

**Affiliations between
Health Centers
and Local Correctional
Facilities to
Provide Continuity
of Care for Offenders**

*Prepared by Feldesman
Tucker Leifer Fidell LLP for
Community Oriented Correctional
Health Services (COCHS)*

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Acknowledgements/Disclaimer

Affiliations between Health Centers and Local Correctional Facilities to Provide Continuity of Care for Offenders explores various models to provide health care access to the community's offender population in a manner that optimizes the community-based delivery model and other benefits associated with community health centers.

The purpose of this manual is to familiarize readers with local correctional systems, the health care needs among offenders, and the benefits of linking offenders with the health center medical home model of care. This manual further provides readers with the knowledge and tools necessary to evaluate, identify and implement a local correctional facility affiliation that is appropriate for their particular health center and community.

This publication was prepared for Community Oriented Correctional Health Services (COCHS) by attorneys with the law firm of Feldesman Tucker Leifer Fidell LLP (FTLF). It is designed to provide accurate and authoritative information in regard to the subject matter covered. While incorporating certain principles of Federal law, this manual is published with the understanding that it does not constitute, and is not a substitute for, legal, financial or other professional advice. Further, this manual does not purport to provide advice based on specific state law, nor does it address all the unique policies and procedures within each local correctional facility. Health centers should consult knowledgeable legal counsel and financial experts to structure and implement a health center-local correctional facility affiliation arrangement that is legally, financially and operationally appropriate given the particular health center's respective goals, objectives, expectations and resources.

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Community Oriented Correctional Health Services (COCHS)

COCHS is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community. COCHS promotes a proven program that has been identified as a model by the Commission on Safety and Abuse in America's Prisons and various justice, correctional and health care associations.

COCHS is supported by a grant from the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Additionally, COCHS receives programmatic support from the Jacob & Valeria Langeloth Foundation and the California Endowment.

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CHAPTER 1 Introduction

Affiliations between Health Centers and Local Correctional Facilities to Provide Continuity of Care for Offenders provides an overview of affiliation opportunities available to health centers seeking to collaborate with local correctional facilities in their service area. Specifically, this manual:

- Describes the medical home model of care as a strategy to address offenders' health needs.
- Defines key terms for the purposes of this manual, including *Federally Qualified Health Center (FQHC)*, *Local Correctional Facility* and *Affiliations*.
- Explores reasons to partner health centers and local correctional facilities, and the benefits of such partnership.
- Discusses legal and policy requirements for health centers to address when considering whether to develop a particular health center-local correctional facility affiliation.
- Explores various affiliation models and describes factors to consider in assessing the feasibility and viability of a particular affiliation, given Federal rules and requirements applicable to health centers.¹
- Provides key terms for written agreements to implement an affiliation approach that is compliant with applicable health center Federal rules and requirements.
- Describes steps health centers can take to promote offenders' continuous access to health care after confinement.

This introductory chapter addresses:

- *What is the Medical Home Model?*
- *What is a Federally Qualified Health Center (FQHC)?*
- *What is a Local Correctional Facility?*
- *What is an Affiliation?*

What is the Medical Home Model?

Collectively, individuals confined in local correctional facilities are one of the most disenfranchised and medically underserved populations in our nation. Despite offenders' significant health needs, some jurisdictions do little to assure access to adequate and continuous health care. Available medical services are typically limited to the acute care episode and are intermittent and fundamentally inadequate.

This health crisis among the offender population is not an isolated problem removed from main stream society. Rather, offenders frequently cycle in and out of local correctional facilities and are members of the communities presently served by the health center.

A key strategy to improve offenders' health outcomes, prevent recidivism and reduce health care costs is to provide offenders with a "medical home." According to the Health Resources and Services Administration (HRSA), a "medical home" is not a building, house, or hospital, but rather an approach to providing comprehensive primary care.² The Academy of Pediatrics defines a medical home as primary care that is:³

- Accessible
- Continuous
- Comprehensive
- Family centered
- Coordinated
- Compassionate
- Culturally effective

The medical home does not limit care to case management, but rather takes a holistic approach to health care.

"To protect our nation, it is absolutely imperative to provide good medical care to incarcerated individuals. And even more than medical care, we must help the men and women in our custody to take better care of themselves and practice healthy behaviors so that they are as healthy as possible when they return to their communities."⁴

***- Rear Admiral Kenneth P. Moritsugu, M.D., M.P.H.
United States Surgeon General***

The medical home model prevents sickness, manages chronic illness and reduces the need for avoidable, costlier care such as emergency room (ER) visits and hospitalization.⁵ The medical home model also results in a better continuum of care and, ultimately, higher quality of care provided to the patient.

A Case Study of the Medical Home Model

The Hampden County Correctional Center (HCCC) in Ludlow, Massachusetts developed a "public health model of correctional health care" using dually-based physicians and case managers working at the jail and at four community health centers. The model emphasizes five elements: early detection, effective treatment, education, prevention and continuity of care.

In 2004, Abt Associates completed an evaluation of the HCCC public health model of correctional care. The report concluded, *"Participation in the HCCC intervention increased utilization of health and mental health primary care from baseline to 6-month follow-up."*⁶

According to the National Association of Community Health Centers (NACHC), Federally Qualified Health Centers (FQHCs or health centers) serve as the medical home for 18 million people nationally.⁷ Given their locations in high-need areas and their obligations to make services available to all residents, health centers are logical partners for local correctional facilities.

Both health centers and local correctional facilities, however, operate within certain legal frameworks that must be considered when developing a collaboration. Additionally, the partners must carefully consider ways in

which the services can be integrated into the health center’s healthcare delivery system smoothly and effectively.

The health center-local correctional facility affiliation models described in this manual address these and other issues by providing mechanisms to directly link offenders with the community-based health center system, thereby promoting the offenders’ familiarity with the health center system and increasing the likelihood that they will continue obtaining services from the health center post-confinement.

What is a Federally Qualified Health Center (FQHC)?

A Federally Qualified Health Center (referred to hereinafter as an FQHC or health center) is a public or private non-profit, charitable, tax-exempt organization that receives funding under Section 330 of the Public Health Service Act (Section 330), or is determined by the Department of Health and Human Services (DHHS) to meet requirements to receive funding without actually receiving a grant (i.e., an FQHC “look-alike”).⁸

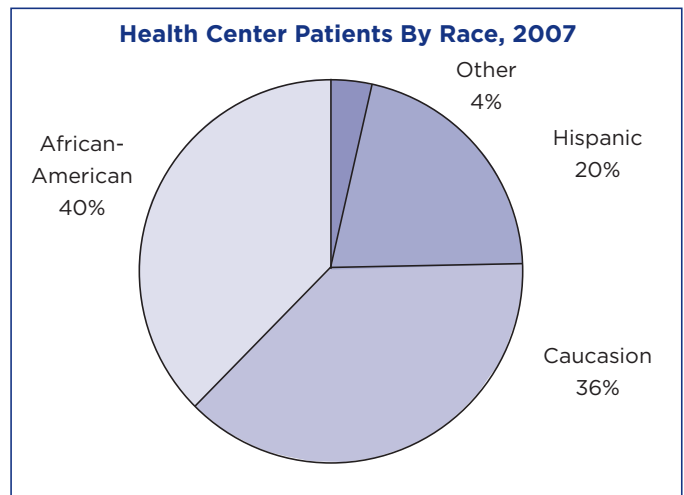
“For more than 40 years, health centers in the United States have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay.”⁹

There are presently over 1,200 health centers operating 6,600 sites in every state and territory.¹⁰ It is estimated that health centers save the national health care system between \$9.9 billion and \$17.6 billion a year by helping patients avoid obtaining care at emergency rooms and making better use of preventive services.¹¹

Health centers successfully overcome barriers to care because they are located in high-need areas, are open to all residents of their service areas, offer services that facilitate access to care such as outreach and transportation, and tailor their services to their patients’ and their communities’ unique cultural and health needs.

Health center patients are some of the nation’s most vulnerable individuals. Recent surveys indicate, among other things:¹²

- 71% of health center patients have family incomes at or below federal poverty guidelines
- 39% of health center patients are uninsured
- 35% of health center patients depend on Medicaid
- Roughly half of health center patients live in economically depressed inner city communities with the other half residing in rural areas



Source: Bureau of Primary Health Care, HRSA, DHHS, 2007 Uniform Data System

Fundamentals of the Health Center Model

There are four cornerstones of the health center model, all of which must continue to be satisfied under any affiliation or collaboration with a community partner. Specifically, the health center must:

(1) be located in a federally-designated medically underserved area or serve a federally-designated medically underserved population;

(2) serve all residents of the health center's service area regardless of ability to pay;

(3) provide a full continuum of primary and preventive care services; and

(4) be governed by an independent community-based board of directors that complies with all Section 330-related size, composition and selection requirements and maintains and autonomously exercises all authorities and responsibilities required of a health center governing board.

With respect to the governing board, Section 330 law, regulation and policy require the following:

Board Composition

- The board size should be between 9 - 25 members.
- At a minimum, a majority of the board members must be active consumers of the health center's services (i.e., persons who utilize the health center as their principal source of primary care and have done so within the last two years) who collectively represent the individuals being served by the health center in terms of various demographic factors, such as economic status, race, ethnicity and gender.
- The remaining non-consumer board members must be representative of the health center's community, and should be selected for their expertise in various fields.
- No more than one-half of the non-consumer board members may be individuals who derive more than ten percent (10%) of their annual income from the health care industry.
- No member of the board of directors can be an employee of the health center or an immediate family member of an employee (i.e., spouse, child, parent, or sibling), by blood, marriage or adoption.

Board Responsibilities and Authorities

The board must exercise the following authorities common to all corporate boards of directors:

- Attend to any matter that the board determines is in the best interest of the corporation, and is within the purposes and objectives of the corporation.
- Take all necessary steps to assure the achievement of the purposes and objectives of the corporation.

Additionally, health center governing boards must autonomously exercise the following authorities without interference from any non-health center individuals or entities:

- Directly employ and approve the selection, annual evaluation and dismissal of the Executive Director/Chief Executive Officer (CEO).
- Prepare and approve the annual budget and project plan, including the annual Section 330 grant application or FQHC look-alike certification/application.
- Adopt and, as necessary, update financial management practices, personnel policies and procedures, and health care policies and procedures.
- Evaluate the health center's activities.
- Establish and maintain collaborative relationships with other health care providers and social agencies in the relevant service area.
- Maintain a commitment to provide services to the medically underserved populations(s) served by the health center.
- Assure that the health center is operated in compliance with applicable federal, state and local laws, regulations and policies.

