Good morning, everyone. We’re going to go ahead and get started with today’s grand rounds, so I would like to introduce Emily Wong and Carrie Gross, who will be our speakers today. Emily Wong is a professor of Yale School of Medicine and directs the SAFE Center for Health and Justice. She leads the Center’s research program, the Health Justice Lab, which receives NIH funding to investigate how incarceration...
influences chronic health conditions including cardiovascular disease, cancer, and opioid use disorder, and uses a participatory approach to study interventions which mitigate the impacts of incarceration. She received her medical degree from Duke University Medical Center and her MAS from the University of California, San Francisco. As an internist, she has cared for thousands of individuals with a history of incarceration and is Co-founder of the Transitions Clinic Network, a consortium of 40 community health...
centers nationwide dedicated to caring for individuals recently released from correctional facilities by employing community health workers with histories of incarceration.

Doctor Kerry Gross is a professor of medicine and public health and founding director of the Cancer Outcomes Public Policy and Effectiveness Research Center. His research addresses comparative effectiveness, quality, and HealthEquity with a focus on cancer prevention and treatment.
He received his medical degree from New York University School of Medicine and completed his residency in internal medicine at New York Hospital Cornell Medical Center.

His research has been supported by the National Cancer Institute and the American Cancer Society, among others. As a former Robert Wood Johnson Foundation Clinical Scholar, Doctor Gross has advanced training in Biostatistics, epidemiology, research, ethics, and outcomes research.
incarceration and cancer care, a key focus for health justice efforts.

Thank you.

It’s a real, real pleasure to be here, to be speaking with my friend and colleague Carrie Gross on a topic probably that hasn’t been covered at the Cancer Center before. And so we just wanted to thank you for the opportunity to be here. This year marks the 50th anniversary of mass incarceration, a term that’s used to describe legal and policy decisions that have led to a massive explosion.
and expansion of incarcerationist

punishment and restrictions on public

social services like food, housing,

and employment, and civic life,

including voting following incarceration.

By almost all accounts,

and also among bipartisan leadership,

it’s been seen as largely ineffective

in reducing crime,

keeping our community safe and

much too costly.

And its effects have been largest

among black people, poor people,

and has left in its way poor health for

individuals who’ve been incarcerated,

but also their families and our communities.
While there are lots of questions about how to undo this harm, I'm certain of two things. As physicians, as researchers, as health system leaders, we've been complicit in creating the circumstances by which mass incarceration and the healthcare system behind bars is virtually invisible to us. I'm also confident that we're responsible for finding these solutions. And so for the next 45 minutes or so, we'd like for you to entertain how extraordinarily wide the reaches of the criminal justice system,
00:03:17.728 --> 00:03:19.480 how it impacts our work to
NOTE Confidence: 0.951366435
00:03:19.538 --> 00:03:21.080 create healthier communities.
NOTE Confidence: 0.951366435
00:03:21.080 --> 00:03:23.140 And hope that at the end you’ll
NOTE Confidence: 0.951366435
00:03:23.140 --> 00:03:24.980 start considering how cancer
NOTE Confidence: 0.951366435
00:03:24.980 --> 00:03:26.820 equity must necessarily attend
NOTE Confidence: 0.951366435
00:03:26.820 --> 00:03:29.074 to the injustices in the criminal
NOTE Confidence: 0.951366435
00:03:29.074 --> 00:03:31.153 legal system in the ways that we
NOTE Confidence: 0.951366435
00:03:31.153 --> 00:03:33.160 all might individually proceed.
NOTE Confidence: 0.842335420416667
00:03:35.760 --> 00:03:36.936 We have no disclosures.
NOTE Confidence: 0.842335420416667
00:03:36.936 --> 00:03:39.728 And so I went to start in a grand
NOTE Confidence: 0.842335420416667
00:03:39.728 --> 00:03:41.648 rounds fashion with a patient to
NOTE Confidence: 0.842335420416667
00:03:41.648 --> 00:03:43.760 ground our conversation for today.
NOTE Confidence: 0.842335420416667
00:03:43.760 --> 00:03:45.624 One of the first patients that I saw
NOTE Confidence: 0.842335420416667
00:03:45.624 --> 00:03:47.704 when I began my career was a 40 year
NOTE Confidence: 0.842335420416667
00:03:47.704 --> 00:03:49.866 old man who was incarcerated just for a
NOTE Confidence: 0.842335420416667
00:03:49.866 --> 00:03:51.844 few years who during his incarceration
was diagnosed with the leukemia.

He was scared out of his mind. It was the first time that he had any sort of health condition and of course he was behind bars, away from his family, away from his social support, and when he was introduced to the care team prepared for his first chemotherapy, he was shackled in the hospital while receiving intrathecal chemotherapy and this was chilling to him. Of course, refused to continue treatment and ended up dying from his cancer.
And I want to begin our conversation this morning about thinking about what our role is as providers to advocate for patients like him and others so that the patient treatment experience is different and humane, honoring him as a person first. From an outside perspective, if you didn’t know the story and maybe you’re just looking at the charts, you might think that the patient’s not compliant. You might think that they’re refusing treatment, but framed a different way, how might the health system do
00:04:47.500 --> 00:04:50.238 differently by those who are most vulnerable?

00:04:50.240 --> 00:04:50.830 And today,

00:04:50.830 --> 00:04:51.125 today,

00:04:51.125 --> 00:04:52.895 we're going to start by defining

00:04:52.895 --> 00:04:54.000 mass incarceration,

00:04:54.000 --> 00:04:56.576 so to give kind of real terms and

00:04:56.576 --> 00:04:58.397 concrete descriptions about what this is.

00:04:58.400 --> 00:05:00.525 Then we'll discuss the healthcare

00:05:00.525 --> 00:05:03.510 system behind bars in carceral systems

00:05:03.510 --> 00:05:06.360 and the experience post release.

00:05:06.360 --> 00:05:07.970 We'll then shift to presenting

00:05:07.970 --> 00:05:10.368 some of our own research on mass

00:05:10.368 --> 00:05:12.552 incarceration and its impacts on health

00:05:12.552 --> 00:05:15.320 outcomes using data from across the

00:05:15.320 --> 00:05:17.720 Yale Cancer Center catchment area.

NOTE Confidence: 0.842335420416667
And lastly, 

end with some concluding thoughts.

And so just to start, 

and maybe this isn’t news to all, 

but I think it’s important for us just to 

land here that the US incarcerates more 

people than any country in the world. 

And there are a number of reasons for this, 

but one is just that we’ve 

criminalized substance use, 

mental health conditions and poverty. 

And so much of what we do is take 

care of health system issues 

within the criminal legal system. 

