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Jails: Inadvertent Health Care Providers

How county correctional facilities are playing a role in the safety net

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The Pew Charitable Trusts

Susan K. Urahn, *executive vice president and chief program officer*

Michael Thompson, *vice president, state and local government performance*

Project Team

Kil Huh, *senior director*

Alexander Boucher

Frances McGaffey

Matt McKillop

Maria Schiff

External reviewers

This report benefited from the insights and expertise of two external reviewers: Ronald Harling, jail superintendent, Monroe County, New York, and Natalie Ortiz, Ph.D., senior research analyst, National Association of Counties. Although these experts have found the report's approach and methodology to be sound, neither they nor their organizations necessarily endorse the report's findings or conclusions.

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Contact: Rachel Gilbert, senior associate, communications

Email: rgilbert2@pewtrusts.org

Project website: pewtrusts.org/correctionalhealth

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Overview

Every year, millions of people are booked into U.S. jails. During 2015, the latest year for which data are available, there were 10.9 million admissions to these correctional facilities, which hold individuals who are awaiting trial or serving short sentences. The government running the jail—usually a county—has a constitutional mandate to provide people booked into these facilities with necessary health care. Counties designing a jail health care program targeted to meet the needs of their incarcerated population have the opportunity to improve the health of people in jail and the broader community, spend public dollars more effectively, and, in some cases, reduce recidivism.

Yet little is known about how jails administer their health care programs and whether these programs further county public health and safety goals. Research is limited on how counties organize their jail health care services, what care they make available and when, and how they ensure they receive value for their investment in health care. Despite growing awareness of the connection between community services for recently released individuals—especially those with mental illness or substance use disorders, collectively known as behavioral health disorders—and a reduction in recidivism, information about how to achieve this result is scarce.

In an effort to give counties tools to improve delivery of services to an underserved population with high needs, The Pew Charitable Trusts, with the assistance of Community Oriented Correctional Health Services, reviewed 81 requests for proposals (RFPs) for contracted jail health care services and conducted in-depth case studies of three jurisdictions. (See the methodology for more detail.) This research revealed wide variation in the ways that counties arrange to provide health care in their jails and the information they supply to help vendors craft bids. Additionally, despite growing recognition of the health needs of those currently and formerly in jail, our analysis found varying approaches to whether and how jails prepare individuals to manage their health once released.

The research found that:

- Many jails contract with vendors to provide health care. In New York state, for example, 84 percent use vendors to provide at least some health care services. The arrangements that counties make with providers vary; for example, one vendor may be responsible for all services, or a county can use multiple vendors across types of health care services such as mental health and dentistry. Payment models can also vary: While some counties share financial risk for costly medical care with the contractor, others have their vendors assume all risk through a negotiated per-inmate, per-day rate.
- The portion of a jail's budget spent on health care can vary widely by county. For instance, in Virginia, jails spend anywhere from 2.5 to 33 percent of their budgets on health care.
- Although most jails conduct bookings 24 hours a day, many do not have medical or nursing staff on site to screen incoming individuals at all times. This can lead to delays in identifying and treating acute, possibly life-threatening health problems, and missed opportunities to divert people with behavioral health disorders into treatment settings rather than jail. Jails with an average daily population (ADP) under 500 are less likely to offer round-the-clock clinical services than are larger ones, a situation probably driven by resource constraints.
- Most of the RFPs that were examined look to national accrediting bodies such as the American Correctional Association and the National Commission on Correctional Health Care to guide how the jail offers health care services. Yet few RFPs laid out performance requirements and financial penalties or incentives that would hold contractors accountable for meeting service requirements.

- Many of the documents reviewed did not include all the information potential bidders likely need to propose an appropriate plan for delivering services at a realistic price. By not providing data on the number of people typically requiring care, their average acuity, or the expected staffing required, counties risk receiving bids that fail to meet the needs of those in jail and may not be comparable to each other.
- Because they house a high concentration of individuals with substance use disorders, jails are a key site for providing drug and alcohol treatment. Yet few of the RFPs requested medication-assisted treatment (MAT), a proven method for treating addiction. And of the 11 that did request this service, all but three restricted the use of this treatment option to pregnant women.
- Because jail stays are short on average, the facilities do not have to provide health care to many people for long; their role is more akin to urgent than primary care. Yet incarceration represents both an opportunity to connect an individual with care upon release and a challenge in terms of a possible interruption in treatment upon entry into jail. To address these challenges, Multnomah County, Oregon, has an ambitious pre-release Medicaid enrollment program, while Fayette County, Kentucky, participates in a statewide health information exchange that allows jail health providers to access individuals' health records dating from before their incarceration. Such care continuity activities can reduce unnecessary and costly emergency room use after release and allow for more efficient and effective care delivery within the jail. For those with behavioral health disorders, connections to care after release are a key part of strategies to reduce recidivism.

The findings show that county jails vary in many ways—from how they pay for their health care to the specific services they offer. Examining these different approaches can help county leaders make more informed choices about how to fulfill jails' role in the health care safety net, achieve their county public safety missions, and spend taxpayer dollars more wisely.

How jails developed a role in the health care safety net

Jails are constitutionally required to provide health care to those in their custody, a principle established by a landmark 1976 Supreme Court decision. *Estelle v. Gamble* found that deliberate indifference to the serious medical needs of incarcerated people violates the Eighth Amendment, which prohibits cruel and unusual punishment.¹ But providing care to the jailed population is a challenge: People with jail stays are more likely than the general population to have diabetes, infectious diseases such as HIV/AIDS and tuberculosis, mental illnesses, and substance use disorders.² For many individuals, the services provided in the jail are the first care they have received in quite some time.³

The government responsible for operating the jail—usually a county—determines how these services are provided.⁴ There are more than 3,000 counties in the United States; like the states in which they are located, counties differ in their size and fiscal resources. While Los Angeles County is home to approximately 10 million people, California's Sierra County is home to fewer than 3,000.⁵ In 2014, Harding County, New Mexico, took in \$1,312 per capita in tax revenue while neighboring San Miguel County took in just \$245.⁶ This variation in size and resources can lead to wide differences in how the jails provide health care and, importantly, what services they offer.

What Is a Jail?

Jails are different from prisons. While prisons are state or federal facilities that primarily incarcerate convicted individuals, jails usually house people in a mix of legal circumstances: many awaiting trial who are therefore legally considered innocent, some convicted of crimes and serving short sentences typically of less than one year, and others who have violated the conditions of probation or parole.

Jails also differ from prisons in the number of admissions and releases each year. During 2015, 10.9 million people were booked in U.S. jails. In contrast, state prisons admitted just over half a million people. Yet on any given day, the number of people held in prison is greater than the number in jail. At the end of 2015, 1.3 million people were held in state prison, while only 693,000 people were held in jail. This is because individuals booked into jails have relatively short stays: Each week in 2015, more than half of the jail population turned over.⁷ As is the case in prisons, individuals who are jailed are disproportionately nonwhite: In 2015, only 43 percent of the jailed population was identified as white, compared with 74 percent of the U.S. population.⁸

Continued on next page

Local governments—usually counties plus some cities—typically operate jails. However, in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont, the state is responsible for both prisons and jails.[‡] These are known as unified system states. The local responsibility for jail operations usually includes funding, although the state may contribute.[§] In Massachusetts, county sheriffs administer jails but receive their entire budget from the commonwealth.^{**} In Virginia, counties contribute funds but also receive appropriations from the state government.^{††} Because of this local control, few states collect data on how these facilities are operated, limiting intra- and cross-state comparisons.

Even within states, jails can look very different from county to county. In 2015, extremely large facilities with an average daily population (ADP, the average number of people incarcerated in a jail on a daily basis) over 2,500 held 21 percent of the national ADP, but another 22 percent was held in jails holding fewer than 250. Some jails are even smaller: 3.4 percent of the national ADP was in facilities of 49 or fewer.^{‡‡} These variations in size lead to variation in the services these facilities offer. Small jails, primarily located in rural areas, often report a lack of funding and personnel that limits their ability to offer critical services, including health care.^{§§}

* Todd D. Minton and Zhen Zeng, "Jail Inmates in 2015," Bureau of Justice Statistics (December 2016), <https://www.bjs.gov/content/pub/pdf/ji15.pdf>; E. Ann Carson and Elizabeth Anderson, "Prisoners in 2015," Bureau of Justice Statistics (December 2016), <https://www.bjs.gov/content/pub/pdf/p15.pdf>.

† Minton and Zeng, "Jail Inmates in 2015"; U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>.

‡ Natalie Ortiz, "County Jails at a Crossroads: An Examination of the Jail Population and Pretrial Release" (2015), National Association of Counties, http://www.naco.org/sites/default/files/documents/Final%20paper_County%20Jails%20at%20a%20Crossroads_8.10.15.pdf; Bureau of Justice Statistics, "Terms and Definitions: Local Jail Inmates and Jail Facilities," last modified Dec. 28, 2016, <https://www.bjs.gov/index.cfm?ty=tdtp&tid=12>.

§ Christian Henrichson, Joshua Rinaldi, and Ruth Delaney, "The Price of Jails: Measuring the Taxpayer Cost of Local Incarceration," Vera Institute of Justice (2015), https://storage.googleapis.com/vera-web-assets/downloads/Publications/the-price-of-jails-measuring-the-taxpayer-cost-of-local-incarceration/legacy_downloads/price-of-jails.pdf.

** Commonwealth of Massachusetts Office of the State Auditor, "Massachusetts Sheriffs' Association Official Audit Report" (2016), <http://www.mass.gov/auditor/docs/audits/2016/201614473j.pdf>.

†† Commonwealth of Virginia Compensation Board, "FY 2015 Jail Cost Report: Annual Jail Revenues and Expenditures Report (Including Canteen & Other Auxiliary Funds)" (2016), <http://www.scb.virginia.gov/docs/fy15jailcostreport.pdf>.

‡‡ Minton and Zeng, "Jail Inmates in 2015."

§§ Rick Ruddell and G. Larry Mays, "Trouble in the Heartland: Challenges Confronting Rural Jails," *International Journal of Rural Criminology* no. 1 (2011): 105-131, http://www.antonioacasella.eu/archipsy/Ruddell-Mays_rural_jails_2011.pdf.