The Correctional Facility must be Community-Based for a Successful Health Center Affiliation

Local correctional facilities where offenders are primarily drawn from the health center's community, as well as from the nearby communities, are best suited for health center affiliations. Consequently, the models described in this manual focus exclusively on potential partnerships with local correctional facilities where the majority of offenders reside in the health center's medically underserved area, or that house offenders that are primarily part of the medically underserved population served by the health center.

For purposes of this manual, the term "correctional facility" does not refer to state operated prisons.

What is a Correctional Facility?

A correctional facility is a place of incarceration by government officials that serves to confine individuals and may be classified as minimum, medium and/or maximum security facilities. These facilities can be operated by a city, county, or state government, or by federal authorities. The broad categories of correctional facilities include the following:

- **Jails** are operated by counties or municipal authorities and generally confine individuals awaiting trial or serving sentences that are typically of less than one year. Individuals awaiting trial may be confined anywhere from a few hours to more than a year, based on the particular jurisdiction's ability to process offenders through the system. Individuals in jail typically await trial and serve their sentences at a facility close to their home, and return to the local community upon release.

- **Prisons** are operated by state, provincial, or the national government and typically house inmates serving longer sentences. Prisons are often located far from the areas where inmates will live after release.

Types of Correctional Facilities

Correctional facilities vary extensively in size, security level, and in the populations they confine.

Secured Correctional Facilities

Offenders in secured correctional facilities may include both convicted individuals and individuals awaiting trial. In addition, a secured correctional facility may confine a broad range of offenders, or a particular sub-population with unique needs, such as those with mental illness.

Secured correctional facilities include, but are not limited to, the following:

- **Pretrial** Offenders are confined in a facility, but are not yet convicted
- **Sentenced** Offenders are convicted and given a short term sentence in a local facility
- **Mixed** Facility includes both pretrial and sentenced offenders
- **Regional or City** Facility serves the needs of the participating jurisdictions
- **Receiving** Facility receives, classifies and then moves offenders to another facility
- **Mental Health** Facility specifically houses offenders with mental health problems
- **Substance Abuse** Facility specifically houses offenders with substance abuse problems
- **Hospital** Facility specifically houses offenders with medical problems
- **Sex Offenders** Facility specifically houses sexual offenders

Medium / Minimum Security Facility

Offenders may be classified to live within a reduced level of security because of the nature of their crime, their participation in programming, or other factors that mitigate the need for secured confinement. The level of incarceration may take on various forms, such as:

- a secured facility with correctional staff, locks and fences; or
- a facility with or without correctional staff that is not well secured.

Community-Based Supervision

Offenders may be permitted to live at home or at another designated residential setting under the supervision of local authority. Typically supervision programs are managed by probation or parole departments. Supervision may come in various forms, such as:

- electronic monitoring;
- drug testing, both regular and random; and
- scheduled or unscheduled check-ins.

Examining the Local Correctional System Population

When discussing health center-local correctional facility affiliations, it is important to look beyond the number of confined offenders at any given time. This snapshot sta-

tistic does not capture the size of the population that passes through in the correctional facility system. The most important statistic is the number of people that flow through the system each year.

- There are over 12 million jail admissions and releases, representing about 9 million unique individuals, each year across the United States.¹³
- More than 1 in every 100 adults is now confined in a United States jail or prison.¹⁴

The length of confinement at local correctional facilities varies, although the vast majority of offenders are confined for less than 6 months.

- The Bureau of Justice Statistics approximates that 20% of annual offender admissions stay longer than 1 month, 13% stay longer than two months, 7% longer than four months and 5% stay longer than six months.¹⁵

The incarcerated population is mostly poor, urban and undereducated. Surveys indicate, among other things:¹⁶

- 60% do not have a high school diploma or general equivalency diploma;
- 46% have a family member who was incarcerated;
- 30% of inmates are unemployed in the month before arrest; and
- 14% were homeless at some point during the year before they were incarcerated.

What is an Affiliation?

HRSA defines an “affiliation” as an “agreement that establishes a relationship between a [health center] and one or more entities.”¹⁷ According to HRSA guidance, health centers are encouraged to affiliate with other entities to strengthen their ability to achieve their mission of providing access to and availability of primary health services to medically underserved and vulnerable populations who reside in a health center’s community.¹⁸

The importance of affiliating with other community-based providers is evident throughout health center-related policy, and is addressed in various grant applications, including New Access Point, expansion, and budget and project continuation applications. For example, the December 2007 New Access Point application stated that competitive applicants must demonstrate “*appropriate collaboration, coordination and integration with the activities of... State and local health services delivery projects and programs providing services to the identified underserved population/community.*”¹⁹ Collaboration within the community is also a key element of the service delivery models and scopes of project of most (if not all) health centers.

Health Center Affiliation Partners

The range of affiliation partners and models is broad and flexible, providing health centers latitude to form collaborations that support and improve the provision of quality health care services to all populations residing in their community. The range of partners that currently affiliate with health centers is exceptionally broad, including, but not limited to, hospitals, health systems, other ambulatory care facilities, behavioral health facilities, assisted living facilities, nursing homes, and Skilled Nursing Facilities.

Models for Health Center-Local Correctional Facility Affiliations

In the context of corrections, health centers nationwide are increasingly affiliating with local correctional facilities and including such services in their scopes of project. The models for such affiliations include:

- Providing services directly at the local correctional facility site (see Chapter 4, page 29);
- Providing triage services at the local correctional facility site (see Chapter 4, page 30);

- Transporting offenders to the existing health center site (see Chapter 4, page 32); and
- Transporting offenders to a new health center site (see Chapter 4, page 32).

While this manual provides a general overview of several health center-local correctional facility affiliation models and describes key legal considerations, it is important to note that every affiliation arrangement will vary depending on the specific goals of the partnership, the offenders’ medical needs, and the organizational structure of both the health center and the local correctional facility.

Section 330-Related Policies Regarding Affiliations

Although HRSA encourages health centers to affiliate with other entities, it expects health centers to remain diligent in complying with all Section 330-related requirements and regulations. HRSA is particularly concerned with potential affiliations that diminish the health center’s role in carrying out its activities, or vesting too much oversight authority in the affiliating entity - all of which are to be avoided if a health center wants to retain federal support and benefits.

To clarify the manner in which health centers can collaborate with other organizations while complying with applicable law and implementing regulations, HRSA issued two policy guidances – Policy Information Notice (PIN) # 97-27, *Affiliation Agreements of Community and Migrant Health Centers*, and PIN # 98-24, *Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers*.

PIN # 97-27 sets out four areas of critical concern that must be considered by health centers prior to entering into any affiliation arrangement.²⁰ Each area is addressed below.

Corporate Structure: HRSA scrutinizes proposed affiliations that impact the corporate structure of the health center to determine whether the particulars of the relationship adversely affect the health center’s compliance with the Section 330 statute and implementing regulatory requirements regarding board selection, composition, and responsibilities and powers (including, but not limited to, autonomous decision-making of the health center board in key areas of policy-making), as described

in Chapter 1, pages 4-5. Generally, these types of arrangements will not be approved unless the health center can demonstrate that it remains compliant with all requirements and continues to exercise all required authorities.

Governance: Under all affiliation arrangements, HRSA requires that the health center board remain compliant with all Section 330-related selection and composition requirements. Specifically, no other party may:

- Select (1) the majority of the health center board members; (2) the majority of the non-consumer members; (3) the board Chairperson; or (4) the majority of members of the Executive Committee.
- Preclude the selection, or require the dismissal, of board members not appointed by that party.

With respect to the board's authorities, as described in Chapter 1, page 5, no other party may: (1) have overriding

approval authority, (2) have veto authority (through "super-majority" requirement or other means), and/or (3) have "dual majority" authority.

Management and Finance: Under the affiliation arrangement, no other party is permitted to: (1) select or dismiss the health center's Executive Director/CEO (no exceptions); and/or (2) select or dismiss the health center's Chief Financial Officer (CFO) or Chief Medical Officer (CMO) (subject to good cause exceptions).

Health Services/Clinical Operations: Under the affiliation arrangement, no other party is permitted to: (1) hire or dismiss the majority of the health center's full-time primary care providers (subject to good cause exceptions); and/or (2) control the health center's relationships with other entities unless there is no impact on compliance with statutory and/or regulatory requirements.

References

1. This manual only addresses affiliation models where clinical services are provided to offenders on behalf, and under the control, of the health center; are subject to the health center's quality review procedure; and are (or will be) included within the health center's scope of project.
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16. Soloman, AL., Osborne, JWL., Lo Buglio, SF, et. al., *Life After Lockup: Improving Reentry from Jail to the Community*, Urban Institute, May 1, 2008, p. 20.
17. See HRSA Policy Information Notice (PIN) # 97-27: *Affiliation Agreements of Community and Migrant Health Centers*, July 22, 1997, p. 5.
18. See id. at p. 4.
19. BPHC New Access Point (NAP) New Grant Competition Announcement Number HRSA 08-077, Fiscal Year 2008, p. 8.
20. HRSA PIN # 97-27 at pp. 9-16.

CHAPTER 2 *Health Center-Local Correctional Facility Affiliations: A Practical Partnership*

Affiliating with local correctional facilities is consistent with and furthers the health center mission to “increase access to and availability of primary health services to medically underserved and vulnerable populations who reside in a health center’s community.”¹ Moreover, this affiliation is also consistent with the correctional facility mission to prevent recidivism and protect the public’s health and safety.

This affiliation partnership is a practical step to assist both health centers and local correctional facilities fulfill their respective missions, thus improving the health, welfare and safety of the offenders as well as the community at large.

“When an individual is released from a prison or jail setting, the corrections system no longer has responsibility, or authority, for his or her care. Many times the inmate is released without much money or support, right back into the old neighborhood without linkages back to the health care community. To ‘close the gap,’ those who are released need continuity of care to maintain the good treatment and care started in the correctional facility. The corrections and local public health systems need to work together to ensure that those who are released continue their treatment and care once they go back to their communities.”²

*- Vice Admiral Richard H. Carmona, M.D., M.P.H., FACS
United States Surgeon General*

This chapter addresses:

- *Health Care Needs Among Offenders*
- *Local Correctional Facility Perspective*
- *Health Center Perspective*
- *Benefits of Health Center-Local Correctional Facility Affiliations*

Health Care Needs Among Offenders

Individuals confined in correctional facilities are at increased risk for several infectious diseases such as HIV/AIDS, sexually transmitted diseases, tuberculosis, dental caries, and abscesses. In addition, drug and alcohol addiction, lack of access to health care and medication, poverty, marginal nutrition, altercations, poor housing and intermittent homelessness raise both the incidence and intensity of other chronic conditions including hypertension, diabetes, seizures, asthma, cardiovascular diseases and gastrointestinal disorders.