There are 7 million individuals that 

are currently under the jurisdiction
NOTE Confidence: 0.93427406
00:05:51.584 --> 00:05:53.995 of the criminal justice system on
NOTE Confidence: 0.93427406
00:05:53.995 --> 00:05:55.920 any given day and this breaks down,
NOTE Confidence: 0.93427406
00:05:55.920 --> 00:05:58.412 and this is slightly an old slide
NOTE Confidence: 0.93427406
00:05:58.412 --> 00:05:59.480 so post COVID.
NOTE Confidence: 0.93427406
00:05:59.480 --> 00:06:01.820 This means that about 1.9 million
NOTE Confidence: 0.93427406
00:06:01.820 --> 00:06:03.859 individuals are behind bars and
NOTE Confidence: 0.93427406
00:06:03.859 --> 00:06:05.934 closer to five millionaire being
NOTE Confidence: 0.93427406
00:06:05.934 --> 00:06:07.594 supervised in the community.
NOTE Confidence: 0.93427406
00:06:07.600 --> 00:06:08.678 And just to break it down to,
NOTE Confidence: 0.93427406
00:06:08.680 --> 00:06:11.590 jails are facilities that house those
NOTE Confidence: 0.93427406
00:06:11.590 --> 00:06:14.339 that are awaiting judication of crime
NOTE Confidence: 0.93427406
00:06:14.339 --> 00:06:17.275 or serving sentences of less than a year.
NOTE Confidence: 0.93427406
00:06:17.280 --> 00:06:18.730 Prisons are those facilities that
NOTE Confidence: 0.93427406
00:06:18.730 --> 00:06:20.525 house those that have been sentenced
NOTE Confidence: 0.93427406
00:06:20.525 --> 00:06:22.555 serving sentences of more than a year.
NOTE Confidence: 0.93427406

13
And so while the population behind jails in any given day is smaller, there’s a huge throughput. So we actually don’t know how many it is, but it’s over 7 to 10 million move in and out of these jail facilities. And then the larger proportion again that’s living in the community with us is on a community system of supervision. And this is broken down into parole and probation. So parole, you’ve been sentenced the crime released from prison and you’re released into the community. And probation are those that are
00:06:49.346 --> 00:06:51.865 sentenced of a crime and now serving
00:06:51.865 --> 00:06:54.115 their whole sentence in the community.
00:06:54.120 --> 00:06:56.076 And so, all told, and again,
00:06:56.080 --> 00:06:57.716 the estimates aren’t perfect,
00:06:57.716 --> 00:07:00.619 But about 7 million adults have a
00:07:00.619 --> 00:07:02.519 criminal record in this country,
00:07:02.520 --> 00:07:04.584 and each of these individuals confront
00:07:04.584 --> 00:07:06.760 a myriad of collateral consequences.
00:07:06.760 --> 00:07:09.196 They’ve served their time and still,
00:07:09.200 --> 00:07:10.640 because of their criminal record,
00:07:10.640 --> 00:07:12.600 face barriers to getting food,
00:07:12.600 --> 00:07:13.582 housing, employment,
00:07:13.582 --> 00:07:16.037 even voting in this country.
00:07:16.040 --> 00:07:16.515 Which,
00:07:16.515 --> 00:07:17.465 all told,
00:07:17.465 --> 00:07:19.840 constitutes the large toll and
NOTE Confidence: 0.93427406
00:07:19.840 --> 00:07:22.520 tale of mass incarceration.
NOTE Confidence: 0.93427406
00:07:22.520 --> 00:07:24.980 Those who are incarcerated are
NOTE Confidence: 0.93427406
00:07:24.980 --> 00:07:27.440 disproportionately poor men of color
NOTE Confidence: 0.93427406
00:07:27.440 --> 00:07:29.424 using life table measurements.
NOTE Confidence: 0.93427406
00:07:29.424 --> 00:07:30.436 In 2021,
NOTE Confidence: 0.93427406
00:07:30.436 --> 00:07:33.532 when you look at the lifetime
NOTE Confidence: 0.93427406
00:07:33.532 --> 00:07:35.695 likelihood of imprisonment for all men,
NOTE Confidence: 0.93427406
00:07:35.695 --> 00:07:37.777 it's one out of 10 men in this country
NOTE Confidence: 0.93427406
00:07:37.777 --> 00:07:39.553 will spend some time in prison.
NOTE Confidence: 0.93427406
00:07:39.560 --> 00:07:42.440 When you break it down by racial categories,
NOTE Confidence: 0.93427406
00:07:42.440 --> 00:07:44.920 again, white men, it’s one out of 20.
NOTE Confidence: 0.93427406
00:07:44.920 --> 00:07:47.038 Black men it’s one in five.
NOTE Confidence: 0.93427406
00:07:47.040 --> 00:07:48.360 And when I started residency,
NOTE Confidence: 0.93427406
00:07:48.360 --> 00:07:50.718 that number was one in three.
NOTE Confidence: 0.93427406
00:07:50.720 --> 00:07:52.995 And so now we’re narrowing the disparity,
but it’s still extraordinarily large. And for Latino men, it’s one in eight. Similarly, incarceration is far less likely for women, but black women are far more likely to be incarcerated in their lifetime compared to white female counterparts. And So what the question I guess that we’re presenting today is as follows that by doctors, they often get asked, you know what’s different among those with the history of incarceration? Aren’t they just like any patients who are poor,
that have many social needs that we’re not attending to or those that are homeless or those that have substance use disorder?

What is it that uniquely defines them as being at poor risk?

And by researchers we get asked the questions of causality. Again, is this really, truly an independent risk factor?

And, you know, I’m not sure we’re ever going to know there isn’t a, an ethical basis by which you randomize individuals to incarceration.

And in the next few slides, what I wanted to do was give you an inside look into pictures.
How many of Y'all have stepped foot into a prison or jail before?
OK, so some, but not all.
And how many have provided healthcare behind bars?
Great, again a few fewer,
but not everyone.
And So what I wanted to do is give you an inside look on what healthcare looks like behind bars and just to try to convince you on face validity alone that exposure to incarceration is a unique experience that definitely impacts health.
And so to start, and I think what drew
me to this field and kind of area is 

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the following fact that Healthcare is 

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constitutionally guaranteed in prison. 

NOTE Confidence: 0.956804545

It’s one of the only places in 

NOTE Confidence: 0.956804545

the United States where we have a 

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constitutional guarantee in care. 

NOTE Confidence: 0.956804545

And so just give a pause to that. 

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And what this means is that there’s 

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a large group of young black men, 

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poor folks that first access 

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healthcare as adults behind bars. 

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In fact, our data and others show that 

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about 40% of individuals are newly 

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diagnosed with the chronic health 

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condition while they’re behind bars. 