Regardless of size, counties have an interest in protecting the well-being of their residents. They do so through monitoring air and water quality, keeping track of infectious diseases such as measles and tuberculosis, and, in a majority of states, providing health care for residents who lack health coverage. In 16 states, counties are even required to contribute funding to their state Medicaid programs. These various roles create a clear financial incentive for counties to promote healthy communities.⁷

Public officials increasingly recognize the relationship between jails and public health. For example, a 2013 audit report issued by the Office of the New York State Comptroller stated that “inmate health care is an important part of a county’s overall public health program because county jail inmates often return to their communities within one year of incarceration.”⁸ Counties that invest effectively in jail health care can improve outcomes for their whole community—those who are in jail and those who are not. After the San Francisco County jail introduced screening and treatment for chlamydia and gonorrhea, a nearby neighborhood clinic reported seeing fewer cases of these diseases among young women.⁹ Providing insufficient or ineffective care, however, can harm community health as well as the individual’s. In Chicago, the Cook County jail’s decision to discontinue universal testing for these diseases among men in 2003 was associated with an increase in female chlamydia cases, potentially because more men left jail untreated.¹⁰

Although the central purpose of jails is to detain people who engage in criminal behavior and pose a threat to public safety, the poor health status and lack of regular care among justice-involved individuals make the facilities a potentially important site for health care interventions. This disconnection between the stated purpose of jails and the health demands now placed upon them is clearly illustrated by the prevalence of behavioral health conditions in jails, such as a serious mental illness (SMI, defined as schizophrenia, psychosis, bipolar disease, and serious and persistent depression), a substance use disorder, or both, known as co-occurring disorders.¹¹

According to one estimate, as many as 20 percent of those in jail have an SMI, compared with only 4 percent of the general population.¹² Historically, many of these individuals would have been housed (sometimes for long periods of time) in state-funded and -operated psychiatric hospitals. However, in the late 1950s, states began to move patients out of large inpatient mental institution settings, a process known as deinstitutionalization. By the end of the 20th century, the number of public psychiatric beds had decreased 95 percent from 1955.¹³

The closure of state hospitals left many individuals with mental illness without adequate treatment, stable housing, or support systems,¹⁴ resulting in an increase in their numbers in jails, often because of a minor, nonviolent crime. One study estimated that in 2000, 40,000 to 72,000 people who would have previously received inpatient mental hospital treatment were incarcerated—14 to 26 percent of all adults with mental illness jailed in that year.¹⁵

According to jail staff, this problem is continuing to grow. A survey of sheriff’s departments conducted in 2011 found that more than three-quarters of jails reported that a greater share of their population had SMI than in the previous five to 10 years.¹⁶ Yet jails were not built to house this population. The experience of incarceration itself can lead to a deteriorated mental state and increased suicide risk.¹⁷ As Deputy Chief Joe Roesch of the Sangamon County, Illinois, Sheriff’s Department told reporters: “We’re adding a segment to our inmate population that probably shouldn’t be there. That’s a tax on the taxpayers as well as us... We have to fund the staff, it costs overtime to make sure that we have enough people working.”¹⁸

Sangamon County is not alone in feeling the strain of jailing people with mental illness. The survey of sheriff's departments also found that those with SMI require additional attention from staff, disrupt normal activities, and can increase the potential for violence. Staff also reported concern that those with mental illness are more likely to be abused by other people held in the jail.¹⁹

In an attempt to adapt to the number of people with mental illness in their facilities, some sheriffs across the country have made changes to how they run their jails. In Cook County, Illinois, which includes Chicago, Sheriff Tom Dart appointed a psychologist, Nneka Jones Tapia, as warden.²⁰ From 2011 to 2016, approximately 40 California counties completed or planned construction projects, many of which were designed to help the jails better meet the needs of those with mental illness, though some argue that money for these projects would be better spent on increasing mental health resources in communities.²¹

While a growing number of jails have made efforts to meet the challenge of playing a larger role in their counties' health care safety net, many fall short. This may be partly due to resource constraints: In one study, less than half of jails reported offering treatment to those with SMI, but jails with more than 250 beds were more likely to report doing so.²² Treatment for medical conditions is also sometimes insufficient. A survey found that in 2011-12, approximately 60 percent of people in jail with a chronic condition reported that they did not take prescription medication during their incarceration. They reported various reasons for this, such as thinking that the medication was unnecessary (30 percent of those surveyed), not yet having seen a doctor (39 percent), or the doctor's opinion that the medication was unnecessary or would not be provided by the facility (36 percent).²³

High recidivism rates among those with behavioral health disorders also consume a large share of local criminal justice resources, leaving less available for achieving counties' goals of making their communities safer. One study of 800 people who were frequently returned to jail in New York City over a six-year period found that they were more likely to have SMI than were other people booked into jail, and nearly all of them reported significant substance use. Serious infectious diseases, including HIV and hepatitis C, were also prevalent in this group, along with chronic diseases such as diabetes and epilepsy. Compared with a random group of 800 other people booked in jail, this cohort cost \$91 million more in custody and health care costs and was incarcerated approximately 15,000 more times. On average, each person cost more than \$161,000 to incarcerate over the study time period.²⁴ Another New York City study found that those with mental illness stayed in jail almost twice as long as the general population, requiring additional spending.²⁵

Like people who disproportionately use hospital emergency department services, those with mental illness repeatedly enter a correctional system that is mismatched to their underlying needs, resulting in an inefficient use of public dollars. To the degree that the high users of both community health and correctional systems overlap, these individuals are responsible for a major portion of county spending across agencies but without desirable outcomes to show for it.

Various solutions have been proposed and attempted to reduce the number of people with substance use disorders and mental illness in jails, and to return jails to their primary purpose of detaining people charged with serious and violent crimes, but accomplishing this is dependent on developing or maintaining a robust, accessible community-wide system for treating these behavioral conditions. At least as far back as 2006, Arthur Wallenstein, then director of the Department of Correction and Rehabilitation in Montgomery County, Maryland, told the Commission on Safety and Abuse in America's Prisons: "What we're building is a solid community mental health system where corrections and the jail is a component of the system, not the focal point."²⁶

The relationship between behavioral health conditions and criminal behavior is complex. For example, a study of 143 offenders with mental illness found that only a minority of their crimes were motivated by psychiatric symptoms such as impulsivity related to bipolar disorder or psychosis.²⁷ Because of this, a holistic response to the various behavioral health and criminogenic (causing criminal behavior) needs of offenders with behavioral health disorders has developed as an important tool to treat this population.²⁸

As a part of this holistic approach, building a strong community mental health system could have a positive impact on the number of people in jail. For example, one study found that on average, a 10 percent increase in public mental health inpatient spending led to a 1.5 percent decline in jail populations.²⁹

Yet for the foreseeable future, jails will continue to serve as part of the health care safety net for a population struggling with multiple physical and behavioral health conditions. This report examines two ways in which jails can fulfill this duty more effectively: by providing high-value care within their walls and by facilitating well-designed health handoffs to community providers at re-entry. As counties make strides in these areas, they have the potential to improve public health outcomes for their entire community and, as part of a broad recidivism reduction strategy, reduce the rate at which those with mental illness and substance use disorders return to jail.

The challenges of providing jail health care

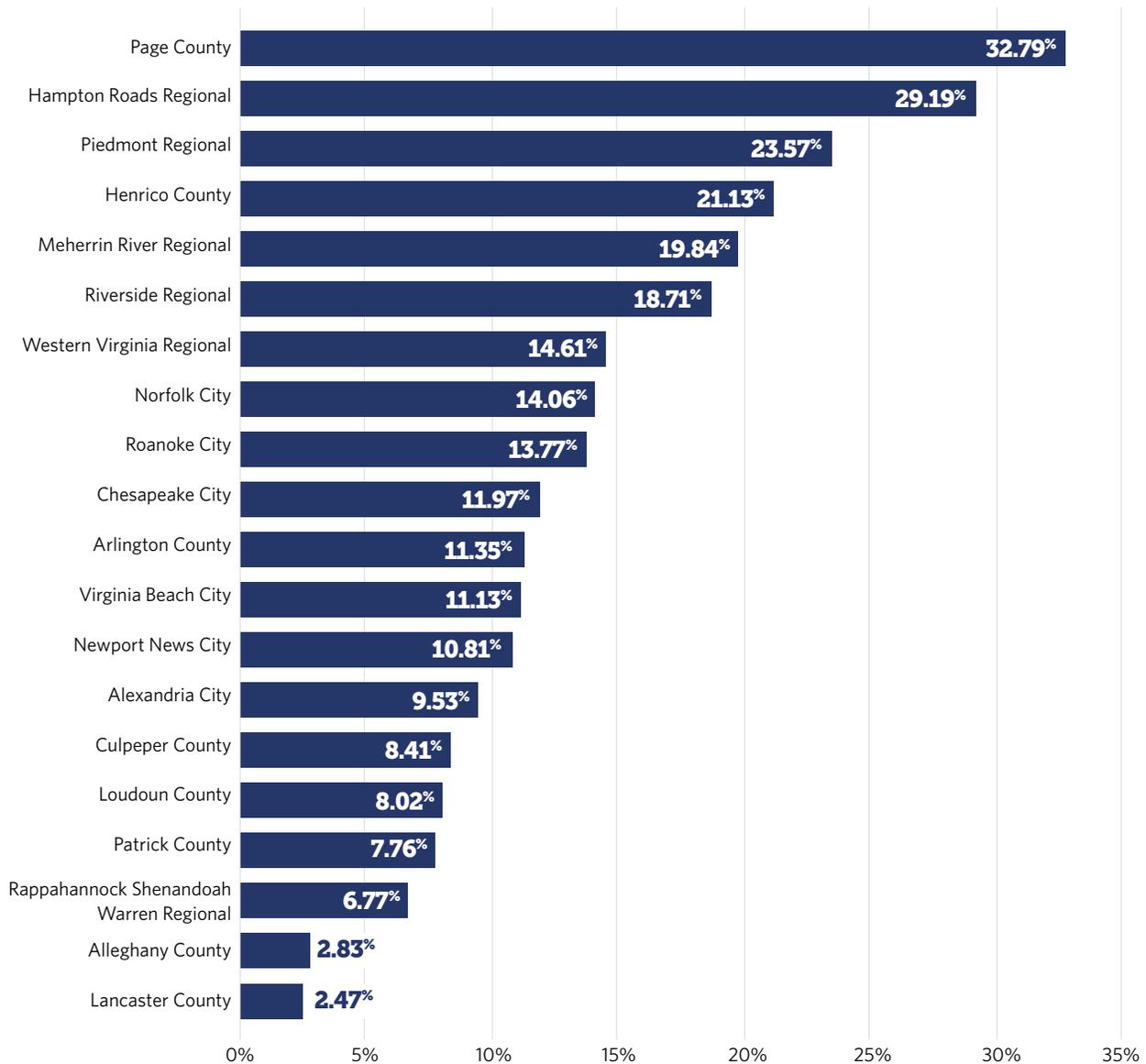
Providing high-quality health care in jails is not easy. Short lengths of stay, along with unpredictable releases, complicate efforts to initiate long-term therapies or care strategies for many people in jail. And resource constraints make it difficult to provide high-quality care to the subset of the jail population with longer stays. The high but somewhat unpredictable volume of people passing through jail doors poses another challenge as jails attempt to screen and assess the health status of all who are booked, with little or no access to their medical histories. The short stays and fast turnover of the jail population also mean that the treatment the jail needs to provide can vary from week to week, which makes budgeting a challenge. The admission of someone with diabetes or schizophrenia, for example, may dramatically increase health care spending during the person's stay. According to the Middlesex County, Massachusetts, sheriff's office: "The unpredictability of health care costs for inmates continues to be one of our biggest budgetary challenges."³⁰