The incidence of medical conditions, though elevated, may be dwarfed by mental health disorders, and it is often hard to know whether mental impairment is the cause or the outcome of “the slings and arrows” of difficult circumstances. In any event, the following studies are pertinent for health centers contemplating working in this environment.

- In 2002, more than one-third of jail inmates (37 %) reported having a current medical problem other than a cold or virus.³

- The jail population is characterized by relatively high rates of chronic diseases, including arthritis (13 %), hypertension (11 %), asthma (10 %) and heart problems (6 %).⁴

- In one series, 64% of jail inmates had a mental health problem.⁵

- Based on several national surveys, compared to the general population, the rate of HIV/AIDS is five times higher among incarcerated individuals, rates of hepatitis C are 9 to 10 times higher and rates of tuberculosis are 4 to 17 times higher.⁶

Prior to incarceration, offenders typically had limited – if any – contact with the health care system. For example, the Hampden County Correctional Center located in Ludlow, Massachusetts found that one-third of the incoming inmates had not visited a medical provider in the past twelve months because of cost. However, nearly half of the men and two-thirds of the women had used the local emergency room for health care in the same period, which represents a serious misallocation of resources.⁷

Given this lack of access to primary health care, offenders frequently present at the correctional facility with significant health care needs. Most offenders report being questioned about their health problems at admission; however, less than half (47 %) receive examinations to see if they are sick, injured, or intoxicated, and even fewer (43 %) receive a medical exam after admission. Of those who reported a current medical problem, 42 % had met with a health care professional about the problem since admission to jail.⁸ Although correctional facilities provide some degree of medical care, even this limited level of care typically terminates upon release.

A comprehensive public health program of early detection/assessment, health education, prevention, treatment and continuity of care is instrumental in reducing the incidence and prevalence of disease in correctional facilities and communities.⁹

Health Centers Cannot Receive Medicaid Enhanced Reimbursement for Offenders While They are Incarcerated

According to Federal law, Medicaid funding cannot be provided for *“any such payments with respect to care or services for any individual who is an inmate of a public institution.”*¹²

A public institution is defined as *“an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. A public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that services no more than 16 residents, or a child-care institution with respect to children receiving foster care or foster care payments.”* Under this definition, a health center qualifies as a “public institution,” and therefore is subject to this Medicaid restriction.

Although Medicaid payment is prohibited, it is not required that individuals in correctional facilities lose eligibility once they become inmates. In fact, some states may enroll individuals in Medicaid at the time of confinement and suspend rather than terminate their eligibility, to be reinstated upon release.

Health centers can play an instrumental role in assuring that eligible individuals are enrolled or reinstated in Medicaid upon release. This may result in community cost-savings because Medicaid-enrolled ex-offenders are more likely to seek primary care treatment at their health center rather than at the more costly emergency rooms.¹³ Further, by assisting in Medicaid enrollment prior to release, health centers promote a post-confinement relationship with the offender patients, thus advancing the medical home model of care. (Additional information regarding post-confinement Medicaid enrollment is included in Chapter 5.)

Correctional Facility Perspective

Staff working for health centers should bear in mind that local correctional facilities face numerous demands, expectations, and pressures that often take precedence over the goals of improving offender health care. The overriding concerns of corrections include 1) maintaining order and security in the facility, 2) protecting the safety of health care and corrections staff, 3) meeting the demands and expectations of the courts, 4) fulfilling federal, state, and local regulations for correctional facilities, and 5) reducing violence and injuries incurred between jail inmates (i.e., separating rival gangs, etc.).

Federal law requires that states and municipalities provide confined individuals with access to health care.¹⁰ This responsibility is particularly challenging given the millions who flow through local correctional facilities and their high rates of physical and mental illness. The cost of providing health care is also heavy burden on the financial resources of the correctional agency. In addition, there is a shortage of health professionals in many jurisdictions.

Correctional facilities use a variety of methods to provide health care to offenders, such as:

- Onsite delivery staff
- Fee-for-service
- Managed care
- Use of local government physicians

In general, when an individual is confined in a local correctional facility, his or her federally-supported insurance (i.e., Medicare and/or Medicaid) will not cover the costs for care. Private insurance may or may not cover the costs for care provided to an individual during confinement. In any event, very few have private insurance.

Some correctional facilities charge offenders a fee for health services. For example, in a survey of jail jurisdictions conducted by the National Commission on Correctional Health Care at the end of 1994, 34% of jails stated that they had a program that charged offenders for health services, and another 15% of jails indicated that they were exploring such a program for implementation. Most programs in place required a fixed payment of between \$2 and \$10 for certain health services encounters.¹¹

Because offenders are generally prohibited from carrying cash during confinement, these “charges” are typically reduced from offenders’ designated personal accounts or collected upon discharge. As discussed above, correctional facilities are required to provide health services to confined offenders. Thus, they are prohibited from denying offenders care if their designated personal account has insufficient funds to pay for the care.

Under the health center-local correctional facility affiliations, the payor for the health center's services is either the city or county. Typically, the health center would not charge or obtain any fees from either the offender patient or from any third party payor. If the correctional facility charges the offender a fee, as described above,

the health center would neither collect nor retain these funds from the offenders' designated personal accounts or upon their discharge. Additional information regarding payment under health center-local correctional facility models is further addressed in Chapter 4, page 35.

Health Center Perspective

Section 330 defines a "health center" as an entity that, among other things, provides required primary health services (and, as appropriate for the particular health center, additional health services) either directly through the health center's staff or through "contracts or cooperative agreements."¹⁴ Neither Section 330 nor the health center implementing regulations at 42 C.F.R. Part 51c require health centers to use (or prohibit them from using) certain sites or facilities in which to provide services to patients.

In addition to providing basic primary and preventive health care services, health centers are required to provide (among other things):¹⁵

- services that "enable" patients to utilize the health center's medical services, including outreach; and
- education of patients and the general population served by the health center regarding the availability and proper use of health services.

Thus, outreach and education to underserved communities is not simply an objective of the health center program - it is also a requirement for participation. Further, by definition, health centers are required to provide these services *"for all residents of the area served*

*by the health center."*¹⁶ As with sites and facilities, neither Section 330 nor the implementing regulations further define which individuals in the community would be "residents." Rather, most health centers define "resident" consistent with its common usage- an individual (or family) who is housed in and declares him or herself to be a resident of an area.

Because offenders in local correctional facilities are currently housed within the community and, more importantly, typically return to the community after confinement, such individuals should qualify as "residents of the area served by the health center." Outreach to the offender population is, therefore, consistent with the requirements of the health center program.

The physical isolation of offenders during confinement creates a challenge for health centers to reach some of the most underserved individuals in their community. However, the period of confinement can also be an ideal opportunity to utilize the health center's community-based model. Offenders can establish a relationship with health centers during confinement, and continue to access care after release, ultimately benefiting the health and safety of the entire community.

FTCA Checklist

Health centers must respond “yes” to all of the following questions to assure that FTCA coverage is available for services provided by the health center providers under the health center-local correctional facility affiliation. Satisfying these questions does not, however, guarantee FTCA coverage. Health centers are encouraged to consult with HRSA to confirm FTCA coverage.

- Does the health center receive Section 330 funding?
- Is the health center deemed eligible for FTCA coverage?
- Are the services provided to the offenders included within the health center’s approved scope of project? (See Chapter 3, pages 22-23 for information on scope of project)
- Is the site where services are provided to offenders included within the health center’s approved scope of project?
- Does the offender qualify as a health center patient and is he or she appropriately registered? (See Chapter 3, page 21 for the definition of “patient”)
- Are the providers for the correctional health services health center employees, OR, if the providers are contractors to the health center, is the contractual agreement directly between the health center and the individual health professional providing services to the health center’s patients and does the contracted provider meet the hour requirements described on page 17?
- Are the services provided included within the provider’s scope of employment/contract?
- Is the health center responsible for billing the payor (i.e., the city or county) for the health center’s services provided to the offender patients?

Benefits of Health Center-Local Correctional Facility Affiliations

The potential benefits of health center-local correctional facility affiliations extend beyond the four walls of the medical room and into the greater community.

Benefits for the Community at Large

- May reduce chronic disease and the spread of infectious disease in the community, including tuberculosis, hepatitis A and B, HIV, and sexually transmitted diseases.
- Immunizations against hepatitis A and B provided to at-risk offenders may improve community immunity and may interrupt disease transmission.¹⁷
- Offenders are more likely to exhibit appropriate behaviors when they are healthy and receiving proper and adequate care; therefore, providing a medical home to offenders post-release may reduce crime in the community and improve public safety.¹⁸
- Promotes offenders’ successful re-entry into the community after confinement, which may result in a decrease in recidivism.
- May reduce the need for more expensive in-patient and specialty care services as well as emergency room visits, resulting in significant savings to the health care system and to the jurisdiction responsible for these costs.
- Allows providers to gather vital patient level data through disease registries.

Benefits for the Offenders

- Provides offenders with a medical home where they can access a full range of quality primary and ancillary care services both during and after confinement, which reduces service gaps.
- Assists offenders in accessing the full range of safety net services and public benefits available in the community post-confinement (e.g., food stamps, substance abuse counseling, Medicaid eligibility, and other social services).
- Prenatal care provided to offenders improves birth outcomes, prevents vertical disease transmission such as HIV and educates women about well-baby care, childhood immunizations and nutrition, decreasing premature birth (with attendant costs) and morbidity.¹⁹
- May reduce chronic disease and the spread of infectious disease within the offender population (i.e., while incarcerated).

Benefits for the Health Center

- Maintains and enlarges the health center’s patient base and target populations.

- Maximizes and enhances the health center’s revenue through contracts.
- Improves the health center’s ability to deliver the proper level of care in an appropriate setting on a timely basis.
- Promotes the health center’s mission to maintain, enhance and increase access to and availability of primary health care services to medically underserved and vulnerable populations who reside in a health center’s community.

Benefits for the Local Correctional Facility

- With good health care during confinement, offenders are likely to be more content and cooperative within the correctional system.
- Identification and treatment of infectious diseases among offenders protects the health of local correctional facility staff by reducing communicable disease transmission.
- May reduce the jurisdiction’s cost of providing health care to offenders and/or its global health care expenditures.
- Promotes partnership with various local organizations, which may expand the local correctional facility’s programs and community support.
- May prevent recidivism, therefore reducing correctional facility overcrowding.

