



A Roundtable Discussion

Criminal Justice and Health Information Technology: What are the next steps?

A Summary Report

September 14, 2012

Washington, D.C.

Introduction

Across the U.S. health care system, hospitals, physician practices, and other providers are adopting new health information technologies, such as electronic health record (EHR) systems, and joining health information exchanges (HIEs). A key element, however, has been left out of the health information technology (health IT) revolution: local and county jails, which serve as crucial safety net health care providers for some of society's most vulnerable populations.

Much is expected to change. Under the Patient Protection and Affordable Care Act (PPACA), Medicaid eligibility in 2014 will be extended to an additional 16 million individuals, many of whom, it is believed, will have had some involvement with local jails. In addition, because the PPACA established parity for mental health and substance abuse treatment, many of these people will have access to behavioral health care services for the first time.

Medicaid expansion creates tremendous opportunities to improve both public health and public safety while reducing health care and criminal justice costs. Research from the state of Washington shows that offering behavioral health care treatment to very low-income adults can significantly reduce crime and recidivism while improving both physical and mental health.

These opportunities could be lost, however, if jails are not brought into the mainstream of the health care safety net. Health IT could help bridge the divide between jails and their communities, leading to more efficient and better coordinated care, significant health care cost savings to local jurisdictions, and improvements to both public health and public safety. But these bridges have yet to be built.

Convening Around Criminal Justice and Health IT

On April 3, 2012, Community Oriented Correctional Health Services (COCHS), with the Robert Wood Johnson Foundation (RWJF), convened *Health Reform and Criminal Justice: Integrating Jails into Health Information Exchanges* to begin the dialogue on how to create connectivity between jails and their communities through health IT.

At that meeting, participants concluded that progress in this area will require leadership from those federal government agencies with an interest in both health IT and the jail-involved population. This led COCHS to convene, on September 14, 2012, *Criminal Justice and Health Information Technology: A Roundtable Discussion*, to identify what key government agencies are doing to address the sharing of health information for justice-involved individuals, and what this might mean for the future as we move closer to Medicaid expansion. COCHS invited five key agencies to describe their work in this area:

- White House Office of the National Coordinator for Health Information Technology (ONC)
- Office for National Drug Control Policy (ONDCP)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Bureau of Justice Affairs (BJA)

- Health Resources and Services Administration (HRSA)

More than four dozen leaders from a broad range of criminal justice, health IT, correctional health care, behavioral health care, and Medicaid organizations participated in the September 14th Roundtable to hear the presentations, learn from each other, and help identify next steps. This report summarizes the discussions from that day.

COCHS President Steven Rosenberg began by noting that COCHS' aims in convening the roundtable were to break down traditional silos between criminal justice and other sectors, to share perspectives, and to ensure that, in the end, everyone is working from a common framework. "The diversity of this group speaks to the need for all of you to build collaborations in this space," he told participants.

He asked participants to think about the variety of efforts that "all of us are taking to bring health care to jails," and he urged them to develop a framework for achieving connectivity in three ways: through products, through systems development, and through standards of care or protocols.

The National Campaign to Spread Health IT

Judy Murphy, the deputy national coordinator for programs and policy at ONC, traced the history of the federal government's efforts to promote adoption of EHR systems across the nation, starting with the creation of ONC under President George W. Bush in 2004. ONC is the principal federal entity charged with coordinating nationwide efforts to promote the use of the most advanced health IT available and the electronic exchange of health information. This movement received a huge boost with enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act of 2009. HITECH created significant financial incentives for providers to adopt health IT if they demonstrate what is known as "meaningful use" to improve individual and population health outcomes.

"Meaningful use" was officially defined in July 2010. According to Murphy, by the end of July 2012, ONC had distributed \$6.5 billion in EHR adoption incentives to 128,000 providers, including more than 2,700 hospitals that have established EHR systems.

However, the HITECH incentives aimed at increasing EHR adoption do not extend to correctional facilities, even though these facilities are required by law to provide health care to individuals in their custody, or to behavioral health care providers. This is one reason why EHR use is still extremely rare in these settings, even though both the criminal justice and the behavioral health care systems stand to benefit substantially from this type of health IT.

To support physician adoption of EHRs, ONC operates 62 regional resource centers that deploy teams of "road warriors" who travel to assist small practices. The strategy has proved "phenomenally successful," Murphy said. Lessons learned from the resource centers' initiatives are available at www.healthit.gov.

In addition, ONC administers the State HIE Cooperative Agreement Program, which funds states' efforts to rapidly build capacity for exchanging health information across the health care system, both within and across states. Under this program, a total of 56 awardees – one for each state and territory – are working to increase connectivity and enabling patient-centric information flow through e-prescribing, care summary exchange, lab reporting, public health reporting, and patient engagement. Although some progress has been made on the HIE implementation front, Murphy said that cultural barriers around sharing information continue to challenge that progress.