NOTE Confidence: 0.956804545

And to me as a primary care physician,
this blew my mind.
But this also was something that really drew me into this work.
After 50 years of this policy,
what we’ve been seeing is the aging of whole generations behind bars,
the media, if you’ll watch,
you know, Netflix,
it gives us the impression that folks that are in prison are actually this young healthy lot.
And the reality of it is,
is like this gentleman who has COPD,
they many individuals are aging behind bars.
85% of those that are incarcerated
have chronic medical condition that warrants longitudinal primary care. This includes physical health conditions like diabetes, hypertension, asthma, infectious diseases like hepatitis, CHIV, of course, substance use disorder, mental health disorders. And then of course because the aging behind bars have higher rates of cancer. And you know, just to take a look at each of these pictures, of course I have permission from the prison and these patients.
to be sharing these photos,
but they’re just waiting to see a doctor.
And so I just want you to Orient
your attention to, like, again,
to the correctional officers
overseeing this delivery of care.
And there’s a patient that’s waiting there
to see a Doctor Who’s held in a cage.
And so this is how Healthcare
is delivered behind bars.
Of course,
there’s a constitutional guarantee to care,
but access is limited by
institutional policies.
And this picture,
I want you to look at that pink slip. So that pink slip is a kite, and it’s a form that at the time this doesn’t happen in California anymore because it’s under federal receivership. But it happens still across the US. Individuals who need to see a doctor have to fill out that pink form. They fill out the pink form, the kite, and then first person that evaluates it is a correctional officer. If there’s medical need deemed by a correctional officer and think about the power kind of hierarchies that exists with incarceral systems,
then it goes to a nurse.

And after it goes to a nurse,

then it goes to a physician for a view,

and then the person can see a physician.

And so you know,

it’s not like in the in the

community you need to see a doctor,

there’s a long wait.

You can always roll up to an emergency

department and you’ll be seen.

It might be ours, you know,

but you’ll be seen and you’ll

be seen by a physician.

It isn’t the case behind bars.

And then of course the self management
of chronic conditions is difficult and it’s just wholly different than how we, our expectations are within the community health system. And so this is a picture of a patient and again, who was first diagnosed with hypertension behind bars, had hypertensive emergency sent to the outside hospital with this diagnosis coming back and we’re doing rounds on those that have come back, you know, and kind of a discharge planning rounds. And I just want to Orient you to the picture. Again, there’s no privacy. He’s in a typical cell block, and you can see that we’ve thrown the
00:12:59.744 --> 00:13:01.600 blood pressure cuff through the hole.
NOTE Confidence: 0.934915741
00:13:01.600 --> 00:13:03.250 The gentleman is strapping it up
NOTE Confidence: 0.934915741
00:13:03.250 --> 00:13:04.779 around his arm. He's not seated.
NOTE Confidence: 0.934915741
00:13:04.779 --> 00:13:06.410 This is not probably a very accurate
NOTE Confidence: 0.934915741
00:13:06.456 --> 00:13:08.015 blood pressure medication, right?
NOTE Confidence: 0.934915741
00:13:08.015 --> 00:13:09.260 Blood pressure measurement.
NOTE Confidence: 0.934915741
00:13:09.260 --> 00:13:12.412 Each morning this person is called by a
NOTE Confidence: 0.934915741
00:13:12.412 --> 00:13:14.512 correctional officer to go get his meds,
NOTE Confidence: 0.934915741
00:13:14.520 --> 00:13:16.680 and so his amlodipine,
NOTE Confidence: 0.934915741
00:13:16.680 --> 00:13:18.732 his lisinopril, is doled out.
NOTE Confidence: 0.934915741
00:13:18.732 --> 00:13:20.676 The nurse gives him a cup,
NOTE Confidence: 0.934915741
00:13:20.680 --> 00:13:22.080 that he takes the cup,
NOTE Confidence: 0.934915741
00:13:22.080 --> 00:13:23.360 he takes the medications.
NOTE Confidence: 0.934915741
00:13:23.360 --> 00:13:26.039 She checks to see if he’s cheeked it.
NOTE Confidence: 0.934915741
00:13:26.040 --> 00:13:27.958 I mean, these are blood pressure medications.
NOTE Confidence: 0.934915741
And then he rolls back to his cell.

And so adherence is almost perfect,

but it’s incredibly passive.

And again,

it’s at the behest of a correctional officer.

Cancer care is similar that they rely
on correctional officers and workers to
get people to go to their mammograms,

get people to go to pap smears.

And so you can see that there’s
a whole different layer by which
chronic conditions are managed that’s
different than in the community.

Similarly, this patient rarely,
if ever most correctional facilities
keeps that medication on his person.
So it doesn’t have to be like today.

I got to eat this after my meal, it’s always in the morning.

He’s always called up at the same darn time, right?

Never draws up his insulin for chemo, for if he’s newly diabetic,

never draws up his own insulin,

never uses a glucometer.

And so kind of what we ask of our patients in the community is horribly different than,

what the carceral system asks of patients behind bars.
Lastly, if this patient needed to see a physician, often, he has to put it down at a $3 Co payment to see the physician. Oh, there’s a little swelling in his legs. Having started on Norvasc wants to see the doctor and you’re asking, well 3 bucks, what’s 3 bucks? Well, 3 bucks is essentially equivalent to four, four days of salary. So if you’re lucky enough to have a job at $0.75 is your daily salary. And so again, to be able to see a physician is a real challenge and especially in navigating these chronic health conditions.
And lastly, I share this that the conditions of confinement impact disease management. This is a patient with COPD who’s oxygen dependent. But you could think about him as also a patient with lung cancer who’s oxygen dependent. Who’s being held in solitary confinement. A solitary confinement is a place where you stay in a 8 by 6 foot cell 23 hours a day, and often when. And you’ll notice of course that the tank is held outside the cell.
And as providers walking by this person’s cell, you would hear him intermittently, bam, on the door. And this was his kind of way of letting us know that the tubing was kinked and he could no longer breathe. The rationale being that the tank it’s too dangerous to have inside, right? That health is secondary to punishment, to control, to safety. And what I want you to think about is putting yourself in the place of the patient. He’s seeing physicians, healthcare providers walk on by him complicit in these health harming behaviors.
And the question is how could you actually treat a system that trust, a system that treats you in this way? When I get asked the question often like, well, this is, you know, horrifying, worrisome, but what does this have to do with me? You know, I practice in the community, almost everyone comes home, is released from these carceral systems. 95% of individuals that are incarcerated ends up back into the community and then over three years.
time and then again five year times, almost 2/3 go back into the carceral system and over five years time, 75%. And So what we have is a large population here in the United States, but in New Haven, even that cycle in and out of these two health systems, ours in the community and the carceral system, what happens when he walks out the door? So y’all know that if you have a patient that’s being discharged from Smilo, even if they’re here for an obstay, you’ve at least arranged the medications,
00:17:17.600 --> 00:17:18.840 a primary care follow up,
00:17:18.840 --> 00:17:20.840 a Cancer Center follow up,
00:17:20.840 --> 00:17:23.040 you’ve faxed the medications over,
00:17:23.040 --> 00:17:25.956 you’ve arranged for an appropriate discharge.
00:17:25.960 --> 00:17:28.335 Many individuals that are released
00:17:28.335 --> 00:17:31.084 from carceral systems have hardly
00:17:31.084 --> 00:17:34.394 any discharge planning set up.
00:17:34.400 --> 00:17:36.493 And what this means is that they’re
00:17:36.493 --> 00:17:38.800 given a short supply of medications.
00:17:38.800 --> 00:17:40.848 Here in Connecticut, it’s about 28 days.
00:17:40.848 --> 00:17:43.662 But in lots of carceral systems around
00:17:43.662 --> 00:17:46.959 the country, it’s no medications,
00:17:46.960 --> 00:17:49.400 mental health substance use treatment.
I’ve had patients released without chemotherapy arranged in the community, and so they’re coming back into a community health system, which we already know. It’s fragmented. It’s hard to coordinate all these health care appointments, as a person in the community right now for me, much less you’ve been incarcerated for two, five years. When people come home, they also often have significant barriers to maintaining their basic needs. Our patients often are coming home without a dime to them.
They do not have a place to find.