Section 330-Related Benefits

An additional advantage of affiliations between local correctional facilities and health centers is that the arrangement, if structured appropriately, may be eligible for certain Section 330-related benefits that assist the health center in providing high quality care to the populations served under the affiliation. The two most notable benefits are Federal Tort Claims Act (FTCA) coverage for the health center and its providers, and discounted drug pricing under Section 340B of the Public Health Service Act.

FTCA Coverage (in lieu of purchasing malpractice insurance).²⁰

- FTCA provides professional liability/medical malpractice coverage for services provided by a health center and its officers, directors, employees and certain contractors to the health center’s patients and generally furnished at the health center’s site(s).²¹
- To be eligible for FTCA coverage, a health center must receive funds under Section 330 and be deemed eligible for coverage. As such, FTCA coverage is available only to the health center; it cannot be extended to a health center’s affiliation partner (and/or the partner’s employees/contractors).
- FTCA is *only* available for:

- (1) the deemed health center (as well as its directors and officers);
- (2) health center employees that provide services on a full-time or part-time basis;

340B Drug Pricing Checklist

Health centers must respond “yes” to all of the following questions to assure that Section 340B drug pricing is available under the health center-local correctional facility affiliation. As with FTCA, satisfying these questions does not guarantee access to 340B drug pricing. To confirm access to 340B drug pricing, health centers are encouraged to register and consult with the Office of Pharmacy Affairs at HRSA.

- Does the offender qualify as health center patient and is he or she appropriately registered? (See Chapter 3, page 21 for the definition of “patient”)
- Is the health center responsible for ordering and purchasing the drugs?
- Can the health center, at a minimum, break-even from a reimbursement perspective?
- Can the health center establish a tracking system (or an alternative system approved by the Office of Pharmacy Affairs) to ensure that the drugs purchased under the Section 340B program are not resold, transferred or diverted to non-health center patients?²²
- Can the health center establish a system to record purchases of covered drugs and any claims for reimbursement submitted for such drugs under Medicaid for the purpose of audits required by DHHS and/or the respective manufacturer with respect to compliance with the prohibitions against (i) drug resale, transfer or diversion and (ii) duplicate Section 340B discounts and Medicaid rebates?

(3) individually contracted providers who furnish services in the fields of general internal medicine, family practice, general pediatrics and obstetrics and gynecology, regardless of the number of hours worked; and

(4) individually contracted providers who furnish services in other fields of practice, so long as they provide such services to health center patients for an annual average of 32 hours a week (i.e., on a full time basis).

■ With certain exceptions, FTCA only covers services provided within the health center's approved scope of project and within the provider's scope of employment/contract.

Discount Drug Pricing Under Section 340B of the Public Health Service Act²³

■ Health center grantees and look-alike entities are eligible to participate in the discount drug pricing program

under Section 340B of the Public Health Service Act. Section 340B drugs may be distributed either directly by a health center pharmacy or through contract with a retail pharmacy.

■ The drugs purchased under the 340B program may be dispensed only to the health center's patients. As such, the health center cannot supply 340B drugs to individuals who are not registered health center patients. (See Chapter 3, Section A for the definition of "patient.")

■ A health center's ability to purchase drugs for offender patients at discounted prices could potentially result in significant cost savings. This provides the health center with an effective means to lower drug prices for its uninsured patients and to provide better health care for its offender patients. The savings is particularly important given offenders' significant health care needs that may require extensive medication management.

References

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4. Id.
5. James, DJ. and Glaze, LE., *Mental Health Problems of Prison and Jail Inmates*. US Bureau of Justice Statistics, September 2006, p. 1.
6. Hammett, TM., Harmon, P., and Maruschak, L., *1996-1997 Update: HIV/AIDS, STDS and TB in Correctional Facilities*. National Institute of Justice, July 1999.
7. Ashe, MJ. and Conklin, T., *A Public Health Model for Correctional Health*, produced by the Hampden County Sheriff's Department and the Massachusetts Public Health Association, October 2002, p. 17.
8. Maruschak, L., *Medical Problems of Jail Inmates*. US Bureau of Justice Statistics, November 2006, pg. 1.
9. Ashe, MJ. and Conklin, T., *A Public Health Model for Correctional Health*, produced by the Hampden County Sheriff's Department and the Massachusetts Public Health Association, October 2002, pp. 1-2.
10. See *Estelle v. Gamble*, 429 U.S. 97 (1976).
11. *Charging Inmates a Fee for Health Care Services*. National Commission on Correctional Health Care, March 31, 1996.
12. Social Security Act, Sec. 1904(a)(28)(A).
13. Ashe, MJ. and Conklin, T., *A Public Health Model for Correctional Health*, produced by the Hampden County Sheriff's Department and the Massachusetts Public Health Association, October 2002, p. 8.

14. See 42 U.S.C. 254b(a)(1).

15. See 42 U.S.C. 254b(a)(1)(iv) and 42 U.S.C. 254b(a)(1)(v); see also 42 C.F.R. 51c.102(y)(13) and (14).

16. See 42 U.S.C. 254b(a)(1).

17. Ashe, MJ. And Conklin, T., *A Public Health Model for Correctional Health*, produced by the Hampden County Sheriff's Department and the Massachusetts Public Health Association, October 2002, p. 7.

18. Id. at p. 8.

19. Id.

20. Although FTCA provides malpractice coverage for actions within the deemed health center's scope of project and the deemed provider's scope of employment, it is somewhat of an open question whether FTCA covers provider liability for lawsuits alleging that their actions violated the Constitution. Because confined offenders have a constitutional right to receive health care, denial of services (whether explicit or implicit) could give rise to a "Constitutional violation." While health centers should be aware of this potential FTCA limitation, they should know also that the same limitation (i.e., vulnerability to a Constitutional action) is likely to exist if the health center has private malpractice insurance rather than (or in addition to) FTCA coverage.

21. Extensive discussion of the legal basis for health center FTCA coverage, as well as the legal requirements and limitations to such coverage, can be found in PIN # 2008-05, PIN # 99-08, PAL # 99-15, and PIN # 97-06. See also PIN # 2008-01 regarding Scope of Project policy.

22. Health center "patients" are defined in "HRSA Notice Regarding Section 602 of the Veteran's Health Care Act of 1992 Patient and Entity Eligibility," 61 Fed. Reg. 55156 (October 24, 1996).

23. See Section 340B of the Public Health Service Act (42 U.S.C. 256b), as amended by Section 602 of P.L. 102-585 (11/11/92).

CHAPTER 3 *Understanding the “Language” of Collaboration*

It is of utmost importance that health centers carefully scrutinize any local correctional facility affiliation opportunity for compliance with all applicable Section 330 statutory, regulatory and policy requirements. This entails, among other things, gaining a working knowledge and understanding of the “language” of collaboration, e.g., who are the patients, what is the health center’s scope of project, and how does the health center maintain compliance with certain specific Section 330-related requirements, as well as other pertinent rules.

This chapter addresses:

- *Who is a Health Center Patient?*
- *What is the Health Center’s Scope of Project?*
- *How does a Health Center Change its Scope of Project?*
- *How does the Health Center Include Encounters on its Uniform Data System Report?*
- *Are there Governing Board Considerations?*
- *Who Owns the Medical Records?*
- *Are there Other Legal Considerations?*

Who is a Health Center Patient?

It is critical that offenders are registered as health center patients. Failure to register an offender as a health center patient threatens FTCA coverage and the availability of 340B drug benefits, and is inconsistent with the medical home concept to care.

FTCA: Except in a few limited circumstances, FTCA only covers health care services provided to health center patients.¹ (See Chapter 2, pages 16-18 for further information on FTCA)

Section 340B: Drugs acquired utilizing Section 340B pricing may only be dispensed to offenders who obtain primary health care services through a health center if the offenders qualify as “patients” of the health center. (See Chapter 2, pages 17-18 for further information on Section 340B)

Section 330 and its implementing regulations and guidance do not define a health center patient. Consequently, for purposes of identifying health center patients for FTCA coverage and Section 340B drug benefits, we suggest that health centers apply the Section 340B definition of “patient.”² According to Section 340B, an individual currently qualifies as a “patient” when the following requirements are satisfied:³

- The health center has established a relationship with the individual and maintains records of the individual’s health care.
- The individual receives health care services from a health care professional who is either employed by or provides health care under a contractual or other arrangement (e.g., referral for consultation) with the health center, such that the responsibility for care remains with the health center.
- The individual receives a health care service or a range of services from the health center consistent with the service or range of services for which the entity received FQHC status (i.e., the services are within the health center’s approved scope of project).

An individual will not be a “patient” for Section 340B purposes if he or she only receives services related to the dispensing of a drug or drugs for subsequent self-administration or administration in the home. In other words, a relationship with an offender based solely on case management is insufficient to establish the individual as a health center patient.

Key Considerations in Registering Offender Patients

Health centers must gather significant information from patients during intake to document their status as health center patients, consistent with the health center’s current registration requirements.

The patient data may be gathered by a health center employee at the local correctional facility, or may be sent from the local correctional facility to the health center. Regardless of the health center’s selected registration procedure, it is critical that the necessary patient information is gathered prior to the provision of care.

Registration information may be sent electronically from the local correctional facility to the health center if the requisite systems are in place.

What is the Health Center’s Scope of Project?

Scope of project defines the persons, activities and sites that the total approved Section 330 grant related project supports (or, in the case of FQHC look-alikes, the persons, activities and sites that the FQHC designation supports).⁴ A health center’s scope of project is important because it (among other things):

- Determines the maximum potential scope of FTCA coverage (subject to certain exceptions).
- Provides the necessary information which enables health centers to purchase discounted drugs through Section 340B.

Scope of project is categorized by five core elements: services, sites, providers, target population. These core elements of the scope of project are defined as follows:

■ **Services:** As noted in Chapter 2, page 15, Section 330 requires health centers to provide, either directly or by contract or referral, all required primary health services. Health centers may also provide additional health services that are appropriate to meet the needs of their patients. Once a service is included in the scope, it must be available equally to all patients, regardless of ability pay. (Additional information on services is provided below.)

■ **Sites:** A site is any place where a health center provides services to a defined geographic service area or population on a regularly scheduled basis. (Additional information on sites is provided below.)

■ **Providers:** Providers are individual health care professionals who deliver services on behalf of the health center on a regularly scheduled basis and who exercise independent judgment as to the services furnished during an encounter.

■ **Service Area:** The service area is the geographic area that is served by the health center.

■ **Target Population:** The target population is the medically underserved community or special population served by the health center (which may be a sub-set of the service area or may include the entire service area).

