In addition, the team plans to rewrite learning objectives, so they are appropriate for the lowest common level of trainee knowledge; specifically, removing acronyms and medical jargon. These areas of concern point to ways in which the program can be improved to promote learning, ease-of-use, and positive user experience in the future. As well, the research team has already increased their sensitivity to adoption mechanisms through engaging with a Community Advisory Board consisting of a broader range of stakeholders, including users, purchasers, and end-consumers of care (i.e., returning citizens who have served prison sentences and are intimately familiar with prison life). Building upon that, in future phases in this program of research, public health nurses are another important stakeholder group to reach out to for their willingness to engage and contribute their expertise to the development of this type of education. The end goal of this line of research is to develop an evidence-based educational product that is ready for large-scale dissemination. A ready-made standardized product requiring minimal human and financial resources will give corrections institutions as well as those who are responsible for either caring for or managing older and dying inmates the opportunity to better understand the issues faced by those who are aging in place and may eventually die within the walls of our nations' corrections settings.

Acknowledgements:

"Enhancing Care of the Aged and Dying in Prison-II." September 15, 2016-April 30, 2018; NCE May 1, 2018-April 30, 2019. National Institutes of Health/National Institute on Aging, Grant # R42AG049570; MPIs Janice Penrod and Susan J. Loeb (year 1); MPIs Susan J. Loeb and Valerie H. Myers (year 2).

"Enhancing Care of the Aged and Dying in Prison." March 12, 2015-February 19, 2016. National Institutes of Health/National Institute on Aging—Grant # R41AG049570; PI Janice Penrod

"Infusing End-of-Life Care Into Complex Organizations: The Prison Study." September 29, 2009 –July 31, 2012; NCE through July 31, 2013. National Institutes of Health/National Institute of Nursing Research—Grant # R01NR011874. MPIs Susan J. Loeb, Janice Penrod, and Christopher S. Hollenbeak

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Module Progress

RAISING AWARENESS

Aging in Prison

Unhealthy choices prior to entering prison and while incarcerated, and the stressful environment of prison all contribute to accelerated aging. As a result, inmates may appear 10-15 years older than their actual age.

For this reason, inmates age 50 and older are considered "older adults." Inmates often age in place due to "get tough on crime" legislation and mandatory minimum sentences.

Aging inmates have some characteristics that may help you become more aware of needs.

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Enhancing Care of Aged and Dying in Prisons

Module Progress

SUPPORTIVE CARE

Who Needs Supportive Care?

Which 3 cases demonstrate the greatest need for supportive care? There are 5 case studies listed. Check the box next to each case best suited for supportive care. You will have three tries to get the answers correct.

- ☐ Joe has a diagnosis of lung cancer. He has been coughing for the last 4 months. Now Joe is trying to adjust to his new reality of being chronically ill.
- ☐ Sally had pneumonia. She was treated in the infirmary and is responding to antibiotics. She still has a cough, but will be returned to her cell block in a few days.
- ☐ Lyle is 89 and has trouble tying his shoes. Recently, Lyle got disoriented when he was trying to get back to his cellblock. He got turned around and was very confused when someone was already in the cell he thought was his. Lyle has been forgetful like this for a few months.
- ☐ Kat started her sentence with a "bad heart." The doctor said her heart failure is getting worse, but can be managed. Kat is anxious and hasn't slept very well recently.
- ☐ Oscar needed stitches after a fight with another inmate. He has no infection and sustained no major injuries.

SUBMIT

Strikes:

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Enhancing Care of Aged and Dying in Prisons

Figure1:
Three ECAD-P prototype modules.

Table 1

Geriatric and/or End-of-Life Care Programs in Corrections	
•	Guiding Responsive Action in Corrections at End-of Life (Ratcliff & Craig, 2004)
•	Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings (National Hospice and Palliative Care Organization, 2009)
•	Leadership Summit on Aging in Corrections (Williams, Stern, Mellow, Safer & Greifinger, 2012)
•	The Gold Coats: An Exceptional Standard of Care (Berry et al., 2016)
•	<i>Toolkit for Enhancing End-of-Life Care in Prisons</i> (Loeb et al., 2018)
•	Correctional Health Care: Practice, Administration, and Law (Aday, 2017)
•	Standards for Health Services in Jails (NCCHC, 2018a)
•	Standards for Health Services in Prisons (NCCHC, 2018b)

Note. NCCHC = National Commission on Correctional Health Care

Table 2**BRAINSTORMING**

Objective: To generate a comprehensive listing of topics related to geriatric care of aging inmates.