They do not have housing, there’s no food, there’s no employment.

And primary among their minds is trying to reunify with their families.

And so, not surprisingly, there’s a worsening of health outcomes, there’s a high risk of death.

And so during residency almost 20 years ago, I became obsessed with what I thought was going to be a real easy questions like we do transitions of care all the time. We're going to transition folks from.
I did residency in San Francisco from the California Department of Corrections back into San Francisco. And because in San Francisco there’s a large robust civil rights community, a formerly incarcerated individuals leaned on them to convene them to say what are the components of healthcare that you want to see in a transitions care program. And they wanted early access. They wanted physicians, healthcare providers that knew about the risks, incarceration could even say welcome home. We know what it was like inside.
We're going to help you come home. But most importantly, they wanted a community health worker person with a history of incarceration to be centered in primary care. That person would help them navigate the healthcare system, which is hard to navigate the social services system. So again, housing, food, employment. But also to say, like, I've been there, I've been incarcerated, I've been successful coming home. And that experience then builds trust in the healthcare system,
rebuilds or builds 'cause it never was there.

Trust in the healthcare system so a person can return home.

And so here's a picture of our late colleague and friend, community health worker Jerry Smart, with doctor Lisa Puglisi, a colleague here in Yale, in our Transitions Clinic program, in the room with the patient helping navigate that care. Since that time in residency, we've studied the program and of course reduces acute care utilization, reduces actually any future criminal justice interaction.
And the program has grown to the largest national network of programs in the country, almost 48 programs in 14 different states in Puerto Rico. And here again just to highlight this, we have a network of programs in Connecticut in the Yale Cancer Center catchment area.

We’ve provided primary care to 1000 patients that have left correctional facilities, again each with a community health worker with histories of incarceration. And we currently have three.
00:20:47.280 --> 00:20:49.120 statewide programs here in New Haven.
NOTE Confidence: 0.961496266666667
00:20:49.120 --> 00:20:51.644 This, this network in Connecticut’s led by Lisa Puglisi,
NOTE Confidence: 0.961496266666667
00:20:51.644 --> 00:20:53.354 who was in the picture before in New Haven,
NOTE Confidence: 0.961496266666667
00:20:53.360 --> 00:20:56.555 Bridgeport and Hartford.
NOTE Confidence: 0.961496266666667
00:20:56.560 --> 00:21:00.223 And we’ve been working closely with state policy makers and the Department
NOTE Confidence: 0.961496266666667
00:21:00.223 --> 00:21:02.768 of Corrections and payers to really think about how we implement the model and how we scale it so that there’s more than just three programs.
NOTE Confidence: 0.961496266666667
00:21:02.768 --> 00:21:05.004 And we’ve been working closely with state policy makers and the Department
NOTE Confidence: 0.961496266666667
00:21:05.004 --> 00:21:07.110 think about how we implement the model and how we scale it so that there’s more than just three programs.
NOTE Confidence: 0.961496266666667
00:21:07.183 --> 00:21:11.957 And so it’s in the delivery of primary care.
NOTE Confidence: 0.961496266666667
00:21:11.960 --> 00:21:15.200 Again, having been here for 15 years
NOTE Confidence: 0.961496266666667
00:21:15.200 --> 00:21:17.454 that we’ve seen a ton of folks
NOTE Confidence: 0.961496266666667
00:21:17.454 --> 00:21:19.542 that have come home either at with cancer or really kind of having not
NOTE Confidence: 0.961496266666667
accessed cancer prevention treatment and have turned of course the literature to see well what’s known about these higher rates of cancer. And so and so doing what I’ll indicate is that we’ve had the literature prior to Carrie and I starting our investigation were single side studies that either studied incarceration outcomes rather cancer outcomes when people are incarcerated or cancer outcomes when people were released. And so but none that combined kind of the full story of how people move in and out of these two systems.
So what we know is that individuals with a history of incarceration had higher rates of cancer risk factors, including smoking, alcohol use, HIV and Hepatitis C. Our team did a study again using available national data showing that the prevalence of lung cancer, cervical cancer and alcohol-related cancers were higher among those that were just as involved compared to those that didn’t have any exposure to the criminal legal system. And then one study again existed in Ontario, Canada found that individuals with a history of incarceration have...
higher incidence of cervical head and neck liver lung cancer compared with the general population.

Of course incarceration was also found to be associated with worst cancer survival and there have been two studies that really highlight this.

We bring this up, one that’s showing that in prison there’s worse survival rates. So these data come from Texas, my home state, and where you see the kind of solid dotted lines is the incarcerated individuals. These data come from those that were
in the Department of Corrections in Texas with cancer, and they compared it to data from SEAR and then they compared it to SEAR data, individuals that are matched demographically. As you can see, there’s decreased survival among those who have cancer behind bars. And then similarly following release, my friend and colleague Ingrid Binzwanger published a study in the New England Journal. Again, these data come from Washington State and found that there’s a significantly increased risk of dying in the
first weeks to months post release.

You can see how high the bar is.

One to two weeks falling release.

I do not have a pointer.

And again,

cancer was one of the primary causes of death in that study.

So again, high rates of mortality,

both incarceration during incarceration and falling release.

But no studies really combine them and no studies have really kind of gotten that mechanism.

So, you know, a lot of people,

a lot of anecdotal evidence
showing poor quality of care.

When you turn to the literature, there hasn’t been a lot of work looking at the quality of care of cancer outcomes. Again, two studies, multiple studies and done looking at the access to palliative care, only one study looking at cervical care, and again, this is a hypothesis, but not really borne out in the literature as of yet.