In evaluating and implementing a health center-local correctional facility affiliation, it is of particular importance that the health center evaluate whether the proposed affiliation includes sites and/or services that are not currently included within its approved scope of project, therefore requiring HRSA’s approval to change its scope of project. If a change in scope of project is required, the

health center must consider applicable requirements, as described in Chapter 3, page 23, as well as the timeline to obtain HRSA approval.

What is a Health Center “Site” for Purposes of Scope of Project?

HRSA broadly defines a service site as “any location where a grantee... provides primary health care services to a defined service area or target population... as appropriate for providing health care services to the target population.”⁵ Health centers may provide services in locations operated directly by the health center, in contracted locations, or in other facilities as appropriate for their patients.

Health centers provide services, either directly or by contract or referral, at a variety of sites, including permanent, seasonal, mobile van, migrant voucher or intermittent.

If a location where services are provided to local correctional facility offenders satisfies the following four conditions, then the location should qualify as a “site” for purposes of scope of project.⁶

- Providers generate face-to-face encounters with patients.
- Providers exercise independent judgment in providing services.
- Services are provided directly by or on behalf of the health center – the health center board retains control and authority over the provision of the services at the location.
- Services are provided on a regularly scheduled basis.

What is a Health Center “Service” for Purposes of Scope of Project?

Health centers provide a broad array of services, including required primary care services as well as supplemental services, based on the identified needs in the community.⁷ Specifically, health center services include the following:

- All required primary and preventive services, including health services related to family medicine, internal medicine, pediatrics, obstetrics and gynecology, diagnostic laboratory and radiological services, and pharmaceutical services (as appropriate);
- Supplemental services including referrals to other providers;

- Case management services including eligibility assistance;
- Enabling services including outreach, transportation and translation;
- Education regarding the availability and proper use of health services; and
- Additional health services as appropriate.

Although it is not required that all the health center’s services are available at every site, offender patients must

have reasonable access to the full complement of services offered by the health center as a whole, either directly or through formal established arrangements.⁸ Furthermore, if a health center provides additional services initially targeted for its offender patients, the general patient population must also have reasonable access to such services. Given the potential challenges in operationalizing these requirements, both should be considered in planning and developing the health center-local correctional facility affiliation, prior to implementation.

How does a Health Center Change its Scope of Project?

Because the scope of project controls how the health center is permitted to utilize Section 330 grant funds and/or grant-related benefits, it is particularly important for health centers to define their respective scopes appropriately. In addition to the services, sites and providers that are furnished, operated or employed by the health center directly, health centers should include those elements provided under affiliation arrangements for which the health center maintains control.

Accordingly, if the health center changes its approved scope of project by adding services (e.g., adding behavioral health services to provide to its offender patients) or opening a new site (e.g., by assuming responsibility for a local correctional facility site), failure to secure HRSA’s prior approval for the change in scope could have serious consequences, including:

- No FTCA malpractice coverage for the employed or contracted health center practitioners providing the additional services, or for the health center itself vis-à-vis such services/sites.
- Allegations that the health center diverted Section 340B drugs by providing them to individuals who are not “health center patients.”

In order to obtain HRSA’s approval, the “change in scope” request must:⁹

- Document that no additional Section 330 funds are needed to support the provision of services at the new site.

- Not shift resources away from providing services to the current target population.
- Further the health center’s mission by increasing or maintaining access and improving or maintaining quality of care for the target population.
- Be fully consistent with Section 330 and the Health Center Program Expectations, including appropriate governing board representation for changes in service sites and populations served.
- Provide for appropriate credentialing/privileging of providers.
- Not eliminate or reduce access to a required service.
- Not result in the diminution of the health center’s total level or quality of health services currently provided to the target population.
- Demonstrate that the health center continues to serve a medically underserved area in whole or in part, or a medically underserved population.
- Demonstrate approval by the health center’s board of directors.
- Not significantly affect the current operation of another health center located in the same or adjacent service area.

For additional information, health centers should review PIN # 2008-01, *Defining Scope of Project and Policy for Requesting Changes*, which provides comprehensive guidance regarding the process for obtaining approval for a change in scope of project.

How does the Health Center Include Encounters on its Uniform Data System Report?

All federally-funded health centers are required to annually submit reports to the BPHC’s Uniform Data System (UDS), including data on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.¹⁰ The data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. The data also help to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations.

The reporting of patient data in the UDS system is based on “encounters.” Encounters are defined as “documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient.”¹¹ To be included as an encounter, services rendered must be documented in a chart in the possession of the health center.

■ To meet the criterion for “independent professional judgment,” the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the encounter and unique to that provider or other similarly or more intensively trained providers.¹²

■ To meet the criterion for “documentation,” the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record are not completed.

■ An encounter may take place in the health center or at any other site or location in which project-supported activities are carried out. Examples of other sites and

locations include mobile vans, hospitals, patients’ homes, schools, nursing homes, homeless shelters, and extended care facilities. Encounters also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the grantee for these services. A reporting entity may not count more than one inpatient encounter per patient per day.

■ Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions do not constitute encounters, regardless of the level or quantity of supportive services.

■ The encounter criteria are not met in the following circumstances:

1. When a provider participates in a community meeting or group session that is not designed to provide clinical services.
2. When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
3. When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
4. Services performed under the auspices of a WIC program or a WIC contract.

In general, it is important that health centers include data related to local correctional facility affiliations in their UDS reports. While not definitive on its own, including such information assists in demonstrating that the local correctional facility offenders are “health center patients” for purposes of FTCA coverage and Section 340B drug benefits. A health center that affiliates with a local correctional facility should also ensure that the services it provides to offenders satisfy the “encounter” definition so that the encounters can be reported in the center’s annual UDS report, regardless of where the encounters take place (i.e., in the health center facility or in a satellite site established in the local correctional facility).

Are there Governing Board Considerations?

A core component of the health center model is the community-based governing board. Section 330(k)(3)(H) states that applicants for FQHC designation must demonstrate that “... *the center has established a governing body which... is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center. . .*”

If offenders constitute a significant sub-population of a health center’s patient base as a result of the affiliation, the health center should ensure that the offender population is sufficiently represented on its governing board.

PIN # 98-12, *Implementation of the Section 330 Governance Requirements*, addresses board representation options for health centers that receive grants under Migrant Health, Health Care for the Homeless, and Health Services for Residents of Public Housing programs. While this policy does not directly apply to the offender population, it addresses relevant options to provide “special populations” a voice on the governing board

when it is inappropriate or impractical to actually provide members of such population with seats on the board. The suggestions include:

- Using a formal advisory board;
- Conducting regularly-constituted focus groups of individuals from the special population that advise the governance body on a routine basis; and/or
- Including on the board representatives of other provider organizations and/or local advocacy groups that have experience serving the special population.

If the health center desires to designate an offender representative board seat, this advocate should be familiar with the general needs of the offender population and should be able to assist the health center assess and respond to the health needs of its offender patients. For example, a health center could nominate a community social worker familiar with recidivism prevention, a family member of a confined offender, a correctional facility counselor, or a member of the correctional facility management team.

Who Owns the Medical Records?

Under the health center-local correctional facility affiliation models, the offenders’ medical records remain the jurisdiction’s property. Similar to other arrangements under which services are provided “off-site” (e.g., school based health centers, hospitalist arrangements), the off-site location (i.e., local correctional facility) maintains custody of the medical records while the health center maintains a paper or electronic “mirror” copy at its facility. The health center is prohibited from owning the medical records because the jurisdiction is, and must remain, ultimately responsible for the health care provided to its confined offenders.

Prior to affiliating, health centers and local correctional facilities must evaluate and identify the procedures and systems necessary to duplicate offender medical records. Medical record duplication may be particularly challenging if the offenders’ medical records are in an electronic format that is incompatible with the health center’s system.

As with other health center patients, the health center must document all offender patient encounters in the applicable offender’s medical record. In addition, the health center must ensure compliance with applicable patient confidentiality requirements.

Are there Other Legal Considerations?

There are additional legal issues that should be addressed in structuring health center-local correctional facility affiliation arrangements. The types of legal issues depend on the nature and complexity of the affiliation itself. In particular, health centers may need to review the following to ensure compliance with applicable laws, regulations and policies:

- Federal tax considerations (Internal Revenue Code)
- Federal fraud and abuse law (e.g., anti-kickback, false claims)
- Federal physician self-referral law (Stark)
- Federal Antitrust law
- Health Insurance Portability and Accountability Act

■ State laws and regulations, including state counterparts to federal laws, licensure, scope of practice (including supervision requirements for particular providers), insurance, etc.

We strongly caution health centers to seek the assistance of qualified legal counsel and other appropriate professional advisors when:

- developing and/or evaluating particular correctional facility affiliation options; and
- conducting due diligence reviews to ensure that the affiliation agreement complies with all applicable requirements.

References

1. Exceptions include, but are not limited to periodic hospital call conducted by health center health professionals, if required to obtain hospital privileges, and formal after hours coverage arrangements. See 42 C.F.R. §6.06(e); 60 Fed. Reg. 49417-18 (September 25, 1995).
2. Insofar as this manual does not address state law considerations, health centers should consult local counsel as to whether there are state law requirements regarding the definition of patient.
3. See 61 Fed. Reg. 55156 (October 24, 1996).
4. HRSA PIN # 2008-01, *Defining Scope of Project and Policy for Requesting Changes*, (December 31, 2007) p. 2; HRSA PIN # 2003-21; *Federally Qualified Health Center Look-Alike Guidelines and Application* (August 20, 2003).
5. PIN 08-01, p. 4.
6. Id. at p. 5.
7. For the complete list of required services, see Section 330 (b)(1)(A) of the Public Health Service Act.
8. PIN 08-01 p. 9.
9. Id. at pp. 21-22.
10. Instructions for completing the UDS is available online at <http://bphc.hrsa.gov/uds/2008manual/default.htm>.
11. *UDS Reporting Instructions for Section 330 Grantees*. DHHS, HRSA, BPHC, September 8, 2008.
12. Note that health centers should check their state independent practice/supervision rules to determine whether specific providers are licensed to act independently.

CHAPTER 4 *Health Center-Local Correctional Facility Affiliation Models*

This chapter describes several health center-local correctional facility affiliation models and the appropriate circumstances under which each model could be used. This chapter also describes certain considerations which apply to all models - financial considerations, key contract terms, and specific terms for purchasing clinical and/or administrative capacity.

The models are not designed to be “one site fits all,” but rather are overall approaches that can be tailored to a particular setting.