Fulfilling this constitutional responsibility is expensive. In Cook County, Illinois, the Health and Hospitals System spent nearly \$100 million providing jail health care in fiscal year 2016—more than seven times what the county spent on traditional public health services.³¹ In Cumberland County, North Carolina, jail health care receives more local funding than any other health program. Officials report that spending on this service rose 63 percent from 2012 to 2015.³² According to one estimate, health care typically consumes 9 to 30 percent of corrections budgets, but this share varies from county to county.³³ For example, an examination of 20 Virginia jails shows that health care spending ranges from 2.5 to 33 percent of their budgets. (See Figure 1).

Figure 1

Virginia Jails Show Wide Variation in Share of Funds Dedicated to Health Care

Percentage of total operating expenses among facilities that contract for medical services



Notes: In Virginia, jails can be run by counties, cities, or a group of local governments that share the responsibility for a regional facility.

This figure shows data only for jails that use outside providers, because those that deliver services through direct employment of clinicians do not account for those costs in a comparable manner.

Source: Pew analysis of Commonwealth of Virginia Compensation Board, "FY 2015 Jail Cost Report: Annual Jail Revenues and Expenditures Report (Including Canteen & Other Auxiliary Funds)" (2016).

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Local governments are at risk of costly litigation if they fail to provide adequate care, and lawsuits are common. A survey of large jails, defined as those holding 1,000 or more people, found that 91 percent had been sued by an individual about medical care, and 14 percent had been the defendant in a class action lawsuit in the three years before the study. Even when a lawsuit does not end in a large settlement or court judgment, responding to these complaints represents a burden on a jail's time and resources.³⁴

Beyond economic damages, lawsuits can lead to court-mandated changes to the way care is provided if the court agrees that there is a pattern of substandard care. Such supervision removes decision-making authority about jail health care from local leaders and puts it into the hands of the judicial system—sometimes at great county expense. This was the case in 2015, when Riverside County, California, settled a federal class action lawsuit regarding health care in the county jail. The settlement requires the county to follow a court-approved remediation plan and pay \$150,000 a year to monitor compliance with the agreement—in addition to paying more than \$1 million for the plaintiffs' attorney fees.³⁵

Designing jail health care delivery systems

Counties have many decisions to make when planning how they will deliver care in their jails. These decisions include:

- **Organizational model:** Will the jail provide services using employed staff, a partner county agency, or an outside private vendor?
 - **Contracting arrangements:** If a county decides to procure health services from a vendor, it must then determine:
 - **Service model:** Will all services be provided by a single contractor, or will certain services, such as mental health, be carved out to a specialized provider?
 - **Payment model:** How will the contractor be paid? Will it receive an hourly payment for the staff it provides, be reimbursed for each service, be paid a flat fee for all services provided during the year, or receive a daily or monthly payment based on the ADP to cover all needed services? And if the last, will that capitation payment include or carve out two of the most expensive and unpredictable services: off-site hospital care and prescription medications?
 - **Partnerships with other county agencies:** Are other agencies within the county capable of providing jail health care or components of it?
- **Staffing:** Given the jail's average daily census, what types of clinicians are required, and in what combination? How many doctors are needed and how many nurses? Is clinical staff required to be on site at all times, providing 24/7 care, or does the county opt to have an on-call arrangement to provide coverage overnight or on weekends?
- **Ensuring quality:** How will the county monitor services so that public funds are spent on safe, effective care? If a county uses a contractor, what provisions will be in the contract to ensure quality care?

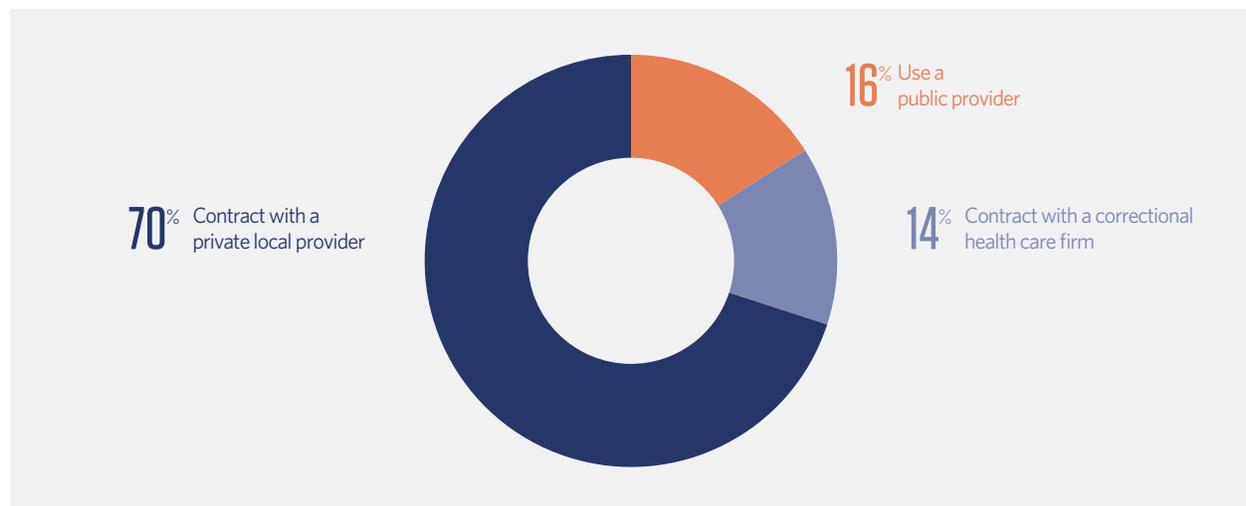
Organizational models

Although all jails share the same constitutional responsibility to provide health care, they can do so in different ways. Data on the prevalence of the various models, limited to studies of the jails in New York and in Virginia, illustrate the variety of these operations, even within the same state.

As shown in Figure 2, 16 percent of the jails in New York state (excluding New York City) were found to use a public provider such as a county hospital or department of health to provide jail health services.³⁶ The remaining 84 percent of New York counties contract with either private local providers such as community physicians or nonprofit health centers (70 percent) or a correctional health care firm (14 percent).

Figure 2

The Majority of New York's Jails Contract for Health Services Organizational models of county facilities



Note: Public providers include county hospitals and departments of health. Private local providers include community physicians and nonprofit health centers. These data exclude New York City jails.

Source: Noga Shalev et al., "Characterizing Medical Providers for Jail Inmates in New York State," *American Journal of Public Health* 101 no. 4 (2011): 693–698.

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In Virginia, almost 90 percent of the jails use vendors to provide at least some health care services, either relying solely on these providers (32 percent) or in combination with health care staff employed by the jail (56 percent). The remaining 11 percent of jails deliver all health care services through directly employed staff.³⁷ The divergent ways in which counties in these two states deliver jail health care reflect the variation in approaches used across the country.

Counties balance several factors when deciding whether to provide care through contractors. On one hand, such a move transfers some responsibility to vendors, even though counties retain accountability for providing a constitutional standard of care. The risk inherent in this arrangement can be compounded if cost-saving incentives are not balanced by a contract that clearly specifies all performance expectations and provides for oversight and performance-improvement procedures.³⁸

On the other hand, outsourcing can free jail administrators from the day-to-day activities of running a health system, affording them more time to focus on their core custodial responsibilities. By contracting with an experienced jail health care provider, the county can also gain access to expertise on delivering care in these unique settings. Finally, depending on the payment model, contracting out can allow for greater budget predictability and financial risk sharing.

The following section of the report discusses how a subset of U.S. counties implement their jail health choices, based on two sources of data (see methodology for more information):

- An examination of requests for proposals (RFPs) issued for jail health services in 81 counties. Issuance of an RFP to obtain a competitive bid for services is a typical activity of governmental entities across a wide variety of purchased services. According to the National Academy for State Health Policy, a request for such services “is best thought of as a problem statement, for which [a government] is seeking the best solution for the best value.”³⁹ Although some aspects of this analysis, such as how a vendor will be paid, apply only to counties contracting out their health care, other aspects, such as staffing patterns, can provide insight into counties’ goals and priorities more broadly.
- Case studies of three counties—Fayette County, Kentucky; Multnomah County, Oregon; and Dallas County, Texas—offer a way to compare a county that procures its health care from outside vendors (Fayette) with two that partner with county agencies to provide care (Multnomah and Dallas).