Murphy also spoke briefly about the National Information Exchange Model that the federal government is developing to connect communities for information exchange. Although ONC is involved with this initiative, work has only just begun.

Who's In Jail

In order to understand why jails and the jail-involved population are so critical to the success of the health IT movement, it's important to first understand who is in jail. COCHS CEO Michael DuBose reported on the characteristics of the jail-involved population.

The nation's 3,300 local and county jails process approximately 13 million admissions a year for 10 million unique individuals. Monthly turnover is about 64 percent.

People in jail are disproportionately male, persons of color, and poor. Fully 90 percent of all detainees have no health insurance. The majority of detainees (approximately 78 percent) are being held for non-violent offenses, and only a small number are charged with felony offenses. Many people in jail manage to post bail, but the ones who don't are often indigent, with high rates of mental health disorders and chemical dependency issues. Sixty-two percent have not been sentenced, and only 4 percent ultimately go to prison.

At booking, arrestees are often debilitated. Eighty percent have a chronic medical condition and have not received medical treatment in the community prior to arrest. Some arrive with injuries, while others have been on a drug or alcohol binge. More than 60 percent of people arrested test positive for at least one drug in their system; 13 percent to 28 percent test positive for multiple substances. Many may go through detox during their stay in jail.

Rates of sexually transmitted disease, mental disorders, and chemical dependency are comparatively high in the jail population. Over two-thirds (68 percent) of jail inmates meet the Diagnostic and Statistical Manual of Mental Disorders criteria for chemical dependency. Of those with a diagnosed mental illness, approximately three-quarters have a co-occurring chemical dependency disorder. Whether for lack of resources, lack of coordination, or lack of access to appropriate health care, in many communities, jails have become the *de facto* providers of mental health and chemical dependency treatment.

In addition, many people in jail have elevated rates of hypertension, diabetes, asthma and lung disease, liver disease (both alcoholic hepatitis and viral hepatic cirrhosis), seizure disorders, and arthritis. The majority have advanced oral health problems.

Currently, most people in jail cycle back quickly into their home communities, where they generally go without treatment for their underlying health problems, which then worsen and become part of the community health burden. When they do get health care, they typically get it at the local hospital emergency department. Untreated health problems – including untreated substance abuse disorders – may also contribute to repeat offenses and recidivism.

However, what DuBose referred to as the “Mancuso Effect” – after Dr. David Mancuso, who led a Medicaid study in the state of Washington – can alter that dynamic. Mancuso’s research demonstrated that providing substance abuse treatment to very low-income adults – a population that overlaps significantly with the jail-involved population – reduces crime, recidivism, and their associated costs. Rates of re-arrest, for example, fell from 33 percent to 17 percent, DuBose said.

These figures show why it is so important, post-2014, to enroll jail-involved individuals in Medicaid. They also demonstrate why, in part, health IT becomes so important to jails. Currently, jails are disconnected from both their communities and the rest of the health care system. Creating connectivity through health IT holds the potential to bring not only jails but the high-need, high-cost populations they serve into the mainstream of health care delivery.

Presentations from Federal Agencies

ONC is the federal government’s lead entity on health IT, but four other federal government agencies have strong motivation for bringing health IT into jails and promoting the spread of connectivity. On September 14th, representatives of these agencies gave presentations on their work in this area.

Office of National Drug Control Policy (ONDCP). Policy Analyst Jayme Delano reported that ONDCP has convened an interagency working group with 34 federal agencies for drug control policy. It agreed, in 2010, to address both health IT and substance use disorder issues, and now meets monthly. It has given to ONC a set of consensus recommendations for developing confidentiality provisions related to health IT.

Substance Abuse and Mental Health Services Administration (SAMHSA). Kenneth Robertson, team leader for criminal justice grants in the Targeted Populations Branch of SAMHSA’s Center for Substance Abuse Treatment, said that SAMHSA has five initiatives related to EHRs and criminal justice addressing jail diversion, trauma and justice initiatives, and system transformations. A large portion of its grant funds are awarded to drug court clients. SAMHSA has 180 active discretionary grants, and is awarding an additional 75 grants, including grants for juvenile re-entry. It also has a three-year ongoing program with BJA to address treatment gaps.

In April 2012, SAMHSA convened an interagency meeting that focused on identifying the information collected by criminal justice systems, as well as guidance and models for data-sharing. Robertson said that, in health IT, SAMHSA views the major issues as the need to increase capacity for EHR adoption, the need for guidance from ONC, the need to resolve compatibility issues among different EHR systems, the need to bridge policy gaps, and the need to fully address privacy concerns.