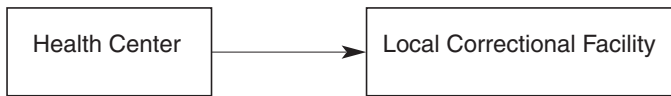
To ensure that services provided to offenders are not furnished in “isolation,” it is important that the health center and the local correctional facility consider, under all models, certain joint activities to facilitate the offenders’ integration into the health center’s health care delivery system. Example joint activities include:

- Designating the same clinicians to work in both the health center and the local correctional facility site.
- Ensuring that copies of the offender patients’ medical records are available at the health center’s sites, even if the local correctional facility maintains custody.
- Providing offenders with information regarding how to access the health center post-confinement.

This chapter addresses:

- *Local Correctional Facility Satellite Site Model*
- *Triage Model*
- *Existing Health Center Site Model*
- *New Health Center Site Model*
- *Considerations in Developing Your Model*
 1. *Negotiating Fees for Services and Assuring Sufficient Financial Resources*
 2. *Model Contract Terms*
 3. *Specific Terms if Purchasing Clinical/Administrative Capacity*

Local Correctional Facility Satellite Site Model



Under the Local Correctional Facility Satellite Site Model, health center clinicians directly provide services to offenders in the correctional facility's existing medical space, which becomes a satellite site of the health center.

Despite locating the clinic at the correctional facility, the clinical care must be provided on behalf, and under the control, of the health center. Furthermore, offenders who obtain services at the local correctional facility satellite site must be registered as health center patients for Section 330-related benefits to apply.

The Local Correctional Facility Satellite Site Model is ideal under the following circumstances:

- Individuals confined in the local correctional facility typically reside in the health center's community, or are part of the medically underserved population served by the health center.
- The local correctional facility has an existing medical clinic with the necessary space and medical equipment.
- The number of offenders at the local correctional facility is sufficiently large to warrant an on-site clinic.
- The local correctional facility clinic has qualified clinical employees and/or contractors (e.g., county physicians) who wish to continue providing care to offenders at the correctional site as employees or contractors to the health center (additional information regarding contracting for providers is included in Chapter 4, page 37).
- The health center is able to provide a full complement of services either directly at the local correctional facility satellite site or through other established arrangements in the community that are accessible to the offender population, and has sufficient resources to supplement on-site services through other arrangements.
- It is difficult to transport offenders outside of the local correctional facility due to transportation barriers and/or the level of security.

Key characteristics of the Local Correctional Facility Satellite Site Model include the following:

- Offender patients receive most (if not all) clinical services at the site located on the local correctional facility's grounds, and the local correctional facility clinic becomes a health center site.
- The health center's providers and administrative staff working at the local correctional facility satellite site are trained and oriented to the special issues of working in a correctional facility.
- The health center must obtain HRSA's approval to add the local correctional facility satellite site to its scope of project and may need to obtain approval if adding new services.
- Offender patients are registered as health center patients when seen at the satellite site.
- Offender patients have reasonable access to the full range of the health center's services either at the correctional facility site or through a combination of the correctional facility site and other accessible facilities (and/or through other established arrangements).
- The local correctional facility has authority to evaluate the health center's provision of services to the offender patients.
- Despite the health center's location at the local correctional facility, the medical care is provided in accordance with the health center's clinical policies and procedures, under the overall direction of the health center's board of directors, and under the daily direction of the health center's management team.
- Referral arrangements are established to provide offenders with health care services unavailable at the local correctional facility satellite site or through the health center's other sites (e.g., an offender is referred to an orthopedist- this may involve either the patient's transportation to the orthopedist, or the orthopedist's provision of services at the correctional facility satellite site); the specifics of the referral arrangement will vary based on the parties' specific negotiations.
- On-call services may be provided by the health center at the local correctional facility site or the patient may be transported to the emergency room by the local correc-

tional facility; the selected arrangement varies on whether the parties have executed a full risk or partial risk contract (i.e., the extent of the health center’s financial responsibility vis-à-vis the compliment of services).

- Ideally, providers who treat the offenders at the local correctional facility satellite site will follow their offender patients when hospitalization is required, and will continue as their providers post-confinement.

Benefits and Drawbacks

Benefits:

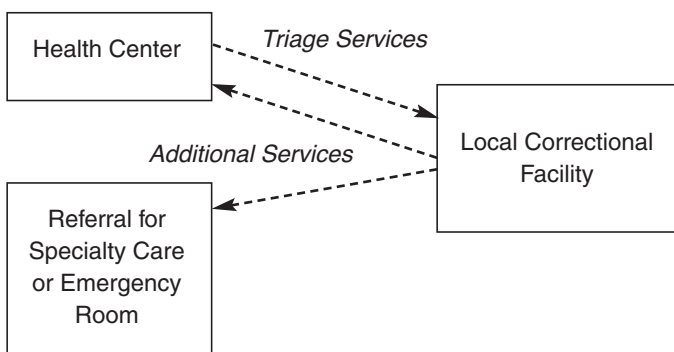
- Allows for offenders to be seen in the environment in which they live.
- Enables offenders to receive timely primary and preventive care services.
- May result in a higher degree of patient-centered care because the providers are more involved with the offenders’ daily care, and therefore have a greater understanding of their physical and mental needs.
- Promotes an integration of the clinical services and the vocational, educational and other rehabilitative support services available through the local correctional facility.
- Allows for scheduling flexibility and is not disruptive to patient scheduling at the other health center sites.

- Avoids public relations challenges and is easier to obtain acceptance and support within the community

Drawbacks:

- Presents an increased need to ensure that offenders who present at the local correctional facility satellite site are registered as health center patients.
- Does not directly familiarize the offender patient with the community-based health center sites.
- Is potentially difficult for offender patients to obtain reasonable access to the full range of the health center’s services located at other sites.
- The existing health center clinical and support staff may be opposed to providing services directly at the local correctional facility (e.g., requires additional transportation, safety concerns, etc.).
- May require the health center to obtain additional capacity (e.g., administrative staff, clinicians, etc.).
- Requires greater negotiation with the local correctional facility because services are provided on-site.
- Requires that the clinicians and administrative staff obtain training pertinent to working in a correctional setting.

Triage Model



Under the Triage Model, a health center triage employee (such as a nurse or an Emergency Medical Technician)¹ examines offenders and provides triage services at the local correctional facility site. If additional services are required, the offender is transported to the health center, a specialist or the hospital’s emergency room to receive such care.

The Triage Model is ideal under the following circumstances:

- Individuals confined in the local correctional facility typically reside in the health center’s community, or are part of the medically underserved population served by the health center.
- The local correctional facility is located within a reasonable distance to the community health center such that transportation to the health center site does not impose a barrier to care.
- The number of offenders at the local correctional facility is too small to warrant an on-site clinic.
- The health center has provider capacity qualified to provide triage services.

- The local correctional facility has established referral arrangements for specialty services.
- The health center has capacity to provide services for additional patients at its existing site.

Key characteristics of the Triage Model include the following:

- The triage employee assesses an offender's health status. Following the evaluation, the triage employee determines whether the problem is:
 1. a minor illness that can be treated by the triage employee;
 2. more serious, requiring further assessment at the health center's existing site;
 3. a medical need that requires referral to a specialist; or
 4. urgent, requiring immediate attention at the emergency room.
- The triage employee has a portable cart containing all necessary supplies and equipment and is trained and oriented to the special issues of working in a local correctional facility.
- The health center must obtain HRSA approval to add the local correctional facility satellite site to its approved scope of project and may need to obtain approval to add the triage services.
- Offender patients are registered as health center patients for, at a minimum, the triage services.
- Offender patients have reasonable access to the full range of the health center's services located at other accessible sites or through other established arrangements.
- The local correctional facility has authority to evaluate the health center's provision of services to the offender patients.
- Despite the location of the triage services in the local correctional facility, the medical care is provided in accordance with the health center's clinical policies and procedures, under the overall direction of the health center's board of directors, and under the daily direction of the health center's management team.
- The local correctional facility is responsible for transporting offenders to the health center site, and the offenders are accompanied by correctional staff; the correctional facility is also otherwise responsible for coordinating transportation to the emergency room or specialist.

- The health center may provide services to the offender population during regular clinic hours, or may designate certain days and hours to provide services solely to offender patients.

- On-call services may be provided by the health center triage employee at the local correctional facility site or the patient may be transported to the emergency room by the correctional facility; the selected arrangement varies on whether the parties have executed a full risk or partial risk contract (i.e., the extent of the health center's financial responsibility vis-à-vis compliment of services).

- Because limited services are provided at a new health center site, securing FTCA coverage under the Triage Model may be challenging; it is critical that the offender patient is registered as a health center patient regardless of whether or not he or she is actually triaged to a health center's existing site.

Benefits and Drawbacks

Benefits:

- Allows for offenders to be seen initially in the environment in which they live.
- Offenders' illnesses are detected early and treated promptly, resulting in prevention of more severe problems.
- Identifies offender patients that require immediate medical care.
- Allows for collaboration with the emergency room if emergent or specialty services outside the health center's scope are required.
- Reduces costs by avoiding unnecessary care and identifying the appropriate provider.

Drawbacks:

- Presents an increased need to ensure that offenders who present at the local correctional triage clinic are registered as health center patients.
- May not directly familiarize the offender patient with the community-based health center sites.
- May not adequately address the mental health needs of offenders because the triage employee may have limited expertise assessing mental health conditions.
- May disrupt a health center's current scheduling.
- May require the health center to obtain additional capacity (i.e., triage providers).

- May present administrative and billing challenges.
- Requires that the triage employees obtain training pertinent to working in a local correctional setting.
- May create safety concerns within the community, which has public relations implications.

- May create safety concerns within the health center – the health center would need to establish procedures to treat offender patients triaged to the center without endangering the safety of the health center’s staff and other patients.

Existing Health Center Site Model



Under the Existing Health Center Site Model, offenders are transported directly to an existing health center site outside of the local correctional facility to receive health center services.

The Existing Health Center Site Model is ideal under the following circumstances:

- Individuals confined in the local correctional facility typically reside in the health center’s community, or are part of the medically underserved population served by the health center.
- The local correctional facility does not have an existing medical clinic, or the medical clinic is insufficient to meet the offenders’ health care needs.
- The number of offenders at the local correctional facility is too small to warrant an on-site clinic.
- The local correctional facility is located within a reasonable distance to the community health center such that transportation to the health center site does not impose a barrier to care.
- Presence of the offenders at the existing health center site will not disrupt current patient scheduling.
- The health center has capacity to provide services for additional patients at its existing site.