Contracting arrangements

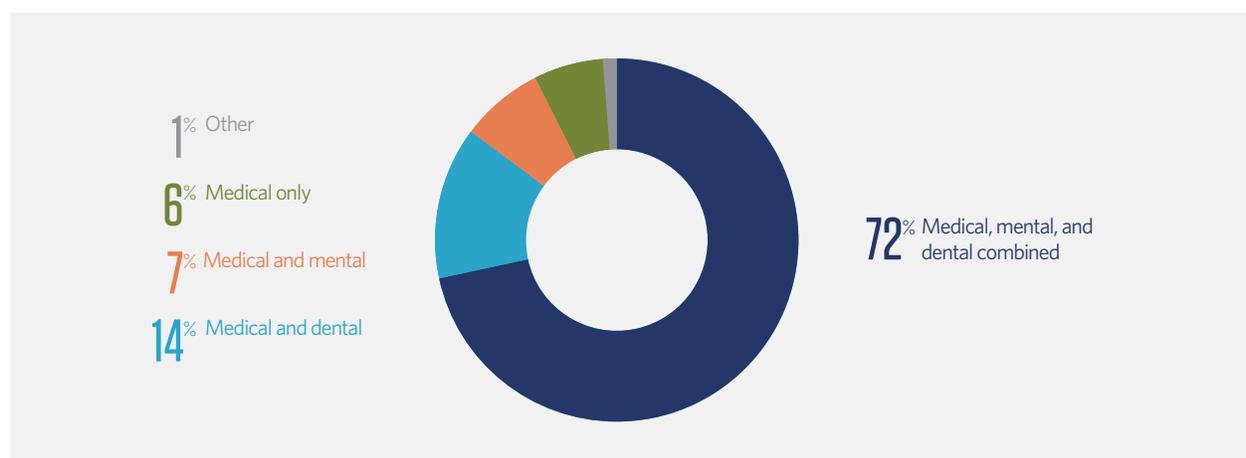
Service models

Once a county has decided to outsource at least some of its jail health care, it must decide which services it would like to purchase and which (if any) it would like to provide through other means. Federal court decisions following *Estelle v. Gamble* have established that, to meet the health needs of their charges, jails cannot provide only primary care and pharmaceuticals but must include mental health and dental services when individuals require them.⁴⁰ Jails can procure these services—medical, mental, and dental—from different providers, but most RFPs in the examined sample (72 percent) requested a combined arrangement in which one organization would provide all three services.

Figure 3

Combined Requests for Medical, Dental, and Mental Services Were Most Common

Percentage of RFPs requesting various service models in the sample studied



Note: One county gave bidders the option to bid on various service lines: mental health only, medical and dental, or the three combined.

Source: Pew analysis of RFPs

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This preference for combined services may reflect the desire to integrate care, parallel to developments within the broader health care community, which is increasingly bringing together primary care and behavioral health services to better serve patients. In this model, multidisciplinary teams of practitioners from medicine and mental health can improve clinical outcomes by helping patients more effectively manage all their chronic illnesses while reducing the stigma of mental illness.⁴¹ Aligning oral health with primary care via use of the same vendor and a shared medical record can further improve clinical outcomes: Primary care providers can educate patients about oral health while dental colleagues from their common employer can treat cavities, one of the most prevalent chronic infectious diseases.⁴² However, in both the community and jail, care can be coordinated among separate providers through methods such as records sharing and shared care managers. To the extent that jails adopt these practices, they can achieve integrated care even with multiple providers.

One advantage to obtaining all services from the same vendor is cost savings. When Escambia County, Florida, was considering privatizing its jail health services, a consultant advised that a comprehensive contract would reduce administrative costs and overhead.⁴³ But counties that tap another agency to provide at least some care in jail may find integration of jail services with those in the community to be worthwhile. For example, while Fayette County, Kentucky, contracts out its medical and dental services to a private provider, mental health services are offered by Bluegrass.org, a private not-for-profit community mental health provider. Through the relationships that Bluegrass.org has developed with other community organizations, it can refer those with behavioral health disorders to appropriate resources after release, such as substance use disorder treatment providers.⁴⁴

Payment models

Once a county has decided which services to procure, it must then decide how the provider(s) will be paid. Pew's review of the RFPs revealed that jails use a range of payment models. (See Table 1.) There is no one proven best payment model. The right choice will depend on, among other factors, the average number of daily bookings (which is usually correlated to the population of the county), the county's willingness and ability to procure ancillary services and medical supplies on its own, and the extent of the services desired.

Payment models can be broadly grouped into two categories: those in which the contractor bears at least some financial risk for costly medical care (risk sharing), and those in which the county assumes the entire risk (no risk sharing). Under a full risk-sharing model, the contractor receives a predetermined fee for providing medical care. If the cost of providing care exceeds this price, the contractor loses money. On the other hand, if the cost of care is less, the vendor retains any money left over as profit. This provides an incentive for the contractor to control utilization. These decisions about payment models parallel decisions that state Medicaid agencies make when considering whether to provide services to enrollees under a fee-for-service or Medicaid managed care system or some combination of the two.

Among the sample examined, counties proposing a non-risk-sharing model often want a limited range of services for a small jail, while those offering a risk-sharing model frequently want their contractor to provide more extensive round-the-clock care to meet the needs of a larger average daily population.

Table 1

Common Health Care Payment Models Used by Jails

Payment model	Description	Example
No risk sharing		
Hourly	The county pays a contractor an hourly rate for providing care in the facility.	In its 2014 request, Midland County, Michigan (ADP*: 250), asked bidders to propose hourly rates for nurses, an office assistant, and a physician.
Fee for service	The contractor is paid for staffing and the services provided.	St. Mary's County, Maryland (ADP: 239), specified that the bidders must submit pricing per service per month including 24/7 nursing coverage and the cost of a physician or physician assistant conducting all necessary sick call visits.
Risk sharing		
Flat fee	The contractor receives a fixed annual fee, often paid in monthly installments, for providing care. The fee amount may be set to cover costs such as labs and hospitalization, or the county may be responsible for paying for these services directly.	In Aiken County, South Carolina (ADP: 345), the bidders were asked to propose an annual fee for providing health care services. The proposed price was to include off-site and diagnostic services, among other necessary care.
Capitated	The contractor receives a set amount per person held in the jail per day. This fee may cover costs such as labs and medications, or the county may retain financial responsibility for such services. If the county is responsible for some services, financial risk to the vendor is reduced.	In Volusia County, Florida, (ADP: 1,417), the winning vendor was to be paid based on the previous month's ADP. The capitated price would include materials, supplies, and off-site services including specialist visits and labs.

* Average daily population (ADP) is the average number of people incarcerated in a jail on a daily basis. All ADPs are drawn from the RFP examined.

Source: Pew analysis of RFPs

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Table 1 provides examples of the basic payment models, but counties sometimes modify these approaches. One common variation in the sample of RFPs was a hybrid of flat fee and capitation in which the fee could be adjusted by a per diem rate for any deviations from the ADP. Other RFPs specified that the vendor would be paid one capitated rate up to the ADP and another, lower capitated rate for any people booked over that number.

If a county decides on a payment model that places the financial risk for care on the vendor, it may limit the vendor's liability for specific expensive services. This allows the county to receive a lower bid than it would otherwise. Jefferson County, Texas (ADP: 853), specified a \$500,000 annual cap on all off-site care, while El Paso County, Texas (ADP: 2,316), and Garrett County, Maryland (ADP: 50), chose to carve out all hospital costs, with the county retaining liability for those expensive services. Such provisions can also apply to costly prescription drugs. While most of the reviewed RFPs specified that vendors were to include the expected cost of medications in their bid, Mercer County, Pennsylvania (ADP: 187), capped its bidders' liability for HIV medications at \$150,000 per year.

Not all RFPs included specific instructions on what care to include, even though responsibility for costly medical services informs the price that bidders propose. For example, several RFPs did not specify whether bidders were to include potential hospitalization costs, which might lead to a county receiving noncomparable bids.

In their contracts with vendors, counties can require cost-containment and utilization management strategies to ensure that care is appropriate and medically necessary. These approaches can have a major effect on jail health care costs. In Washington County, Oregon (ADP: 565), the contract previously limited the amount the county would pay for an individual's care and allowed the vendor to retain savings from keeping off-site care and pharmaceuticals under that amount. These provisions created an incentive for the vendor to keep health care costs down. From 2007 to 2010, however, these incentives were gradually eliminated. The county auditor cited this as one reason that off-site emergency room and inpatient costs nearly doubled from 2006 to 2013 while acknowledging "no opinion on the medical necessity of the off-site referrals."⁴⁵ The basic payment model did not change, but by removing utilization management incentives, the cost of the contract increased substantially over time. Although this example shows that such incentives can be effective at reducing costs, counties that incorporate them into their contracts should monitor the care provided to ensure that these savings are not achieved by denying needed care. (See the "Ensuring quality" section below.)

Some counties try to manage utilization by charging people in jail copayments for health services and/or prescriptions. Guilford County, North Carolina (ADP: 1,030), for example, stipulated in its RFP that for nonemergency care, charges of no more than \$5 for a visit with a nurse and \$10 for a visit with a physician apply—although medical treatment must still be provided if the individual is unable to pay. Other RFPs asked the bidder to propose how the system would be implemented, including the services for which copayments would be applied and the amounts.

The practice of charging copayments is not limited to jails with contracted providers, but data on the prevalence of this practice are limited. In response to a survey of 224 jails conducted in 2005 (the latest year for which data are available), 119 jails reported charging a fee for physician visits and 121 for a prescription.⁴⁶

Although these fees are often intended to reduce the demand for care, they may have unintended consequences. In 2003, the Centers for Disease Control and Prevention (CDC) reported that the Los Angeles County jail system identified nearly 1,700 cases of infections caused by methicillin-resistant *Staphylococcus aureus*. Some incidents were serious enough that the individual had to be hospitalized for wound care. The CDC listed four factors as contributing to these outbreaks, including the fact that "proper access to medical care was hindered by copayments required for acute care visits and by inadequate supplies and staff for wound care."⁴⁷

Research on the effects of copays within the Medicaid program—which caps enrollee contributions at \$4 per outpatient service and \$8 per prescription for adults earning less than 100 percent of the federal poverty level—lend further insight into the effect of charging copays on jail health care utilization.⁴⁸ A recent Kaiser Family Foundation review of research on this subject found "that cost sharing is associated with reduced utilization of services, including vaccinations, prescription drugs, mental health visits, preventive and primary care, and inpatient and outpatient care, and decreased adherence to medications. In many of these studies, copayment increases as small as \$1-\$5 can affect use of care."⁴⁹

In recognition of these potential consequences, the National Commission on Correctional Health Care, a voluntary accrediting body for jail and prison health services, has issued guidelines for establishing a copay program. These include monitoring clinical outcomes to ensure they do not worsen because of these fees, excluding copays for services not initiated by the individual (for example, intake screenings, emergency care, and prescriptions), and ensuring that fees are small and that no one is denied care because of inability to pay.⁵⁰

Partnering with county agencies

Some counties, often large ones, neither contract out their health care services nor directly employ clinicians. Instead, they arrange for other county agencies or county-owned health providers to assume responsibility for these services. To further understand these arrangements, interviews were conducted with officials in two jurisdictions that follow this model: Multnomah County, Oregon, and Dallas County, Texas, which encompass Portland and Dallas, respectively.