Directions: Please list topics related to geriatric care of aging inmates in the text boxes below. There are no “right” or “wrong” responses—we simply want to understand what content you believe is important to enhance the care of aged inmates. Some general content categories are listed to prompt your thinking.

1. Click in the text box below to write your topics related to

•General Care Issues	•Injury Prevention
•Aging Process	•Pharmacotherapy Issues
•Demographics Assessment/Evaluation Health Promotion	•Geriatric Syndromes

2. Click in the text box below to write your topics related to Special Concerns.

•Cardiovascular System	•Urinary Tract
•Respiratory System	•Women's' Health
•Nervous System / Cognitive Impairment	•Endocrinology
•Musculoskeletal System	•Oncology
•Gastro-Intestinal System	•Skin and Special Senses (Eyes/Ears/Taste)

NARROWING

Objective: To differentiate essential content from non-essential content areas

Directions: Each item from the initial brainstorming survey completed by you and/or your colleagues is listed below. Consider how essential this content is to enhancing the care of aging inmates. Then, rate each item as essential, high priority, medium priority, low priority or not a priority.

[List used from Table 3: Brainstorming]

RANKING

Objective: To prioritize essential content for integration into Enhancing Care of the Aged and Dying in Prisons (ECAD-P) learning system

Directions: Each of the items listed below were ranked as a “High Priority” or “Essential” by respondents in Round 2. In this final activity, select the top ten content areas that you believe should be integrated into the ECAD-P learning system. 1. Choose the 10 most essential topics that should be included in the caring of the aging inmate learning system by clicking and dragging to the text box. While there are many options, you may only select ten content areas in your response. Please use the Comments Section to add any comments regarding your selection. 2. Then arrange the topics in order of importance by placing the most important topic at the top of the list and the least important at the bottom (click on topic and drag).

[List used from Table 3: Narrowing]

Table 3

Round 1: Brainstorming Generate a comprehensive list of topics	Round 2: Narrowing Differentiate essential from non-essential	Round 3: Ranking Prioritize integration of essential content
Advanced care planning	Aging, general	1.Aging, healthy
Aging, general	Aging, normal changes related to	2.Aging process
Aging, healthy	aging versus when things are	3.Geriatric syndromes
Aging process	abnormal such as incontinence,	4.Chronic disease, signs and
Age related medical issues	dementia	symptoms of
Arthritis	Aging process	5.Health promotion
Assessment evaluation	Age related medical issues	6.Aging, normal changes related to
Atypical presentation of	Atypical presentation of different	aging versus when things are
different diseases		abnormal such as incontinence,
	Balance and strength	dementia
Balance and strength	Behavioral problems associated with	7.Palliative care (tied)
Behavioral problems associated with mental health issues	mental health issues	7.Pain and symptom management
	Chronic disease, signs and	(tied)
Cardiac health	symptoms of	
Chronic disease, signs and symptoms of	Conflict resolution	
Conflict resolution	Dementia and cognitive impairments	
	Diseases	
Delirium		
Demographics	Exercise	
Dementia and cognitive impairments	Functional assessment	
Diabetes	Geriatric syndromes	
Exercise	Health promotion	
Functional assessment	Medication management	
Geriatric syndromes	Multiple co-morbidities	
Health promotion	Nutrition	
Incontinence	Oral healthcare/dental care	
	Pain and symptom management	
Medication management	Palliative care	
Multiple co-morbidities	Pharmacotherapy issues	
Nutrition, general and special dietary considerations	Smoking cessation	
	Wellness	
Obesity		
Oral healthcare/dental care		
Pain and symptom management		
Palliative care		
Pharmacotherapy issues		
Smoking cessation		
Specialized housing in the correctional setting		
Wellness		

Round 1: Brainstorming Generate a comprehensive list of topics	Round 2: Narrowing Differentiate essential from non-essential	Round 3: Ranking Prioritize integration of essential content
Women's health		

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