Key characteristics of the Existing Health Center Site Model include the following:

- The health center would typically continue to perform and be responsible for the same scope of services that it currently delivers at its existing site(s); as such, the health center would not be required to obtain a change in its

approved scope of project, although it may be advisable to inform HRSA of the affiliation (however, if the affiliation expands such that there is a new service and/or a new site, the health center must obtain HRSA approval to change in its scope of project).

- Offender patients are registered as health center patients when they arrive at the health center.
- Offender patients have reasonable access to the full range of the health center’s services either at the existing site or through a combination of the existing site and other accessible facilities (and/or through other established arrangements).
- The local correctional facility has authority to evaluate the health center’s provision of services to the offender patients, but the health center retains all responsibility.
- The local correctional facility is responsible for transporting offenders to the existing health center site, and the offenders are accompanied by correctional staff.
- The health center may provide services to the offender population during regular clinic hours, or may designate certain days and hours to provide services solely to offender patients.
- The health center and the local correctional facility are able to arrange for appropriate on-call or after hours coverage for times when the health center’s existing site is closed.
- Ideally, providers who treat the offenders at the existing health center site will follow their offender patients when hospitalization is required and will be the offenders’ providers post-confinement.
- Because services under this model are provided at an existing health center site, there is a reduced concern that FTCA coverage would fail to cover services provided to offender patients; nevertheless, it is critical that offenders are registered as health center patients prior to providing services.

Benefits and Drawbacks

Benefits:

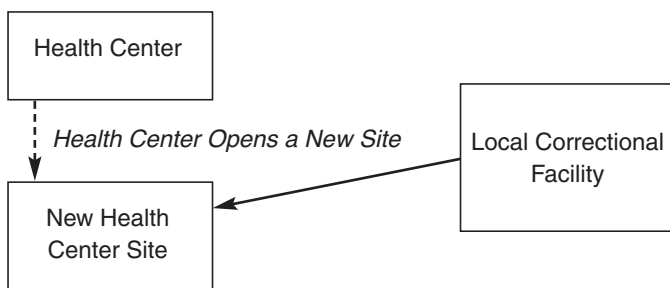
- Promotes the medical home concept, continuity of care and the integration of offenders back into the community.
- Health center does not need to obtain a change in scope from HRSA to add a new site (but may need to obtain a change in scope if adding new services).
- Increases offenders' access to the full range of services in the health center's scope of project.
- May increase existing patient population's access to services that are initially targeted to the offender patient population but are available to all patients (e.g., behavioral health services).

Drawbacks:

- Creates a delay in care.

- May disrupt a health center's current scheduling.
- May require the health center to obtain additional capacity (e.g., administrative staff, clinicians, etc.).
- May require facility renovation (i.e., separate doors and waiting rooms).
- May create safety concerns within the community, which has public relations implications.
- May create safety concerns within the health center – the health center would need to establish procedures to treat offender patients without endangering the safety of the health center's staff and other patients.
- Lack of presence at the local correctional facility hinders the health center providers' ability to become involved with the offenders' daily care.
- Isolation from the local correctional facility may make it more difficult to collaborate with the programs available at the correctional facility (e.g., substance abuse counseling).

New Health Center Site Model



Under the New Health Center Site Model, offenders are transported directly to a new health center site outside of the local correctional facility to receive health center services. The new health center site may be a permanent facility or a mobile van. Mobile van sites can be transported within close proximity to the local correctional facility. As an analogy, the use of mobile van sites for local correctional facilities is similar to the use of mobile van sites for migrant populations.

The new health center site could target the offender sub-population, but would be available and reasonably accessible to any existing health center patient or to any individual in the new site's "community" requiring services.

Establishing a new health center site can be costly. If adding the new site through a change in scope process, to obtain HRSA approval, the health center must demonstrate that operating the new site will not require additional Section 330 funds (among other things), as described in Chapter 3, page 23.

Health centers may wish to explore whether New Access Point funding opportunities are available to support the establishment of the new site. If such funding is unavailable, the health center must consider whether it has sufficient resources to pay for the anticipated costs of adding the site.

The New Health Center Site Model is ideal under the following circumstances:

- Individuals confined in the local correctional facility typically reside in the health center's community, or are part of the medically underserved population served by the health center.
- The local correctional facility does not have an existing medical clinic, or the medical clinic is insufficient to meet the offenders' health care needs.

- The number of offenders at the local correctional facility is too small to warrant an on-site clinic.
- The local correctional facility is located within a reasonable distance to the new health center site such that transportation does not impose a barrier to care.
- Presence of the offenders at the existing health center sites would disrupt current patient scheduling.
- The health center does not have the physical space to provide services for additional patients at its existing site.
- The health center has sufficient capacity to staff an additional site.

Key Characteristics

- The health center must obtain HRSA's approval to add the new health center site to its scope of project and may need to obtain approval if adding new services.
- Offender patients are registered as health center patients when they arrive at the new site.
- Offender patients have reasonable access to the full range of the health center's services either at the health center site or through a combination of the health center site and at other accessible health center and non-health center facilities (and/or through other established arrangements).
- The local correctional facility has authority to evaluate the health center's provision of services to the offender patients, but the health center retains all responsibility.
- The local correctional facility is responsible for transporting offenders to the new health center site, and the offenders are accompanied by correctional staff.
- The health center may provide services at the new health center site solely to the offender population, or it may provide services to the entire patient population and either designate certain days and hours to furnish services solely to offender patients or treat the offender population during regular clinic hours.
- The health center and the local correctional facility are able to arrange for appropriate on-call or after hours coverage for times when the health center's sites are closed.
- Ideally, providers who treat the offenders at the new health center site will follow their offender patients when hospitalization is required and will be the offenders' providers post-confinement.
- Because services under this model are provided at a new health center site that will be added to the health center's approved scope of project (and, thus, is not

owned or operated by the local correctional facility), there is a reduced concern that FTCA coverage would fail to cover services provided to offender patients; nevertheless, it is critical that the new site is included in the health center's scope of project and the offenders are registered as health center patients prior to providing services.

Benefits and Drawbacks

Benefits:

- Promotes the medical home concept, continuity of care and the integration of offenders back into the community.
- Is not disruptive to patient scheduling at the other health center sites.
- Increases offenders' access to the full range of services in the health center's scope of project.
- May increase existing patient population's access to services that are initially targeted to the offender patient population but also provided to all patients (e.g., behavioral health services).

Drawbacks:

- Creates a delay in care.
- Health center clinical and support staff may be opposed to providing services directly at the new health center facility (e.g., requires additional transportation).
- Will likely require the health center to obtain additional capacity to staff the new site (e.g., administrative staff, clinicians, etc.)
- May require health center to purchase, build and/or renovate a facility.
- May create safety concerns within the community, which has public relations implications.
- May create safety concerns within the health center – the health center would need to establish procedures to treat offender patients at the new health center site without endangering the safety of the health center's staff and other patients.
- Lack of presence at the local correctional facility hinders the health center providers' ability to become involved with the offenders' daily care.
- Isolation from the local correctional facility may make it more difficult to collaborate with the programs available at the correctional facility (e.g., substance abuse counseling).

Considerations in Developing Your Model

Negotiating Fees for Services and Assuring Sufficient Financial Resources

Under each health center-local correctional facility model, the local correctional facility (via the city or county) pays the health center a fair fee based on arm's length negotiation for services rendered by health center's staff. This negotiated fee may be based on a:

- Current Procedural Technology (CPT) code;
- Per hour rate;
- Per visit rate; and/or an
- Aggregate amount that does or does not include various risk sharing arrangements for services provided outside of the local correctional facility.

Inapplicability of the Sliding Fee Scale

Section 330 requires health centers to *"have prepared a...schedule of discounts adjusted on the basis of the patient's ability to pay."*² This sliding fee scale is used to determine fees for patients that are underinsured or uninsured and pay the health center's charges "out-of-pocket." The discount on the fee varies based on the patient's income level. The sliding fee is not applied when a patient is privately or publicly insured.

Under the health center-local correctional facility affiliation models, the jurisdiction is the third party payor for the health center's services; technically, the offender patients are neither underinsured nor uninsured. The health center does not bill or otherwise retain payment from the patient or from a third party payor (including Medicaid and Medicare).³ Consequently, the sliding fee discount requirement is inapplicable for offender patients, and the health center need not conduct patient income verification to identify ability to pay.

Patient Fee Considerations

If the local correctional facility charges patients a fee for health services, as described in Chapter 2, page 14, it is critical that all cost-sharing amounts are retained by the local correctional facility and are not off-set against the payment to the health center. In this regard, the local correctional facility must not deduct the amount of the co-pays from the health center's rate. Ideally, a local correctional facility employee, as opposed to a health

center employee, is responsible for collecting patient fees from offenders' designated personal accounts or upon discharge.

Assuring Sufficient Financial Resources

In calculating the appropriate rate, it is critical that the health center document that the health center-local correctional facility affiliation will not require additional Section 330 funds. This breakeven budget is a requirement to obtain HRSA approval to change a health center's scope of project.

Model Contract Terms

Health centers must memorialize the local correctional facility affiliation through a formal written agreement.

In the affiliation agreement, each party agrees to provide certain identified services (i.e., specific health care services, space, equipment, payment) and to comply with specific requirements and limitations. This written agreement is critical to demonstrate compliance with various federal (and often state) laws and guidance, and is frequently necessary to obtain HRSA's approval for a change in scope of project. Informal "handshake" agreements are insufficient.

There are several key contractual terms applicable to all health center-local correctional facility affiliation models, including:

- Individuals served are health center patients and the health center retains financial and legal responsibility for services provided by health center providers; however, the local correctional facility maintains responsibility for meeting the standard of care required under the Constitution which defines health care to prisoners as a right rather than a privilege.
- The local correctional facility and health center collectively define the standards of care and establish the clinical protocols. (Note: If the parties are unable to agree upon standards of care that meet the minimum quality requirements of the health center, the parties should not execute the affiliation.)
- The scope of the contracted services will not exceed the health center's current or potential ability to provide services, taking into consideration all resources available to the health center to assist in providing such services.