Multnomah County, Oregon

Multnomah County operates two adult jails, Multnomah County Detention Center and Multnomah County Inverness Jail. Over 38,000 people pass through their doors annually. More than 60 percent of them have serious chronic health conditions such as diabetes, HIV, or a behavioral health disorder.⁵¹

To meet the health needs of these individuals, care is provided by the Corrections Health Division (CHD), a subdivision of the county Health Department, which provides medical and behavioral health care to low-income residents. Nationally, 11 percent of all county public health departments play at least some role in the provision of jail health care.⁵²

The arrangement appears to be meeting the county's needs. According to a report authored by community members, the care provided by CHD within the jail is "sufficient, comprehensive, and accessible."⁵³

This model's greatest potential lies in its ability to keep patients served by county health services connected to the same system of care, regardless of whether they are in jail. Multnomah County's provision of correctional health care has features in common with the public health model of correctional care pioneered by Hampden County, Massachusetts. By employing Baystate Brightwood Health Center of Hampden County to provide jail health services, the county has improved the post-release health status of people leaving the jail and lowered their hospital utilization rates and illegal drug use compared with before they were incarcerated.⁵⁴

A key component of the public health model is that it is "dually based": Providers in the jail also serve patients in the community, which reduces disruptions in care as individuals enter and leave the jail.⁵⁵ Although Multnomah County does not have dually based personnel per se, patients can receive consistent treatment protocols and compatible medications while incarcerated because services are provided through the same agency in the jail and in the community. (See the "Sharing health information" section below.)

Dallas County, Texas

In Dallas, the public Parkland Hospital provides health care to those in the jail, which has 72,000 annual bookings.⁵⁶ A similar arrangement exists in other very large jurisdictions that have county-owned and -operated hospitals, such as Cook County, Illinois, and New York City. Providing jail health care through public hospitals could potentially offer seamless services to many people in jail who tend to receive community-based health care—when they obtain any at all—at these safety net providers, which would have access to their records across settings.

The bulk of the revenue for the Dallas hospital comes from property taxes raised by the county. After a federal investigation in 2006 found that the jail's previous provider was violating its constitutional obligation to provide an adequate level of care,⁵⁷ the Dallas County Commission gave Parkland responsibility for providing the jail's health care and passed a law dedicating a portion of the hospital system's property tax allocation exclusively for this purpose.

According to officials interviewed in the county, this dedicated revenue stream has ensured that the funding for correctional health is adequate and dependable, allowing the jail to proactively address the health needs of its population. As an example, these officials pointed to the opening of a \$50 million clinic within the jail with 282 beds and a full-service pharmacy. The facility also offers a dental office, a radiology unit, and two intensive care units (one for men and one for women). According to county officials, these capabilities will reduce the need for transfers to Parkland Hospital for treatment.⁵⁸

Staffing

Health care is fundamentally a service. As such, staffing decisions are foundational to determining the level and timeliness of care that a jail can offer. For example, jails usually conduct health screenings as part of the booking process. If too few nurses are assigned to booking, or if bookings occur when nursing staff is not present in the facility, serious delays can result, or correctional officers, who are generally not trained medical professionals, conduct the important initial screening. In recognition of the gravity of this responsibility, Virginia Governor Terry McAuliffe in 2017 included \$4.2 million in his budget “to provide for training of jail staff in mental health screening and to provide grants to jails for mental health assessments.”⁵⁹ (See “The Critical Role of Health Screenings in Jails” below.)

Staffing is also one of the largest costs of jail health care, as is the case in community facilities.⁶⁰ A review of health spending in Arizona jails found that spending on medical personnel accounted for more than 60 percent of the total overall medical budget.⁶¹ Yet investing in the appropriate amount and mix of staff can be cost effective. Having providers in house can allow the jail to treat patients there, without incurring expensive hospital visits. Hospital stays are made more expensive by the need for correctional personnel to accompany and remain with the patient to ensure the security of both the jailed individual and other hospital patients.⁶²

The type of staff employed is important, too. State laws limit the actions that health workers can take, known as their scope of practice. While physician assistants and nurse practitioners can serve as primary care providers, registered nurses (RNs) can make nursing assessments and initiate nursing care plans but cannot make medical diagnoses. Licensed practical nurses (LPNs) are more limited in their scope and cannot deliver care without supervision. These different types of providers all have a critical role to play in the delivery of care in jails, but the mix must be right. If too few RNs are used, for example, LPNs may be assigned work outside their legal scope of practice, putting the county and the patient at risk.⁶³

Having the wrong mix of health care staff can also make the jail ineffective at meeting its patients’ needs even if safety is not compromised. Hennepin County, Minnesota, for example, conducted a survey of people in its jail and discovered that far more of them had mental health problems than previously thought, yet they were not being assessed and diverted to treatment in the community; instead, they often had long jail stays. To address this problem, the jail brought in psychologists to better evaluate and refer patients.⁶⁴

Jails vary in staffing levels requested

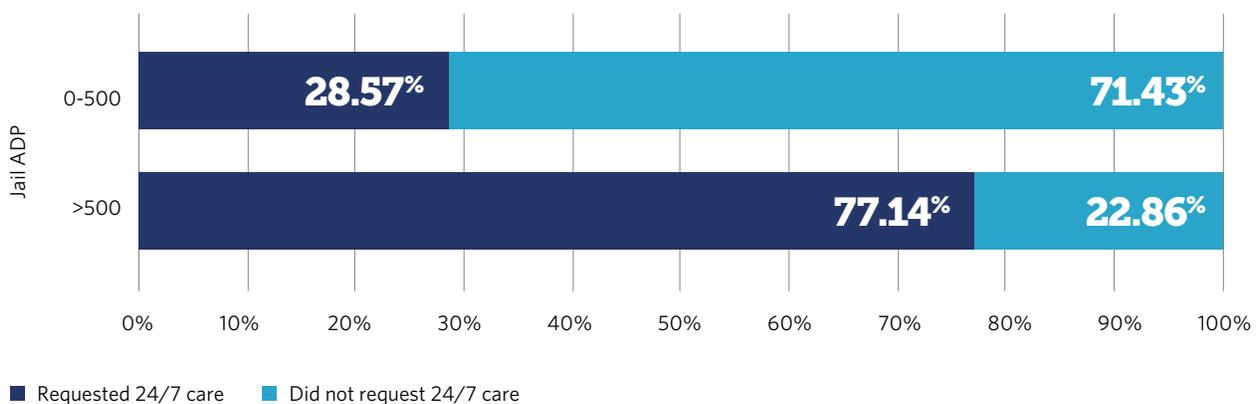
To learn more about counties’ decisions on staffing levels, Pew examined the RFPs for requirements concerning the hours during which a vendor must ensure the presence of health care professionals in the facility. Coverage is one of the most important decisions a county makes when designing a jail health care system, regardless of whether it provides services directly or contracts with a vendor.

The advantage of offering 24/7 care is that patients can be screened as they arrive, often outside business hours, without having to wait until the medical unit opens in the morning. This improves patient safety by quickly identifying those in need of urgent treatment. In addition, it relieves nonclinical correctional officers of the burden of using their judgment to make what could potentially be a life-or-death call about someone's condition.

However, offering care round-the-clock is costly: Rather than paying for 40 hours of nursing a week, jails must pay for 168 hours. The cost of staffing may explain the disparity in requests for 24/7 care by small and large jails. As Figure 4 shows, most jails in the sample with an ADP over 500 requested on-site staff at all times, while the reverse was true for smaller facilities.

Figure 4

Larger Jails in the Sample Were More Likely to Request 24/7 Care Percentage of RFPs requesting round-the-clock staffing, by jail ADP



Source: Pew analysis of RFPs. Average daily populations (ADPs) were collected from self-reported data included in these documents. This figure excludes data from the 11 documents that did not include comparable ADPs.

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Yet small counties have an especially important, and growing, role to play in the criminal justice system. In the 1970s, counties with fewer than 250,000 residents held 28 percent of the jail population; in 2014, counties of this size held 44 percent of the population.⁶⁵ With smaller counties less likely to offer 24/7 care, those held in their facilities might be at higher risk of acute health problems initially going undetected and untreated.

The Critical Role of Health Screenings in Jails

Regardless of how a jail chooses to provide care—through contractors or direct service, through one contract or multiple, round-the-clock or during limited hours—conducting a medical and mental health screening at intake is a crucial step to ensuring the safety of both the person being booked and jail personnel, and to promoting public health.

Given the short stays of many people in jail, screening may be the only interaction they have with a clinician, providing an opportunity to identify their health needs and potentially link them to care upon release. Given the heightened acuity of the jail population, health interventions during booking can have a major impact on the health of the community.[†]

Screening plays two especially important roles for people in jails who have behavioral health problems. First, it ensures that the jails are able to hold the individuals safely. If the jail discovers that someone is overdosing, going into withdrawal, or at risk of attempting suicide, it can take steps to ensure that person's well-being. These steps might include bringing them to a hospital, keeping them in the jail but monitoring them while providing fluids and other therapies as they withdraw from substances, or performing frequent visual checks to ensure they do not harm themselves.