And then some discussion about, of course, what are the social determinants of cancer outcomes. And again, people don’t have transportation,
food, housing, a job. They often lack insurance, healthcare, access. They have these competing priorities, again with family trying to meet the terms of parole, probation. And then there’s the real stigma having been incarcerated. And all these may play a role in how they access cancer care coming home. And so this was a something that was important to both myself and Doctor Gross. And so we started thinking about, well, how can we together and with the
amazing resources within the state, think about how it is that we can start informing what is driving the higher rates of poor health outcomes among those that are just as involved care. Thank you, Emily, and thank you to the Cancer Center for inviting us to have a discussion with you today about this issue of, frankly, if we’re thinking about health justice, unfortunately, as Emily points out, we need to be thinking about criminal justice, and we’re thinking about HealthEquity. We need to be thinking about systemic racism and structural factors such as
mass incarceration that are affecting all of our patients and all of our populations here in the state of Connecticut as well as here at Smilow. Our collaboration with Copper Center and Emily’s wonderful group has really been personally an inspiration for me seeing this, this mission driven group of people who are not only doing research but are also advocating for change. And I think this is a testament to the amazing environment here at Yale and that our offices were next door to each other for like 10 years.
And we kept thinking, oh, you’re thinking of cancer outcomes and you’re thinking of improving HealthEquity and health justice for the current formerly incarcerated patients and people. Why don’t we collaborate? It took us a while to figure it out, but it worked well. And I think I would just use this as a brief pause to encourage all of you to look outside of your primary domain, find people who share your values in your mission. Reach out to them, because those are often the most fruitful,
fruitful collaborations.

What do I do?

This.

OK, so Emily has done an excellent job of cultivating the intuition.

There are three distinct risk strata that we should think about as we shift over to talking about our particular research endeavor, so that there are people who are never incarcerated, people who are currently incarcerated, and then there’s third risk group or people who were recently released. That Bin Swagger article highlighted
in the first one to two weeks after release is what is it, a four fold increase in risk of death. But also as Emily pointed out the whole point of the Transitions Clinic is during that very initial transition that’s it’s a very fraught time with increased risk. So anyway that’s why we have three groups here and we’ll go through these in greater detail. For our study based upon the prior literature, we looked at the relation between these three risk strata and and the incidents or a detection of
NOTE Confidence: 0.951507974545455
00:28:13.864 --> 00:28:15.800 an imprompt diagnosis of cancer.
NOTE Confidence: 0.951507974545455
00:28:15.800 --> 00:28:18.590 The second outcome of interest was
NOTE Confidence: 0.951507974545455
00:28:18.590 --> 00:28:22.800 cancer care and third was cancer survival.
NOTE Confidence: 0.951507974545455
00:28:22.800 --> 00:28:24.774 Anybody want to hazard a guess
NOTE Confidence: 0.951507974545455
00:28:24.774 --> 00:28:27.040 for people who are incarcerated,
NOTE Confidence: 0.951507974545455
00:28:27.040 --> 00:28:29.920 what is the most common cause of death?
NOTE Confidence: 0.667354906666667
00:28:39.760 --> 00:28:42.076 We’re in Cancer Center Grand Round
NOTE Confidence: 0.667354906666667
00:28:42.080 --> 00:28:45.660 Cancer I know you all like it’s too
NOTE Confidence: 0.667354906666667
00:28:45.660 --> 00:28:47.944 easy so that’s one of the motivating
NOTE Confidence: 0.667354906666667
00:28:47.944 --> 00:28:50.937 factors for for for our work is cancer
NOTE Confidence: 0.667354906666667
00:28:50.937 --> 00:28:53.247 is highly relevant to the incarcerated
NOTE Confidence: 0.667354906666667
00:28:53.319 --> 00:28:55.279 current and former population
NOTE Confidence: 0.667354906666667
00:28:55.280 --> 00:28:57.800 call out to our amazing study team
NOTE Confidence: 0.835027513333333
00:29:00.280 --> 00:29:03.436 we include people from both the
NOTE Confidence: 0.835027513333333
00:29:03.436 --> 00:29:06.183 site center copper but also
NOTE Confidence: 0.835027513333333
00:29:06.183 --> 00:29:07.377
people who work within the state Department of Corrections that the state Department of Public health. It’s really been a wonderful and diverse group. Again mission driven being that I would say that the buzzwords people that are really wanted to not only do research but use the evidence to drive change and it’s been an honor to be a part of this group. So first let’s talk about cancer incidence and diagnosis. Our first study that I’ll highlight was led by a Generous Aminowa looking at cancer incidence,
addressing the questions what is the cancer incidence in the incarcerated and post incarcerated population compared to the general population and how does this differ across race and ethnic groups. So this slide is incredibly over simplistic. These arrows make these linkages look very easy. This collaboration between the state Department of Health tumor registry, the Department of Corrections would not have been possible without years of prior collaboration with these different groups. And anyway, so the arrows kind
of like oh it's just easy.

So the tumor registry data was linked with the state Department of Corrections data, their master file as well as the movement file which tracks when people are released and readmitted if that happens. So looking at cancer incidents there are some chat methodologic challenges. We don’t have all the data that you traditionally would have when looking at the denominator. So for the incarcerated population, because people are going in and out, we just looked at the mid year inmate population.
For the post incarcerated population for our denominator we discharge, we basically looked summed the number of people who are discharged every year discounted by about a third because of recidivism. So it’s just an estimate of how many people were released and in the community at any given time. Then the Connecticut general population cancer types, we like to excuse me, all invasive cancers as well as screen detectable defined as such. So what we found overall cancer
00:31:34.292 --> 00:31:36.702 incidence on the left side of this
NOTE Confidence: 0.759775751428571
00:31:36.702 --> 00:31:38.801 figure is the general Connecticut
NOTE Confidence: 0.759775751428571
00:31:38.801 --> 00:31:41.720 population people who were incarcerated.
NOTE Confidence: 0.759775751428571
00:31:41.720 --> 00:31:44.564 You see, there’s a dramatically
NOTE Confidence: 0.759775751428571
00:31:44.564 --> 00:31:46.916 lower cancer incidence rate,
NOTE Confidence: 0.759775751428571
00:31:46.920 --> 00:31:50.478 but in that post incarceration period,
NOTE Confidence: 0.759775751428571
00:31:50.480 --> 00:31:53.560 defined as one within one year after release,
NOTE Confidence: 0.759775751428571
00:31:53.560 --> 00:31:55.636 there’s then a substantial bump up,
NOTE Confidence: 0.759775751428571
00:31:55.640 --> 00:31:56.562 substantial increase,
NOTE Confidence: 0.759775751428571
00:31:56.562 --> 00:31:59.789 which raises the concern that maybe there’s
NOTE Confidence: 0.759775751428571
00:31:59.789 --> 00:32:01.951 under diagnosis while incarcerated and
NOTE Confidence: 0.759775751428571
00:32:01.951 --> 00:32:05.120 then there’s a catch up period afterward.
NOTE Confidence: 0.759775751428571
00:32:05.120 --> 00:32:09.515 We then looked at strata by whether
NOTE Confidence: 0.759775751428571
00:32:09.515 --> 00:32:11.840 the cancers were screen detectable
NOTE Confidence: 0.759775751428571
00:32:11.840 --> 00:32:13.640 such as you know, colorectal,
NOTE Confidence: 0.759775751428571
00:32:13.640 --> 00:32:14.432 cervical, etcetera.
Again for the if you look at the Gray bars, these are the screen detectable bars. So it’s cancers. There’s a dramatic decrease in the incarcerated population. If you look at the relative change and then there was a slight bump after release for the non screen detectable cancers for which they were not routinely recommended screening tests. There’s less of a substantial decrease when you go from general population to incarcerated and then still there’s a bump afterward. So this suggests that maybe
the screen detectable cancers.