Maureen Boyle, lead public health advisor on health IT for SAMHSA's Center for Substance Abuse Treatment (CSAT), said that the agency's top priority is determining how it collects and shares behavioral health information in a way that complies with federal health privacy law. She noted that SAMHSA is incorporating EHR adoption into all its discretionary grants, although it is not yet mandatory. In addition, SAMHSA has been working on modular software development that can take behavioral health assessment "to the next level."

Robertson cited the criminal justice systems in Los Angeles and Chicago as examples of models that are "ahead of the curve" in terms of bringing EHR systems to bear on their jail populations. However, he cautioned that he has yet to see a truly successful model – merely "pieces" of successful models.

Bureau of Justice Assistance (BJA). Senior Policy Advisor Christopher Traver said that BJA awards grants at the state, local, and tribal levels for evidence-based programs. It works with an advisory group to advance a criminal justice mission, which includes addressing privacy issues. Increasingly, he said, BJA is recognizing it has many "touch points" with the health care community. He noted that criminal justice, probation, and parole all have roles to play in providing health care to the criminal justice population, but that confidentiality issues need to be addressed so that information can be shared appropriately and effectively. He said that pilot projects are underway in Rhode Island, Maryland, and Massachusetts to study what happens when people are released from jail into treatment with community-based service providers. Traver said that a prescription drug monitoring program supported by BJA has achieved some success in sharing data across state lines. This can help prevent "doctor shopping" by people with substance use issues.

Gary Dennis, another senior policy advisor at BJA, cited efforts in Travis County, Texas, to reduce the jail population by targeting so-called "frequent flyers" with co-occurring disorders and mobilizing resources to address their needs for mental health services, housing, and jobs. The idea is that this will help break the cycle of reincarceration for this population. In the process, Dennis said, county officials have had to deal with issues concerning health information-sharing and privacy.

Traver challenged the other participants at the September 14th Roundtable to identify actions for achieving specific goals, including advocating for inclusion of criminal justice as partners in community health care; developing best practices on sharing health information within the constraints of federal and state privacy laws; establishing pilot projects that make the best strategic use of limited funding resources; and refining technical standards for data-sharing.

Health Resources and Services Administration (HRSA). Yael Harris, director of HRSA's Office of Health Information Technology and Quality, noted that HRSA supports 1,200 community health centers, which serve more than 20 million mostly low-income people a year. She said that HRSA has as a goal the implementation of EHR systems in all community health centers by the end of 2012. In addition, HRSA is working with SAMHSA to develop integrated health solutions for behavioral health problems. HRSA has created a decisions tree tool for navigating the privacy provisions – otherwise known as “42 CFR Part 2” – of the Health Insurance Portability and Accountability Act (HIPAA) for use by providers and consumers alike. Harris said that HRSA is also working on a project to “enhance linkages” between HIV-positive people and jail settings in 10 sites, and has developed a manual for using buprenorphine in criminal justice settings that is available online.

Privacy Concerns

Concerns about HIPAA compliance in connection with the jail-involved population emerged repeatedly during the September 14th Roundtable. Melissa Goldstein, associate professor of health policy at the School of Public Health and Health Services at George Washington University, gave a presentation on the implications of privacy regulations in connection with the exchange of health information for jail-involved individuals.

Goldstein began by acknowledging that health IT could have a substantial impact on the criminal justice-involved population. At the same time, health information must be shared appropriately. This will require coordination at the federal, state, and community levels, with attention to integrating the criminal justice population into the larger health care system.

She cited two overarching goals. The first is to improve care and continuity of care for people who cycle in and out of jails. The second is to improve the public health. It is important to remember that when people leave jail, they return to their home communities, where, Goldstein noted, they are “in the public sphere.” If people released from jail have untreated contagious diseases, these diseases can spread throughout the community.

With respect to privacy, Goldstein noted that HIPAA applies to what are referred to as “covered entities,” which include some correctional institutions. It may not, however, apply to all components of the criminal justice system. For example, a nurse or doctor providing treatment at a jail might fall under HIPAA, but a judge or probation officer with whom they might share a patient's information might not fall under HIPAA.

Privacy of health information and the need to secure patient consent for sharing health information are important issues for treatment of mental illness and substance abuse. Patients may be reluctant to share such information. They may be afraid that sharing such information will be used against them in court. In other words, freely disclosing information related to their mental health or substance disorders could result in their being incarcerated for longer periods.

In correctional settings, the concept of obtaining “consent” from an incarcerated patient takes on a whole new dimension, Goldstein acknowledged. “What is real consent in the criminal justice environment, where everyone has a gun?”