Second, screening for behavioral health problems using a validated tool can help counties make pretrial release decisions along with a broader assessment of an individual's risk of criminal behavior. The tool can also be used to identify and refer those who may be eligible for a post-booking diversion program as part of an overall strategy to reduce the number of people with mental illness and substance use disorder in jails.[‡]

Jails in some states, including Texas and Minnesota, are legally required to conduct brief screenings upon entry.[‡] The American Correctional Association and the National Commission on Correctional Health Care, which are voluntary accrediting bodies, require jails to routinely conduct screenings for physical and mental illnesses in order to receive accreditation. Yet despite the strong case for screening, laws requiring it, and agreement among experts about its necessity, it does not always occur in a timely manner.[§] As a result, significant health problems—such as a ruptured spleen or suicidal ideation—can be missed, sometimes resulting in deaths and litigation.^{**}

Staffing challenges might contribute to the delay in conducting screenings. As previously discussed, many jails in the RFP sample did not require health care professionals to be on site at all times. One way to overcome these challenges is to train correctional officers to administer brief, validated screening tools to identify suicide risk and other behavioral health problems. For example, although unlicensed staff members should not administer blood tests for HIV, they can be trained to ask and record the answers to a brief list of questions about an individual's mental state at booking.^{††}

Continued on next page

- * For example, such interventions can link people living with HIV with care. Liza Solomon et al., “Survey Finds That Many Prisons and Jails Have Room to Improve HIV Testing and Coordination of Postrelease Treatment,” *Health Affairs* 33, no. 3 (2014), <http://content.healthaffairs.org/content/33/3/434.full>.
- † Risë Haneberg et al., “Reducing the Number of People With Mental Illnesses in Jails: Six Questions County Leaders Need to Ask,” Stepping Up Initiative (January 2017), https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.
- ‡ Texas Administrative Code Title 37, Part 9, Rule §271.1, [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=37&pt=9&ch=271&rl=1](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=37&pt=9&ch=271&rl=1); Minnesota Statutes 641.15, subd. 3a, <https://www.revisor.mn.gov/statutes/?id=641.15>.
- § Matti Hautala, “In the Shadow of Sandra Bland: The Importance of Mental Health Screening in U.S. Jails,” *Texas Journal on Civil Liberties and Civil Rights* 21, no. 1 (2015): 89–126.
- ** Estate of Rice ex. rel. Garber v. City and County of Denver, Civil Rights Litigation Clearinghouse (March 17, 2014), <https://www.clearinghouse.net/detail.php?id=11185>; Estate of Claypole v. County of San Mateo, Civil Rights Litigation Clearinghouse (Oct. 1, 2015), <https://www.clearinghouse.net/detail.php?id=14524>.
- ** National Institute of Justice, “Mental Health Screens for Corrections” (2007), <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>.

Ensuring quality

Regardless of how a county provides care, making sure that a satisfactory level of quality is being delivered should be a priority. Doing so serves three important purposes. First, it ensures that the county is spending public dollars wisely and not paying for a level of care it is not receiving. Second, it can protect the county from costly litigation that may be brought by those who receive inadequate care. Finally, providing high-quality care can improve both the individual’s and the public’s health. For example, by examining its process for screening for and treating dangerous skin infections such as methicillin-resistant *Staphylococcus aureus*, the Douglas County, Nebraska, jail was able to successfully treat more of those infected, preventing them from spreading it to others when they returned to the community.⁶⁶

Two common methods of quality assurance are discussed below.

Accreditation

Accreditation is a common method in health care of signaling a minimum consistent level of quality in and across facilities. The American Correctional Association and the National Commission on Correctional Health Care accredit institutions by making site visits, conducting interviews, reviewing charts and administrative records, and observing how jail medical facilities operate. They then compare their findings with a set of standards created by the accrediting body.⁶⁷

By either seeking formal accreditation or using the accreditation standards as guidelines, counties often look to these organizations for help in running a high-quality jail health system. All but 14 of the RFPs examined specified that the vendor was required to meet at least one standard from one of these organizations.

Accreditation alone is not sufficient for ensuring quality, however. One major limitation is that inspections occur infrequently, usually only once every three years. Quality could dramatically decline between site visits. Because of this, some jails complement accreditation with internal efforts to maintain and improve quality, a step recommended by the accrediting bodies. A second limitation, according to some health care researchers, is that like most medical quality monitoring approaches, accreditation largely measures processes, such as the timeliness of screenings, rather than outcomes, such as the number of hospital emergency room visits for ambulatory care sensitive conditions—conditions that have been shown to be preventable by adequate, timely primary care that should be delivered in the jail.⁶⁸

Holding contractors to high standards

Whether a government contracts for waste management services, information technology infrastructure, or correctional health care, it is important to communicate performance expectations to bidders. Yet less than a third of the jail health RFPs examined outlined performance requirements and penalties. This is a missed opportunity for counties to ensure that the jail provides high-value care. Without including such performance standards in the RFP and resulting contract, the county has little recourse for poor performance outside of terminating the contract. As the Washington County, Oregon, auditor pointed out: “Termination is a drastic remedy that could create hardship for the county and endanger the health of inmates, because replacing the jail healthcare provider is a months-long process.”⁶⁹

Among the performance requirements that were set forth in the reviewed RFPs, many related to providing adequate staffing. Such requirements can help ensure the safety and health of people in jail. Other RFPs imposed performance requirements for discrete tasks, such as requiring intake screenings and more extensive health assessments to be done within a specific period after the individual’s arrival.

Some of the RFPs used performance requirements as a way to manage costly emergency department utilization. For example, one county specifies that if an on-call provider does not respond to a page in a timely manner, causing the patient to be sent to the emergency room, then the contractor will be responsible for the hospital bill.

Another common performance requirement is that the contractor maintain accreditation for the facility from the American Correctional Association or the National Commission on Correctional Health Care. Several RFPs state that the county reserves the right to penalize the vendor up to \$5,000 for failing to maintain accreditation.

If an RFP and an ensuing contract include performance standards, sufficient resources should be dedicated to monitoring the contractor to ensure it is meeting its obligations, and assessing penalties if it is not. In October 2016, the Nassau County, New York, comptroller found that although the contract with a jail health care vendor contained 27 performance standards, appropriate penalties were never assessed, because the county had not designated someone to monitor the contractor’s performance.⁷⁰

To fill this role, some counties contract for a third party to monitor health care in their jails. While such a position is often imposed by a court order, Chatham County, Georgia, began to use one in 2016 when it issued a new jail health RFP. The Monroe County, New York, jail has voluntarily employed one since it contracted out its jail health care services to a private vendor.⁷¹ The county took an additional step to ensure quality in its 2014 RFP when it required the winning bidder to pay for an annual peer review of its medical director by a qualified doctor to be selected by the county sheriff’s office. On the state level, the New York attorney general announced in September 2014 that for a period of three years, all county jails that use the firm Correctional Medical Services to provide health care must employ a contract monitor pursuant to a settlement for inadequate care in 13 upstate counties.⁷²

Crafting RFPs to obtain high-value care

When seeking a contractor to provide health care, counties must issue high-quality RFPs containing clear expectations. Counties can obtain higher value for their investment in jail health care through better-informed decisions when they make their expectations as clear as possible and give sufficient information to providers to craft their bids. Lack of specific expectations or historical utilization information gives an advantage to the incumbent contractor, because only it has accurate historical information upon which to base the bid, and conversely puts at a disadvantage other bidders, who must rely solely on their experience providing jail health care elsewhere in calculating a bid price.

One of the most important types of information that a county can include in its RFP is data about past health care utilization, such as inpatient hospitalizations and prescriptions. This information helps vendors develop sound pricing and staffing plans to address the likely number of jailed individuals and their acuity. Counties risk receiving bids that fail to meet their needs if they do not disclose basic historical data on health care usage and needs. As a result, providers may overbid to reduce the risk of inadequate payment to cover the needed care, especially if the county has decided on a payment model that puts risk for hospitalization and other costly services on the vendor. But the absence of good information can also lead to underbidding by providers. If the demand for care is greater than the county contracted for, this could result in costly emergency department visits and other expenditures. In the worst-case scenario, a jail that contracts for too little care could see an increase in its mortality rate from incorrectly diagnosed or treated conditions—a potentially costly situation if litigation results.

Pew's review of RFPs found that the size of the county was related to whether the document contained utilization data. Overall, inclusion of this data was not common—the information was found in just one-third of all documents—but counties with a population over 250,000 were much likelier to include this information. (See Figure 5.)

Figure 5

Larger Counties in the Sample Were More Likely to Include Utilization Data

Percentage of RFPs including such information, by county size



Note: County population estimates were collected for the year in which the RFP was issued.

Source: Pew analysis of RFPs and U.S. Census Bureau Annual Estimates of the Resident Population, April 1, 2010, to July 1, 2016

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Among counties that provided utilization data, the amount of information varied greatly. The RFP of Ellis County, Texas (ADP: 363), issued in 2013, stipulated that the vendor would pay for any off-site hospitalizations and specialist visits as well as all medications dispensed, and it provided information that would allow bidders to factor these costs into their bids. Its RFP included data on the typical number of intake screens, sick calls, physicals, X-rays, lab tests, hospital admissions, and more. In contrast, the RFP issued by a similarly sized South Carolina jail in the same year requested a flat annual fee for providing its jail's medical care. The vendor would pay for the same services as Ellis County, but the RFP omitted the historical utilization data that Ellis County provided.

However, not all RFPs without utilization data left the vendor in the dark. By detailing a requested or even required staffing pattern, some counties apply their historical knowledge of their jail population's needs to make their own determination of necessary personnel, thereby removing vendor discretion in this important matter. Sumner County, Tennessee (ADP: 585), did not include utilization data in its 2015 RFP but did specify the types of staff needed and the number of hours the county requires of each position (see Table 2), enabling potential vendors to calculate a realistic bid price. In contrast, a Virginia jail included neither utilization data nor a description of staffing needs in its 2010 RFP. Even detailed staffing requirements, however, can leave bidders uninformed about other costly elements of care that the vendor may be responsible for, such as pharmaceuticals.