The reason why there’s such a huge drop is that there’s less screening in the incarcerated population. However, we don’t have screening data. That’s next one of our next studies we’ll be addressing.

Alana Richmond here in general medicine led the next study, incarceration and cancer stage of diagnosis. So here this is looking at the Y axis, the percent of people in each group whose cancer was diagnosed at an early early stage. The incarcerated group, roughly 45%, recently released a little more,
and this is, but these are both lower than the general Connecticut populations. So we show this to our collaborators in the Department of Corrections and they said, well, it's not really fair because the full state of Connecticut has different demographics than people who are at risk of incarceration. Maybe you could choose a different comparison group to kind of level the playing field. So maybe just looking at people who have Medicaid statewide,
Connecticut,

maybe they're a little more similar to

And this is again for us the beauty

of having these collaborations with

stakeholders who can call us out on

our initial plan that we're going to publish.

They're like wait,

hold on guys,

that's that's not a good idea.

Let's try something a little different.

So we added a state of Connecticut

Medicaid population and still we

basically the percent early

diagnosis as you can see was

Medicaid is definitely lower than
the full state of Connecticut, but still is a little bit higher than the incarcerated population. We then looked at colorectal cancer. Now here are the stories, a little bit different. The full state of Connecticut did have more early stage of diagnosis, but all the other groups were roughly equal. So maybe the incarcerated people in this case, where they were pretty much equally likely of being diagnosed with the early stages of the full state of Connecticut prostate cancer.
A slightly different story in that the state of Connecticut Medicaid was substantially better, more likely to be early diagnosed than the incarcerated into a degree of the recently released population. So take home points here, which will be reiterated by looking at the adjusted standardized incidence rates. So the incarcerated group is the center column there and basically 0.28. That means compared to people in the general population, people who are incarcerated have
28 percent of the risk of being diagnosed at an early stage and then recently released compared to the general population also is lower, but not as lower. So I’m not going to go through these numbers in great detail because they show the same thing. Basically there is a decreased likelihood while you’re incarcerated of being diagnosed at an early stage and this seems like there may be a bounce back after after you’re released. And that also applies to late stage cancer. Moving on to mortality outcomes among
people who were diagnosed with cancer. This is led by Damalola Oladeru.

Here we compared these three groups, people who were diagnosed with cancer while they were incarcerated as about 200 people. People who were diagnosed after release and then the large never incarcerated population. As you can see, people who were diagnosed while incarcerated or post release or substantially younger than the general population, again more likely to be black or Hispanic. And the most common cancer types are
slightly different between these groups, largely reflecting probably differences in risk factors as well as age, age, distribution of the different populations with GI, mainly colon and liver, long male reproductive and leukemia particularly common in the incarcerated population. But to cut to the chase, what we found when you look at ALL 'cause mortality, these are survival models that are based on our Cox proportional hazards model. The never incarcerated group has a much
better survival outcome than either the incarcerated or post release group. This means you were diagnosed after released or diagnosed incarcerated and the hazard ratio is basically two, SO twofold greater risk of death if you’re in either of these groups. We then added a stage of diagnosis to the model to see because as you saw from the prior studies that there was a distribution, a difference in stage of diagnosis. With incarceration it didn’t really change the hazard ratio hardly at all the like the risk of death went from like 2.1 to 1.9 after you
account for stage of diagnosis. So, so there are other factors that are causing this difference in risk of death. You want to look at cancer related mortality. This was interesting. So I wanted to pause here because we were just talking earlier about transitions being a fraught time after being released to the community. Here you see again the never incarcerated folks have the best cancer mortality, but the incarcerated people are in the middle and the post release.
actually have the worst cancer
NOTE Confidence: 0.871217403846154
survival really making us worried
NOTE Confidence: 0.871217403846154
about what’s happening after release
NOTE Confidence: 0.871217403846154
with regard to being people connect,
NOTE Confidence: 0.871217403846154
being connected to care.
NOTE Confidence: 0.9474627725
OK. So then our third outcome of
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interest is looking at the quality
NOTE Confidence: 0.9474627725
of cancer care, addressing how
does incarceration affect quality.
NOTE Confidence: 0.9474627725
We have an ongoing study that
NOTE Confidence: 0.9474627725
we’re not going to be presenting
NOTE Confidence: 0.9474627725
today doing chart review,
NOTE Confidence: 0.9474627725
looking at specific quality measures
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and comparing incarcerated with non
NOTE Confidence: 0.9474627725
incarcerated individuals is care
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different for individuals diagnosed
00:38:56.204 --> 00:38:58.800 during incarceration versus post release.
00:38:58.800 --> 00:39:02.356 And we set out to identify perceptions
00:39:02.360 --> 00:39:04.216 regarding accessing high quality
00:39:04.216 --> 00:39:07.000 cancer care in the correctional system.
00:39:07.000 --> 00:39:08.960 And in the immediate post release period.
00:39:08.960 --> 00:39:10.742 Let me turn the microphone back
00:39:10.742 --> 00:39:11.800 over to Doctor Wong.
00:39:14.320 --> 00:39:14.400 All
00:39:17.830 --> 00:39:20.422 right. And so our last part of our study
00:39:20.422 --> 00:39:23.445 is really trying to center this work again
00:39:23.445 --> 00:39:25.985 in the voice and perspective patients.
00:39:25.985 --> 00:39:29.125 And so we have a a last name focused on kind
00:39:29.125 --> 00:39:31.201 of what are patient perceptions regarding
00:39:31.201 --> 00:39:33.915 quality of cancer care in the correctional
00:39:33.915 --> 00:39:35.875 system and immediately post release.
This is being led by Alana Rosenberg and our team as well as doctor Dina Schulman Green at NYU now. In this study we’re conducting in depth interviews with purposeful sample of people just released from prison or diagnosed in the community. And so either they were diagnosed while they’re incarcerated or diagnosed in the community. And again, these are preliminary themes. We still haven’t quite finished up recruitment, but the themes are the access, which I think is going to
be of critical importance. But also fragmentation of care. And not just, again, in the transition from the carceral system to the community, but even in communications that are bidirectional from the community back to the carceral system or transitions between different carceral facilities. Each individual facility has a different kind of structure. And once you transition from one Correctional Facility to another, that often creates different
barriers to care. 
NOTE Confidence: 0.89337902625
There were conversations and 
NOTE Confidence: 0.89337902625
a theme of communication, 
NOTE Confidence: 0.89337902625
wanting more transparency in the care plan, 
NOTE Confidence: 0.89337902625
wanting availability of records. 
NOTE Confidence: 0.89337902625
And so patients would often report that 
NOTE Confidence: 0.89337902625
they had no idea what was going on, 
NOTE Confidence: 0.89337902625
didn’t have medical records, 
NOTE Confidence: 0.89337902625
they have to pay for their medical records. 
NOTE Confidence: 0.89337902625
And so this was a a real issue 
NOTE Confidence: 0.89337902625
of knowing kind of centering 
NOTE Confidence: 0.89337902625
the care plan around the patient. 
NOTE Confidence: 0.89337902625
Of course trust in healthcare writ large, 
NOTE Confidence: 0.89337902625
but especially with within the 
NOTE Confidence: 0.89337902625
Department of Corrections was an issue. 
NOTE Confidence: 0.89337902625
There were questions about the
00:41:11.395 --> 00:41:13.395 competence of care and the commitment
00:41:13.395 --> 00:41:15.130 to actually patient centered care
00:41:15.130 --> 00:41:17.192 again both in the community as
00:41:17.192 --> 00:41:19.040 well as in the carceral system.
00:41:19.040 --> 00:41:20.798 Not surprisingly there were was a
00:41:20.798 --> 00:41:22.792 theme of kind of the correctional
00:41:22.792 --> 00:41:24.316 system and correctional officer
00:41:24.316 --> 00:41:26.743 role that as I'd indicated before
00:41:26.743 --> 00:41:28.431 that often times correctional
00:41:28.431 --> 00:41:30.928 officers were the arbiter of care.
00:41:30.928 --> 00:41:33.756 They were kind of in charge of
00:41:33.756 --> 00:41:36.525 triage that they also could detect
00:41:36.525 --> 00:41:38.660 that the criminal justice system
00:41:38.660 --> 00:41:40.320 was primary before healthcare.
00:41:40.320 --> 00:41:42.476 And so they would comment on shackling