Greg Warren, president and CEO of Baltimore Substance Abuse Systems, noted that, in Maryland, “the vast majority of substance abuse treatment is court-ordered.” How then can a patient or client be expected to “trust” the system with accurate information about his or her substance issues? “Accurate referral depends on accurate information,” Rosenberg observed. “To make the information reliable, the client must feel safe. If this is to be used for court-ordered, evidence-based treatment, the issues on accuracy are challenging.”

As jails move forward implementing health IT, it becomes even more important to guard against privacy breaches, which would only diminish patients’ trust in their providers, said Homer Venters, assistant commissioner of correctional health services for the New York City Department of Health and Mental Hygiene.

Rosenberg noted that there are different ways to obtain patient consent that may impose varying levels of burden on jails. For example, is consent required for every health care transaction in which a patient participates? Is it required every time that information is to be shared? Is it possible for patients to grant blanket or time-limited consent? HIEs that adopt very “conservative” consent policies may make it “next to impossible for jails to participate,” Rosenberg said.

Other Discussion

Other issues that came up during the roundtable discussion included funding constraints, the potential for increased liability, cultural resistance to health IT, intake challenges, and the need to create systems for enrolling detainees in Medicaid post-2014.

Cost is one of the most frequently cited barriers to implementing health IT in jails. County governments that are already financially pressed are often unwilling to invest money to put EHR systems in jails. Warren said that it is important to articulate a “value proposition” for correctional health IT. Mancuso’s research on the ripple effects of providing substance abuse treatment to jail-involved populations will be critical to making that value proposition. Installing an EHR system with HIE in the jail system could save lives, Warren noted. But in order to justify that expenditure, county officials need to be convinced that it will cut costs in other ways, like reducing the number of emergency room visits to the county hospital.

Other participants noted that health IT systems could help make jails safer. For example, Robertson, of SAMHSA, said that increasing and improving health care services in the jail can track inmate assaults. Venters agreed, “The EHR is potentially a tool for inmate safety and human rights.”

However, some counties may worry that having health IT systems in their jails may increase their liability exposure. As Rosenberg put it, EHR systems and information exchange will “shine a light” on how health care is provided inside the jail. “We may have systems of care in the jail that do not meet community standards,” he noted. In the end, though, jails need to be

integrated into the broader health care system, and health IT will be crucial to achieving that integration.

Moving Forward: Next Steps

At the end of the day, having shared their perspectives, ideas, and concerns, participants spent some time focusing on next steps. Rosenberg spoke of the need to gain widespread acknowledgement of jails as important providers of health care and of the impact that the jail-involved population has on both public health and overall health care costs. He named five cross-cutting areas of activity where greater cooperation and coordination are needed:

1. Identify and develop products that promote connectivity.
2. Identify and develop systems of care by building uniform assessment tools and clinical protocols for treating jail-involved individuals.
3. Identify and develop systems of information transfer that ensure privacy, meet HIPAA requirements, and collect comprehensive and accurate information.
4. Identify and develop standards of care to bring best practices into jails and bring health care provided in jails into alignment with health care provided in the community.
5. Identify and develop protocols for information-sharing.

Warren added another area of activity around communicating what he called “the value proposition” for health IT in local correctional settings. The idea is that, without health IT, jails will be unable to leverage new opportunities created by the PPACA to reduce an array of costs associated with justice-involved individuals. These opportunities have been identified in Mancuso’s research,¹ which found that when the state of Washington provided substance abuse treatment to chemically dependent, very-low-income childless adults, emergency room use plummeted by 35 percent, average per-person medical cost savings of \$2,500 annually were achieved, and rates of re-arrest fell substantially. This reduction in arrests saved local law enforcement, jails, courts, and state correction agencies an additional estimated \$5,000 to \$10,000 for each person treated.

Thus, a range of stakeholders now have strong incentives to create linkages between jails and community health care providers in order make the best use of these opportunities. Health IT

¹ See Shah MF, Mancuso D, Yakup S and Felver B. The Persistent Benefits of Providing Chemical Dependency Treatment to Low-Income Adults. Washington State Department of Social and Health Services, Research and Data Analysis Division, November 2009, <http://publications.rda.dshs.wa.gov/1397/>. Also: Mancuso D and Felver B. Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits. Washington State Department of Social and Health Services, Research and Data Analysis Division, February 2009, <http://publications.rda.dshs.wa.gov/1372/>.

can help establish these linkages through EHR systems that support bi-directional information exchange and community, county, state, and regional HIEs.

Conclusion

Roundtable participants agreed that articulating a value proposition based on Mancuso's research should be a priority. All stakeholders should understand and appreciate this underlying value proposition and be able to employ it in policy discussions to help align policies so that health IT can be incorporated into correctional settings. With Medicaid expansion little more than a year away, the need to mainstream jails into the health care system using health IT is critical, they said.