Table 2
Staffing Requirements in Sumner County, Tennessee

Position	Hours
Medical team administrator and RN	80 hours per week (40 hours each)
Qualified mental health professional	30 hours per week
Physician/provider	8-10 hours per week on site, with 2 visits per week
Dentist	16 hours biweekly on site
Dental assistant	16 hours biweekly on site
LPN(s)	Coverage to encompass all medical, dental, and mental health services for the stated ADP (336 hours weekly)
LPN(s)	Coverage to encompass all intake screenings, 24 hours per day, 7 days per week (168 hours weekly)

Source: Sumner County Sumner Jail, Bid 20-150420 (2015)

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Planning for a healthy re-entry period

The vast majority of those who enter a jail return to the community—and do so quickly. The average length of stay in jails is 23 days, and many leave sooner, often within a few hours of booking.⁷³ Given the health challenges faced by this population, it is not surprising that it is approximately twice as likely as the general population to be hospitalized; uses emergency departments more often, once back in the community; and represents a disproportionate share of spending on those services.⁷⁴

In some cases, these health problems lead to a heightened risk of death—not just high cost utilization. A study focused on New York City jails found that individuals discharged from jails were more than twice as likely to die from drug-related causes as other city residents within the two-week period after release.⁷⁵ Another study found that people with sporadic jail stays and episodes of homelessness were more likely to die from HIV-related causes than were other homeless individuals.⁷⁶

For people leaving jails, making connections to primary care and other services could improve health outcomes, decrease mortality rates, and save money. For example, justice-involved people with HIV who stay connected to primary care go to emergency departments less frequently than those without such a connection to care, and they experience a longer time span between release from jail and their first emergency room visit.⁷⁷

For individuals with behavioral health disorders, such connections could play a role in reducing recidivism rates and the overrepresentation of these individuals in correctional institutions.

Some studies have found that proactively and systematically addressing behavioral health needs can bring about a variety of benefits for people with mental illness and their communities, such as decreased use of emergency rooms, reduced recidivism, and correctional cost savings.⁷⁸

Despite the potential for care continuity services to further a broad range of county goals, from public health to public safety, it can be difficult for jails to offer them. Short stays make it difficult to conduct thorough health assessments and make appropriate community referrals. Release dates are also unpredictable, especially for those not sentenced, who may be released from court, rather than the jail itself, making it difficult to execute a release plan. Compounding these challenges is that jails often lack the capacity to provide substantive programming. Even if they offer such services, they need the cooperation and participation of community-based and other organizations such as the Veterans Health Administration, to which people leaving jails are likely to be referred.⁷⁹

Still, some counties have found ways to overcome these challenges. The following section draws on the case studies and RFP analysis to examine four critical ways of addressing health needs at release—helping people in jail to access health insurance, facilitating connections to care, sharing health information, and providing evidence-based treatment to those with opioid use disorders—and gives examples of counties leading in these areas.

Facilitating health coverage

Health insurance is a key ingredient of access to quality care for everyone, including for individuals involved with the justice system. But many offenders—nearly 80 percent, according to some estimates—have historically returned to their communities uninsured.⁸⁰

An important tool to address this problem is the Medicaid program. Medicaid may not be billed for health services provided to an incarcerated person with the exception of inpatient hospital stays over 24 hours. Because of this prohibition, some states—19, as of May 2016—have traditionally terminated coverage for people in correctional facilities, including local jails.⁸¹ This requires a new application to be processed after release, potentially delaying resumption of coverage.

Counties in states that terminate coverage upon jail admission can address this problem by facilitating individuals' Medicaid reapplication upon release and by initiating applications for those who were not previously enrolled. In all states, doing so would also help people who are eligible for the program but not yet enrolled. In states that expanded their Medicaid eligibility criteria under the terms set in the Affordable Care Act (ACA), an estimated 25 to 30 percent of all those released from jail could enroll in the program.⁸² In states that have not expanded, a smaller portion is probably eligible under traditional criteria for aged, blind, disabled, or pregnant applicants.

According to a survey of county jails conducted in 2015, 28 percent of counties screen for Medicaid eligibility, although this percentage is likely to have increased since the survey was conducted.⁸³ In Illinois, the Cook County Health and Hospitals System works with a social services agency to screen detainees for eligibility when they enter the Chicago area jail. Speaking of the coverage expansion for individuals passing through his jail, Cook County Sheriff Thomas Dart said: "I have the highest level of confidence that this will either keep them from coming back, or extend out the period of time before they come back."⁸⁴

The Multnomah County Health Department sent its staff into the jail to assist with enrollment, signing up more than 12,000 individuals between 2013 and 2015 through in-person direct assistance with Medicaid applications. Because some left the jail before their applications were completed, the Health Department coordinated with probation officers to help these individuals finish enrolling.⁸⁵ Other Oregon jails (75 percent of which were already enrolling their jail populations into Medicaid in 2014 or planning to start in 2015, according to a survey of all 30 Oregon jails) used corrections staff, community partners, or other county staff to help with enrollment, which ranged from one day per week to each weekday, depending on the jail.⁸⁶

Such programs have been effective at reaching people who have been in jail. For example, researchers at Johns Hopkins University found that the uninsured rate for adults in the community with a substance use disorder and with prior-year involvement with the criminal justice system (having been arrested and booked or on probation or parole in the previous 12 months) fell from a consistent 38 percent in 2004-13 to 28 percent in 2014, the first year of the ACA Medicaid expansion.⁸⁷

Another avenue for post-release health care services is available for justice-involved military veterans. Approximately 7 percent of those incarcerated in jails were reported to be veterans during 2011-12, a decrease from previous years.⁸⁸ The Veterans Health Administration, America's largest integrated health system, provides care at 1,245 facilities, including 170 medical centers and 1,065 outpatient sites.⁸⁹ Such facilities may provide crucial care for justice-involved veterans in all 50 states but especially for those not eligible for their state's Medicaid program. In January 2016, Middlesex County jail in Massachusetts even opened a housing unit for military (HUMV), both sentenced and awaiting trial. The sheriff's office said the unit "was conceived and designed as a collaborative effort of the Middlesex Sheriff's Office together with incarcerated Veterans with a goal of treating and preparing them for successful reentry. ... HUMV staff work with offenders to create individualized comprehensive reentry plans which address the specific needs of each Veteran."⁹⁰

Continuing care post-release

Insurance is just one key ingredient in ensuring a smooth health care re-entry. People leaving jails also require access to providers who meet their unique needs—and they might require help doing so. Many have lower functional literacy than the general population, have little experience with primary care, and face multiple challenges after release, such as finding housing and employment, which may make seeking health care a low priority.⁹¹

To address these issues, some jurisdictions have developed case management or other transition programs to help people leaving jails navigate the complex health care system. Such programs have shown particular promise for engaging people with HIV, substance use disorders, and mental illness in treatment after release.⁹²

Some of the RFPs requested that vendors help link people leaving jails to care. Mercer County, New Jersey, and Douglas County, Nebraska, for example, both requested that the selected vendor provide at least one discharge planner responsible for developing a referral network for those exiting jail. Such a staff member can be particularly valuable in states such as Nebraska that have not elected to expand Medicaid and have many uninsured people leaving their facilities. Douglas County's RFP directs the vendor to include resources for people without health coverage in the referral network.

Even if a county provides discharge planning, the person leaving the jail has the ultimate responsibility for care after release. In recognition of that responsibility—and the difficulty some people in jails may have shouldering it—several RFPs ask the vendor to provide patient education. Fulton County, Georgia, for example, has an explicit requirement that “discussions with the inmate concerning the importance of follow-up care and aftercare will be documented in the medical record.”

Such planning—both connections to care and patient education—can be complicated by unpredictable release dates. Because medical staff do not always know when those they treat will be released, some of the RFPs set forth one set of expectations for when the release date is known and another for when someone is released unexpectedly. In Jackson County, Missouri, for example, the RFP requests that the vendor attempt to arrange appointments for people leaving the jail when the release date is known but requires only education about community resources if the date is unknown.

To address unpredictable releases, some counties requested follow-up communication from the vendor. The RFPs in Howard County, Maryland, and McHenry County, Illinois, ask that the vendor send a letter to the last known address of the person leaving the jail when follow-up care is required, directing the individual to contact jail medical services for more information and referral to care.

Many of the RFPs examined did not request any discharge planning. This does not mean, however, that these services are not provided in these counties. Care continuity activities can be conducted by a range of organizations. In Massachusetts, all but one county has a relationship with a community health center, which sends staff to the jail to help those leaving to enroll in medical insurance and learn about community resources.⁹³ In Hennepin County, Minnesota, county social workers come to the jail to provide these services.⁹⁴

Even if other organizations are responsible for the majority of services, contracted medical services still have a critical role to play in facilitating care continuity by providing bridge medication. Nurses are needed to provide these small supplies of medication meant to give jailed individuals time to connect to care in the community,

whether this supply takes the form of the remaining medications that have already been ordered for them, specially prescribed medication to take with them at discharge, and/or a prescription that can be filled in the community.⁹⁵ Despite the necessity of involving contracted providers in this care continuity service, only 13 of the RFPs examined requested it.

Sharing health information

As people move from jails to community settings and sometimes back again, the quality of care they receive can be enhanced by the transfer of medical records between correctional health systems and community providers. This can also be an important step for individuals moving through settings within the corrections system, such as from jails to prisons. Records sharing—whether paper-based or through electronic means—can save time and money by conveying critical patient information such as medical history, diagnoses, current medications, and laboratory test results and improves the likelihood that successful treatment plans will continue without delay or disruption. To better improve care continuity in their jurisdictions, Fayette County, Kentucky, and Multnomah County, Oregon, have found ways to integrate jail medical records into the data systems used by community providers.

In Fayette County, the jail connects to the Kentucky Health Information Exchange (KHIE), a statewide system for securely sharing health records among providers in the commonwealth.⁹⁶ Joining KHIE allows the jail's medical personnel to access patients' medical histories and provide care more efficiently. The county is working on sharing the jails' data with community providers to improve care continuity on release.

Multnomah County is taking advantage of the possibilities for care continuity afforded by sharing health information. Jails in the county use an electronic health record (EHR) called EPIC, which is the system used by many community providers in the area, including those that are employed by the county division providing jail health care.⁹⁷ Through the EHR, data are shared across the community health system so that local providers stay up-to-date on the health needs and treatment history of their patients.⁹⁸ This allows these providers to pick up where the jail left off.