77
and also the presence of correctional officers in the healthcare space as they were getting their treatment. And then importantly, as we all know as primary care providers, as cancer providers, the themes of family, family supports came up both as advocates from the outside, but also the importance of supporting a person through a life shaking experience like being diagnosed with cancer and getting treatment and clarifying the care plan. And so usually we like to have their voices. We couldn’t get this prepared in time,
but I'll just read these out loud that in terms of trust in the healthcare system, one person comments, medical care is so expensive now that when you’re inside, when you’re an inmate, you’re really not looked upon, you’re a liability. This guy’s got 30 years, he’s going to die in prison anyway or he’s getting released, so we’ll let them deal with it when he gets out. And so this is both the commitment but also really signaling that,
hey, because there’s fragmentation in the healthcare system, the care isn’t going to be delivered in the way that’s central to the patient. The importance of family was mentioned and this participant notes you got to go a whole lot of things for them to get you an appointment. I got two sisters that are in my corner. I call them and tell them and they would call the prison and keep complaining. And so who doesn’t love a sister? But that’s the sisters that are calling in to make certain that cancer care is is being arranged. And what happens again when
you're aging behind bars,
when you don't have sisters,
you don't have family members that
can advocate that even know to
advocate for your cancer care and
then importantly access this patient.
This participant is a New Haven resident
just released with advanced cancer
and he says a Co worker just tried
to hook me up with a medical cap,
but they said something that
I wasn’t eligible.
I forgot the exact reason we had to
jump through a hoops to try to give
me that one time, that medical van.
I had no way to get to my chemo. I was hoping that they could at least put me in Smilo here. That’s right here. It had been a whole lot easier instead of going all the way out to New Haven. And I think it’s important here just to frame that, as Doctor Gross presented, we have work here in the community to be kind of tackling to improve the care for this vulnerable population. Of course there’s work in the carceral system, but thinking about what it is that we can do right here, right now,
I think it's a central focus of the work that lies ahead for us. And so in summary, we hope that you take away these key points that incarceration has a substantial impact on overall health. It's a profound mediator of health disparities and you know, it may be a key mediator in looking at black white disparities. We don't measure it in our large population based, national population based studies. We don't often understand that it may be a key mediator in looking at black white disparities.
and socio economic disparities.

And and it needs more attention.

Incarceration is associated with increased risk of cancer

incidence later stage of diagnosis,

higher cancer mortality rate.

And this is both for those who

are incarcerated and those who are

returning home to the community

and patient experience with cancer

care while incarcerated and falling

release shows multiple domains

in need of improvement.

And so you know,

often when we give these talks,

we’re left with like, well,
what can we do, you know, And so I just wanted to present some ideas that Carrie and I had and perhaps there are many others in the room. But for those that have you that are involved in clinical care is to focus on centering care around the patient and not the inmate. So remove those shackles. We have the ability to also ask correction officers to leave the room in certain ways. Over the last 50 years, we’ve ceded power to a carceral system in our own healthcare system and there are ways that we can do so.
And again, if you’re looking for guidance on the Safe Center website, there are kind of guidance about what we can and can’t do within a healthcare system.

Secondly, consider compassionate release. There’s policies, statutes in Connecticut now that enable you especially as oncologists to write for compassionate release. In 2019, prior to COVID, when we did a FOIA of our records, only three people in the state of Connecticut were released under compassionate release.
The best way that we found, and we've been able to do this for certain patients, is to engage with the medical provider behind bars. Often times they too are advocating and often feel like it's easier for a community provider to be in partnership. These requests have to go through the Connecticut Parole board, but letters from outside physicians saying we've got this person coming home, they're in our care will do better, the patient will do better if they come home is the kind of deciding.
factor in moving forward

with compassionate release.

And then of course,

if you practice within Bridgeport, New Haven and Hartford,

refer your patients that you’re seeing that have just been released from a carceral system to our Transitions Clinic programs.

Again on the Safe Center website, you’ll see the contacts for community health workers. Again,

y’all do everything for your patients and we know often times primary care can shift over to oncologists.
But what’s additional about Transitions is having a community health worker. That’s how the history of incarceration. Having real specific knowledge, research resources and expertise to attend to, especially the social determinants of health for when people return home. Unique to our Transitions Clinic in New Haven, we have a partnership with the Yale Law Schools Medical Legal Partnership where we have Yale Law School students and staff lawyer.
that are attending to the civil legal needs of individuals that come home. And so there's additional benefit to having primary care rooted within Transitions Clinic. If you're a researcher, I think you will know especially those of you that run clinical trials. Rarely do clinical trials include incarcerated people. And I think that this is, as we all know, clinical trials are real beacon of hope for certain patients with certain cancers and it is possible to include them.
It takes a lot of advocacy.