- The health center agrees to be responsible for services it directly provides or for which it arranges provision.
- Offenders are treated similar to all other health center patients regarding standards of care, clinical policies and protocols, and quality assurance protocols.
- The local correctional facility has authority to evaluate the clinical services provided to the offender patients, but the services provided are under direct control and supervision of health center governing board and management staff.
- The assigned health center employees and contractors must conform to the local correctional facility's security standards; the jurisdiction can terminate the right of a health center employee or contractor to be within the correctional facility or to otherwise serve offender patients at other sites if the jurisdiction is dissatisfied with the performance of a clinician or if the provider presents a safety and/or security hazard.
- The health center retains sole right to hire, evaluate and terminate employment of health center clinicians assigned to care for the offender patients.
- The health center cannot terminate an offender patient. However, the health center has the right to assure the safety and security of its employees and patients by requiring additional correctional officers upon a safety and/or security threat.
- The health center directly provides or is able to make arrangements for after hours-coverage (whether the health center is financially responsible for payment associated with such services will depend on the negotiated agreement).
- The local correctional facility would own and maintain physical custody of all related offender patient records; the health center would be provided a mirror copy of all related patient records.
- The health center charges a negotiated and all inclusive rate to the payor (i.e., jurisdiction, county, municipality or correctional facility) and will not bill any offender patient or third party payor.
- The local correctional facility is solely responsible for the charging of services rendered to offender patients, if applicable.
- The health center clinicians retain independent professional judgment in providing all services (including initial health assessments and intake).
- The health center is responsible for securing FTCA coverage in lieu of purchasing malpractice insurance for

itself and its employed clinicians. The agreement should describe the parties' additional insurance obligations.

- The health center agrees to assist the local correctional facility in responding to patient grievances related to the health center's services.
- The parties agree to a particular dispute resolution and/or mediation process should conflicts occur.
- The term of the agreement as well as appropriate termination clauses, including termination for material breach (with a reasonable right to cure) and immediate termination for other specified causes (such as significant security concerns) are defined in the agreement. The parties should determine whether to allow the ability to terminate without cause.
- The health center and local correctional facility are obligated to maintain the confidentiality of patient records and other confidential/proprietary information related to the parties.

Terms specific to the Local Correctional Facility Satellite Site Model include:

- The local correctional facility provides the health center with adequate space, equipment, supplies and, as necessary and agreed upon, support staff to perform contracted services.
- The agreement includes provisions that ensure FTCA coverage for clinicians (i.e., must be in the health center's scope of project and in the clinicians' employment description).
- The local correctional facility must provide general liability insurance.
- The agreement must include requirements to ensure the safety of the health center staff.
- The agreement specifies training requirements for health center staff working at the correctional facility satellite site.
- The agreement includes provisions specifying when and by whom offenders will be registered as health center patients.

Terms specific to the Triage Model include:

- The local correctional facility provides the health center with adequate space, equipment, supplies and, as necessary and agreed upon, support staff to perform contracted services.

- The correctional facility is responsible for transporting patients to the health center site and for staying with the patients until services are completed.
- The agreement includes protocols to ensure safety of the health center staff and the other patients.
- The agreement includes provisions specifying how and by whom offenders will be registered as health center patients.

Terms specific to the Existing Health Center Site Model and the New Health Center Site Model include:

- The correctional facility is responsible for transporting patients to the health center site and for staying with the patients until services are completed.
- The agreement includes protocols to ensure safety of the health center staff and the other patients.

Specific Terms if Purchasing Clinical/Administration Capacity

Health center-local correctional facility affiliations may require additional clinical capacity beyond that provided directly by the health center, particularly if services are provided at a new site and/or if the health center's patient base significantly increases.

Given the challenges surrounding provider recruitment and retention, health centers may decide to contract for the purchase of clinical capacity. These contractual arrangements are particularly appropriate, and frequently necessary, if the local correctional facility has an existing health clinic with qualified providers. Contracted clinical personnel may include:

- Individuals employed by, or contracted to, the local correctional facility.
- Individuals from the community who work in private practice.
- County or state clinicians.

When entering into agreements under which the health center purchases additional capacity from another entity to supplement the services provided by the center directly, health centers should consider the following:

- HRSA prefers that health centers directly employ the majority of their primary care clinicians (from an organizational, rather than site-by-site perspective). Whenever

a health center considers purchasing some level of clinical service capacity, it should first consider whether it is more beneficial for it to contract for services rather than to perform such services directly (e.g., if the work cannot be performed directly on a more efficient basis).

- If a health center can demonstrate that a purchase/lease arrangement for the majority of primary care clinicians will result in programmatic benefit and that the health center will maintain accountability for the services provided through the contracted provider(s), HRSA may approve an exception to its direct staffing preference.⁴

In order to promote offenders' access to care through the health center after release, it is critical that the contracted providers are familiar with, and supportive of, the health center and the medical home concept of care. The correctional services cannot be provided in isolation, but rather must be linked to the greater health center system.

FTCA Considerations

For clinical capacity purchase arrangements to be eligible for FTCA coverage, the agreement must, at a minimum, be directly between the health center and the individual health professional providing services to the health center's offender patients. An agreement between the health center and another entity organization (i.e., the local correctional facility or county) will not extend FTCA coverage to the individual health professional who is an employee of that entity.

Lease of Clinical Personnel Contract Terms

If the health center purchases clinical capacity currently contracted to the correctional institution (or to another entity), the following terms should be included in the purchase of clinical capacity agreement regardless of what affiliation model is implemented. While these terms provide a general overview of key provisions, the specifics of each contract will vary based on the particular affiliation arrangement.

The contracted staff will:

- Provide clinical services to correctional patients on behalf of the health center.
- Provide services consistent with the health center's Section 330 grant (or FQHC project requirements) and applicable health care and personnel policies, procedures, standards and protocols, and under the direction of the health center's management team.

- Satisfy the health center's licensure, credentialing and other professional qualifications requirements.
- Develop, maintain and furnish programmatic reports and records, as required by the health center.
- Comply with the local correctional facility's applicable policies and procedures.

The health center will:

- Maintain responsibility and authority for approving, monitoring, evaluating, and, as necessary, suspending or removing contracted personnel from providing services to the offender patients, based either on the health center's own determinations or upon request of the jurisdiction.

- Pay a fair fee based on arm's length negotiation for services rendered by contracted staff.
- Arrange for the provision of orientation and training by the local correctional facility.

The local correctional facility will:

- Have the right to require the health center to remove any contracted clinician from providing services to its confined offenders based on agreed upon provisions (i.e., provider fails to follow the correctional facility's safety policies and/or procedures, provider is not appropriately licensed or credentialed, etc.).
- Provide the contracted clinician with orientation and training on applicable correctional facility operations, policies and procedures.

References

1. States vary regarding the requisite qualifications necessary to provide triage services. Consult your state's applicable licensing board for guidance.
2. See 42 CFR 51c.303(f).
3. Also note that the health center cannot use Section 330 funds to support the provision of care at the local correctional facility.
4. The policy and process by which a health center can request and obtain an exception to direct employment preferences is ad-

ressed in HRSA PIN # 98-24, "Amendment to PIN # 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers," (August 17, 1998). The health center is not required to obtain a formal exception to the direct staffing model if it purchases or leases less than a majority of its primary care clinicians; nevertheless, the health center must maintain accountability for the services provided by purchased/leased clinicians.

CHAPTER 5 *Building the Bridge: Assuring Continuous Access to Care After Confinement*

Health centers can take simple steps to ensure that access to quality care at its sites continues following the offender's release back into the community. This is particularly critical for offenders with serious chronic medical conditions.

Health centers can:

- Provide information to assist offenders to locate and access the health center's sites and other community safety net providers after their release.
- Consider providing transportation services if the location of the health center sites appears to present a barrier to access.
- Schedule appointments at the health center for patients post-confinement.
- Educate offenders on the prevention of chronic diseases, including HIV and hepatitis.
- Educate offenders with chronic disease regarding disease management/self-care.
- Start the application process for Medicaid thirty days before release to avoid delays in securing health benefits; these benefits are needed for access to health care services once in the community, as applicants are not entitled to government funding while in the correctional facility.
- Collaborate with other community safety net providers.
- Address non-medical discharge needs, when applicable and in accordance with existing re-entry planning, if any, including transitional housing, vocational training or placement, family reintegration and financial assistance including Social Security and Medicaid.
- Assure that offenders on medication regimen leave the correctional facility with necessary drugs and prescription refills to the level allowed by the jurisdiction to minimize missed doses until their first post-incarceration health care appointment at the health center.

CHAPTER 6 *Conclusion and Next Steps*

While forming a health center- local correctional facility affiliation can involve complex legal issues and limitations, experience has demonstrated that the benefits may be well worth the effort.

As an initial step, the health center should

- clearly define its goals and objectives for entering into a collaboration;
- determine whether the health center and local correctional facility organizational structures and staffing can accommodate the intended provision of health services to offenders;
- evaluate whether the clinical cultures of the health center and local correctional facility are compatible;
- ensure that the affiliation is financially feasible and beneficial;
- carefully consider and determine the appropriate affiliation model by which to achieve these goals and objectives; and
- secure community support and leadership to implement the partnership.

To ensure that all issues and considerations are carefully planned and executed, the health center, in collaboration with the local correctional facility, should engage in a deliberate, step-by-step approach to planning, negotiating and establishing the chosen affiliation approach. Finally, the health center must consider all legal and policy requirements and ramifications related to establishing the affiliation, to ensure not only smooth implementation, but also a successful future.

APPENDIX *Useful Resources*

Community Oriented Correctional Health Services (COCHS) is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community, located at <http://www.cochs.org>.

National Association of Community Health Centers (NACHC) is the trade association for health centers nationwide and is dedicated exclusively to expanding health care access for America's medically underserved populations through the community-based health center model, located at <http://www.nachc.com>.

Organizations

- American Correctional Association: Healthcare Professional Interest Section, Health Care Certification Program, located at <http://www.aca.org/certification>.
- American Correctional Health Services Association, located at <http://www.achsa.org/index.cfm>.
- Centers for Disease Control and Prevention, Correctional Health, located at <http://www.cdc.gov/correctionalhealth>.
- National Commission on Correctional Health Care, located at <http://www.ncchc.org>.
- Reentry Policy Council, located at <http://www.reentrypolicy.org>.
- United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, located at <http://www.ojp.usdoj.gov/bjs/>.
- United States National Institute of Corrections, located at <http://www.nicic.org>.

Manuals, Guidance and Reports

- Jails and Community-Based Health Care, Robert Wood Johnson Foundation (September 2008), available at <http://www.rwjf.org>.
- Sourcebook of Criminal Justice Statistics, Bureau of Justice Statistics, available at <http://www.albany.edu/sourcebook>.
- One in 100: Behind Bars in America 2008, The Pew Center on the States (February 2008), available at <http://www.pewcenteronthestates.org>.
- A Public Health Model for Correctional Health: A Guide for Correctional Facilities to put Public Health Services into Practice, produced by the Hampden County Sheriff's Department and the Massachusetts Public Health Association (October 2002), available at <http://www.mphaweb.org>.
- Life After Lockup: Improving Reentry from Jail to the Community, Urban Institute (May 2008), located at <http://www.urban.org>.