To address the problem of disparate amounts and types of health information accompanying those being transferred from a county jail to a state prison, a Pennsylvania state regulation requires that a standard health form accompany each such individual.⁹⁹

Using jails to combat the opioid epidemic

Substance use disorders are exceedingly common in the justice-involved population. In 2006, over 64 percent of people in prison and jail met the medical criteria for a substance use disorder.¹⁰⁰ Opioid use disorder is especially prevalent in this population, particularly among those with co-occurring mental illness, nearly 10 percent of whom used opioids in the month before being booked in jail.¹⁰¹

Such a prevalence of substance use makes jails an important site for initiating drug treatment. These programs can be very effective. For example, as of 2015, 18 county jails in Kentucky offered state Department of Corrections-sponsored substance use disorder treatment programs that were shown to reduce drug usage from a pre-incarceration rate of 96 percent (of all program participants as self-reported) to a one-year post-program rate of 48 percent. These programs also showed a \$4.29 return for each dollar of program cost across both jail and prison participants.¹⁰²

One option is medication-assisted treatment (MAT), a combination of psychosocial therapy and U.S. Food and Drug Administration-approved medication.¹⁰³ Research shows that this is the most effective intervention to treat opioid use disorder and is more effective in several domains than behavioral interventions or medication alone.¹⁰⁴ MAT significantly reduces illicit opioid use compared with nondrug approaches,¹⁰⁵ and increased access to these therapies can reduce overdose fatalities.¹⁰⁶ By reducing risky behaviors such as injection of illicit drugs, it also decreases transmission of infectious diseases such as HIV and hepatitis C.¹⁰⁷

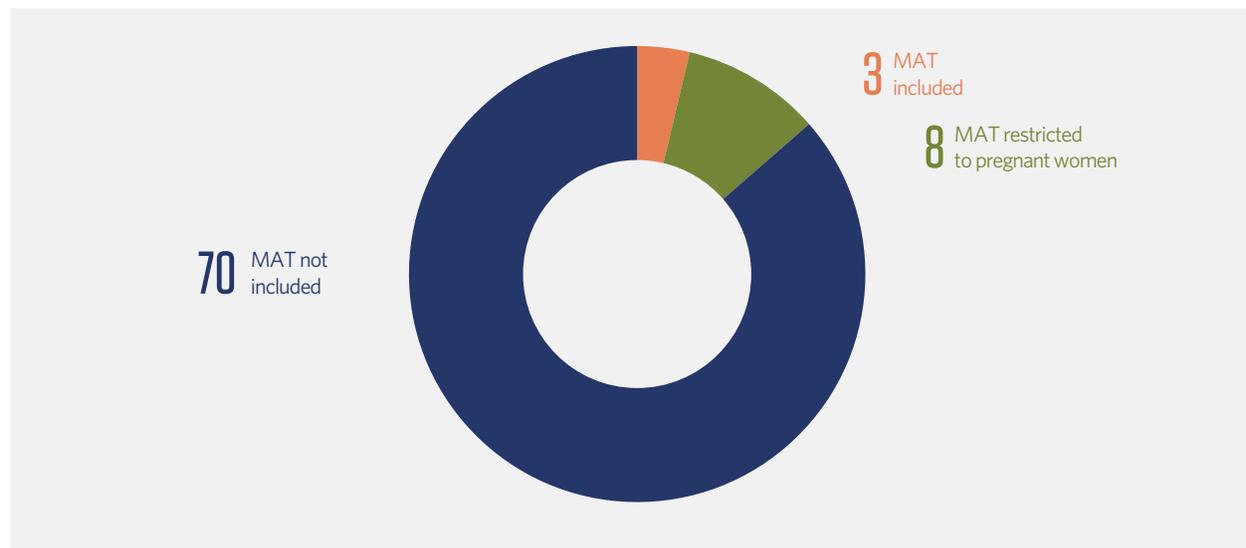
These medications have shown particular effectiveness for people leaving jails. One study found that providing MAT doubled the time to relapse (from five weeks to 10½ weeks) and that relapse occurred less often in those who received the medication than those who had not.¹⁰⁸ In another study, those receiving such treatment were less likely to return to jail, and spent a longer time in the community before returning, than others with opioid addictions.¹⁰⁹

Yet as Figure 6 shows, only 11 of the RFPs reviewed requested any form of MAT from their provider.¹¹⁰ Of the 11, eight restricted the use of MAT to pregnant women, a special population whose opioid use poses risks to fetal development and can cause preterm birth and neonatal abstinence syndrome, a condition in which the infant goes into withdrawal after birth.¹¹¹ The three documents that included a broader request were from DeKalb County, Georgia; Manatee County, Florida; and New York City. DeKalb County's and New York's RFPs were unclear about whether they expected the provider to initiate MAT for those with opioid addictions who were not yet in treatment or simply continue it for those already on such a regimen; Manatee County's requested only continued treatment.

Figure 6

Despite Evidence of Effectiveness, Few of the County Documents Examined Request MAT Services

Number of RFPs requesting MAT services



Note: Jails may seek drug treatment services from community providers, which may include MAT, so the actual proportion of jails providing MAT services in this sample may be higher than shown here.

Source: Pew analysis of RFPs

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If more counties requested these services from their contracted providers—and for all patients who would benefit from them—they could more effectively combat the opioid epidemic and reduce recidivism. However, jails and prisons have been reticent to provide MAT despite its potential benefits. According to other Pew research, only 13 departments of correction provided MAT at release in 2016. However, a number of states that did not provide the medications that year reported interest in doing so in the future.¹¹² An increasing number of jails may also be exploring the possibility of providing this service.

An evolving landscape

Jail health care delivery systems have come a long way since the constitutional right to care was established in 1976. Accrediting bodies help counties fulfill this obligation, but the increased acuity of jail detainees highlights the need for greater attention to monitoring and measuring health care quality. And as new opportunities to improve the health of justice-involved populations have arisen, some counties have led the way with the expectation that such interventions would pay dividends by reducing recidivism, emergency room visits, and hospital admissions.

Over the past few years, a range of initiatives have emerged as counties consider innovative approaches to running their jails and diverting ill individuals from jail in favor of more appropriate treatment. The Stepping Up Initiative provides a forum for sharing best practices for reducing the number of people with mental illness in jails, while the MacArthur Foundation Safety and Justice Challenge provides funding to counties to help them develop and implement solutions to safely reduce their overall jail populations.¹¹³ The Data-Driven Justice Initiative brings communities together to identify the processes and policy frameworks needed to reduce the cycle of incarceration among individuals with complex health needs who repeatedly enter jails, emergency rooms, shelters, and other public systems.¹¹⁴

Yet although interest has steadily grown in returning jails to their core functions and reducing recidivism, little is known about how individual county jails are shaping their health care and release programs to further these goals. While much more remains to be learned about current practices and programs that have shown success in achieving the safety and public health goals common to all counties, this report aims to help fill this knowledge gap.

Conclusion

Jails have become an important part of local health systems, and counties have responded to this challenge in a wide variety of ways. Some procure health care services from providers with deep community ties, and others seek services from private vendors with long experience serving the jail population. In between are counties that use a hybrid approach, combining the services of public and private providers to meet their needs.

Counties that contract out for jail health services need to recognize and capitalize on the crucial opportunity to further their public health goals through carefully crafted, detailed RFPs and close oversight of the resulting contracts. And all counties should consider efforts to connect people leaving jails to care in the community. Given the high prevalence of infectious diseases, chronic conditions, and especially, mental illness and substance use disorders among this population, jailed individuals and other county residents would benefit from acknowledgment that jails are a frequent source of health care and a vital link in the web of services that counties provide.

Methodology

RFP analysis

To conduct the review of RFPs, Pew and Community Oriented Correctional Health Services examined a convenience sample of documents published in the online procurement database Find RFP (findrfp.com) from June 2008 to May 2015. RFPs, rather than executed contracts, were selected for the basis of analysis because of their public nature. One limitation of this approach is that additional data pertaining to jail operations and requirements might have been released by a county during a question-and-answer process or during a site visit for bidders. In addition, final negotiations on contract language between the selected vendor and the issuing jurisdiction might have modified some of the terms found in the original RFP.

An initial random sample of 100 documents was selected from this collection. This sample was then refined to exclude documents that did not include requests for medical services, were duplicates, were from states with unified jail and prison systems (where both jails and prisons are administered by the state), or were issued before 2010. The last were eliminated because of significant changes made in the community health care system since 2008 and the likelihood that a more recent RFP had been issued. It also should be noted that some counties may have issued more recent RFPs than those analyzed here. This study produced a final sample of 81 documents from 28 states. (See Table 3.)

Table 3
 Sample Includes 81 RFPs From 28 States

State	Number of RFPs	State	Number of RFPs
Alabama	0	Montana	0
Alaska*	0	Nebraska	2
Arizona	0	Nevada	1
Arkansas	1	New Hampshire	0
California	3	New Jersey	1
Colorado	3	New Mexico	2
Connecticut*	0	New York	2
Delaware*	0	North Carolina	2
Florida	3	North Dakota	0
Georgia	12	Ohio	1
Hawaii*	0	Oklahoma	0
Idaho	1	Oregon	3
Illinois	2	Pennsylvania	3
Indiana	0	Rhode Island*	0
Iowa	0	South Carolina	6
Kansas	0	South Dakota	0
Kentucky	1	Tennessee	1
Louisiana	1	Texas	4
Maine	0	Utah	0
Maryland	4	Vermont*	0
Massachusetts	0	Virginia	3
Michigan	5	Washington	4
Minnesota	0	West Virginia	0
Mississippi	1	Wisconsin	6
Missouri	3	Wyoming	0

* State with a unified system in which jails and prisons are administered by the state

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Because this study did not randomly sample from all jail health care RFPs published in the United States over the study time frame, statistical inferences based on this research are not possible. Rather than a statistical analysis, Pew conducted a qualitative content analysis. However, as a first-of-its-kind study, this report provides new insights into how some jails procure their health services and may be used to inform county decision-makers about important factors related to jail health care.

Case studies

The county case study sites—Multnomah, Oregon; Dallas, Texas; and Fayette, Kentucky—were selected in order to provide insight into three different ways of organizing jail health care. For these case studies, researchers from Community Oriented Correctional Health Services reviewed publicly available documents and made site visits, conducting interviews with key personnel. These included health care staff, jail administrators, jail health directors, a member of the county legislative body, and a representative from a community-based organization. The interviews provided a range of perspectives on the provision of jail health care in these communities.

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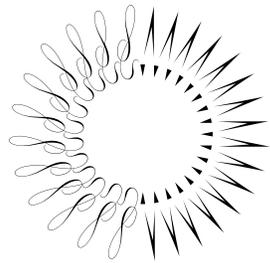
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