We've been working at the safe center nationally trying to think about how it is that we can have more individuals that are incarcerated participate in clinical trials. But if those of you that are running trials please reach out to us, we would love to be in conversation, advocate for the linkage of CR data or cancer registries that are linked to correctional data. Again, you can see the from the work that we've been able to do with the tumor registry in the Department of
Corrections that this is how we can illuminate the actual disparities that exist within our state. To then be able to identify meaningful places of change, if you run the health system here at SMILo, creating partnerships of the Department of Corrections to improve prevention and treatment efforts both in reach into the carceral system. But also thinking about how do the outreach efforts that the L Cancer Center is already making really target this population, those individuals that have just been released and their families.
And lastly, concentrating our efforts on eliminating the social barriers to care. And so I'll end here, which is to say that these patients here and every day remind us that this work is urgent. That even as we forge forward with the science that we need solutions now that there are really things that each and every day that you can do in clinical care, in research and in your work leading at the Cancer Center that will make a difference for these patients.
So with that, we thank you for your attention and really appreciate the opportunity to be here.

Thank you so much for that fantastic talk. We have time for questions.

The cost benefit of early screening and diagnosis is well known to us with a fairly substantial literature, not for every cancer but for most cancers. So you actually save money if you have a Primary Health care system that does a good job with screening and early diagnosis. Is this an argument that that has been made in the carceral setting with the research that you’re describing?
Is there a signature paper, a series of papers that we could cite as we argue these cases? Because I mean, we know Byron Kennedy well, the medical director of the Department of Correction. He used to be, of course, the health director here in New Haven before that health director in Rochester, an enlightened MDPHDA graduate, you know, an alumnus of Yale. So it’s a window of opportunity, but he has to make the economic arguments. And if you can actually improve cancer care and save money,
that argument might work better than the humanitarian argument. Well, I appreciate this question. And, you know, I think what’s interesting is twofold. So in fact, of course, we’re partnering with Doctor Kennedy right now and Doctor Richardson who run the medical services behind bars. And let me just give you an example of kind of what they’re up against. So I think that they plainly know and I don’t want to put words into their mouth, plainly know the cost savings and the like larger health benefits of early screening. But to give an example,
it’s been nearly impossible prior to kind of FIT tests etcetera to actually get colonoscopies arranged. And what it means is that, you know there wasn’t access within the healthcare system in the community where they could do it or they feel like mammograms or getting a diagnostic biopsy, we’re deprioritized. And so it really is more of an indictment I think of kind of our statewide community healthcare systems and the ability for our cultural system providers to be able to access the screening. It’s so much so that of
course now that for instance, colorectal screening has transitioned from colonoscopies etcetera, that they now have instituted. Again, trying to think about how you scale up fit testing etcetera within the carceral system, knowing the value of early screening and knowing that again rates of colon cancer are climbing among black men in particular and that this is an important issue to really lean in on. I would just also add briefly that first of all for the patients with cancer who were in our study that who are incarcerated,
the average length of stay was, I mean
time incarcerated was four to five years.
So there was plenty of time to
potentially diagnose them early.
The challenge is that these cancer screening tests, they’re cost effective,
they’re usually not cost saving, right.
So it’s like $50,000 per quality.
So it’s not an investment or
quality investment per survival.
So part of it comes down to,
it comes down to the cost argument,
but also comes down to the
moral and ethical argument too.
to highlight now that you bring this

up is these data that we present

are from 2006 to 2016. And so

again there’s an opportunity now to see how

screenings change given different modalities.

So, but thank you for your question.

Thanks so much for this talk. It has made

me think so much. My name is Jen Capo.

I serve as the Chief of Palliative Care

here at Smilo and across the hospital.

We’ve just encountered a lot of moral

distress about how several patients

have been treated at the end of life.

We’ve just encountered a lot of moral

and we noticed the suffering that’s
not only physical with access to adequate symptom management, but also just a tremendous suffering that comes from all the psychosocial distress that accompanies not only a cancer diagnosis but this history of incarceration. And so, you know, there is some data looking at the integration of palliative care into the care of patients who are incarcerated. As a team in Connecticut, what would you want us to advocate for? How could we best affect the patients in our state?
What would be the best next steps to care, to provide better care, you know? So I appreciate that. It’s lovely to meet you in person in this way. And I think the first I would say first and foremost and without a doubt is get people home. So you know, it, it blows my brains that like really. And it’s not that only three people applied and got compassionate release. Many people have applied and only three got it. And so you know, when you’re seeing people in care within the Cancer Center, when you’re seeing a person that’s
00:55:03.800 --> 00:55:05.403 shackled getting care to when
00:55:05.403 --> 00:55:07.089 you’re seeing a person that has
00:55:07.089 --> 00:55:10.557 clinic and you know that they’re at.
00:55:10.560 --> 00:55:11.142 And again, of course physicians were notoriously
00:55:11.142 --> 00:55:12.597 bad at predicting kind of when
00:55:12.597 --> 00:55:14.079 the end of your days are,
00:55:14.079 --> 00:55:15.195 of course physicians were notoriously
00:55:15.200 --> 00:55:16.958 but you know what I mean?
00:55:16.960 --> 00:55:19.720 One to start investigating how
00:55:19.720 --> 00:55:22.480 compassionate release can be used.
00:55:22.480 --> 00:55:23.965 And and again, it’s always with patient permission
00:55:23.965 --> 00:55:26.440 that either you’re reaching out
00:55:26.440 --> 00:55:28.035 to also and I’ll just not just
00:55:28.035 --> 00:55:30.434
those that are incarcerated,

but for those that are on parole too.

So you know, just to give you an example,

just because you’re at the end

of your days doesn’t mean you’re parole and probation terms end.

And it is incredibly freeing at the end of your days to not have to report back to parole and probation.

And these are ways that we can again get people out of the large reach of the criminal justice system.

Reporting means that every week you’re going in, you’re *dehumanizing* you know,

in a cup to provide your urine.

It’s deeply dehumanizing.
And for some of these individuals, it could have been 5-10, fifty years where they’ve been doing so.

We’ve had patients 50 years who’ve been under the crucial system.

And so that’s one.

Secondly, I would say you know to me some of the questions I mean I think that you’re raising and again I would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this, would have lots to say about this.

And again trying to think about how the policies again in the carceral system can include advanced directive.
planning that includes family.

It’s, you know again at the end of our days, the regrets that I’ve seen patients have are ones where they haven’t been able to collect with family members.

Also again, we didn’t touch on this in this talk that 50% of Americans in the United States have an immediate family member that’s had a history of incarceration, that’s healing and important healing that comes from the family members being able to reintegrate with their loved ones that are behind bars,
being able to have these conversations. And if you think about patients that are behind bars for them to come up with their advanced care directed thank you. I'm going to set a advance directives without family members in the room, which currently they're often not. There was this paper that was recently published where if you don’t have a family member sometimes it’s the carceral system that that is your, you know, proxy. These are the places I think that from a policy standpoint, you know,
clinically and then policy need advocacy.

Thank you so much again to Doctors Wong and Gross for your talk today. We appreciate.