Contracting for Health Care Services in Local Jails and Juvenile Detention Facilities: Achieving a Community-Based Standard of Care

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

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Acknowledgements/Disclaimer

Contracting for Health Care Services in Local Jails and Juvenile Detention Facilities: Achieving a Community-Based Standard of Care reviews the legal basis for incarcerated individuals' right to health care, and describes how the process of procuring health care in a corrections facility can be used to establish an effective correctional health care delivery system with a community-based standard of care. The guide further illustrates how community health centers are often logical partners to provide medical and mental health care services to the incarcerated population.

This guide was prepared for Community Oriented Correctional Health Services (COCHS) by attorneys with the law firm of Feldesman Tucker Leifer Fidell LLP. It is designed to provide accurate and authoritative information in regard to the subject matter covered. While incorporating certain principles of federal law, this guide is published with the understanding that it does not constitute, and is not a substitute for, legal, financial or other professional advice. Further, this guide 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. Readers should consult knowledgeable consultants and legal counsel to implement a correctional health care delivery system appropriate for their situations.

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.

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CHAPTER 1 *Introduction*

Since the establishment of incarcerated individuals' right to medical care in the 1976 Supreme Court case of *Estelle v. Gamble,* jails and juvenile detention facilities have come under increasing scrutiny.[1] Newspaper articles frequently highlight stories of inadequate treatment, costly settlements, corruption, and general mismanagement of jail and juvenile detention health care programs. The federal government is also increasingly involved in monitoring the provision of health care in jail and juvenile detention facilities.

Many jails and juvenile detention facilities (collectively referred to as "correctional facilities" that engage in "corrections" activities) do not fully understand their responsibilities related to health care. Strained resources, isolation from community providers, and lack of familiarity with clinical care contribute to the disconnect between corrections and the health care system. In addition, the culture of health care, which emphasizes empathy, healing, and prevention, is often in conflict with the culture of corrections, which emphasizes command, accountability, and control.

Although these two cultures appear disparate, there can be significant synergy between them, particularly if the health care system can successfully contribute to the responsibilities of corrections by reducing chronic disease, preventing the spread of communicable disease, managing mental illness, and improving the overall health status of the incarcerated population. This effort improves the working conditions for corrections staff, who, in turn, maintain safety for the health care staff working in the corrections environment.

Increasingly, correctional facilities are contracting with outside entities to provide health services. Although contracting can be an effective means to coordinate care, it does not shield state and local governments from accountability to provide health care that satisfies incarcerated individuals' rights under the Eighth Amendment of the United States Constitution, which prohibits cruel and unusual punishment.[2] Private contractors to state and local governments who provide health services to incarcerated individuals are often acting on behalf of the government for purposes of the Eighth Amendment.[3] In other words, the governments that hire the private contractors to provide health services remain liable for failing to provide constitutionally adequate care.[4]

The purpose of this guide is to provide the reader with information about the evolution of incarcerated individuals' right to health care, current trends in monitoring and enforcement, and considerations relevant to the procurement of health services.

For purposes of this guide, the term "correctional facility" refers specifically to those jails and juvenile detention centers operated by counties or municipal authorities where offenders primarily reside in the surrounding community. The term "correctional facility" – as used throughout this guide – does not refer to state-operated prisons.

For purposes of this guide, the term "incarcerated individuals" refers to both children and adults detained in a correctional facility, as well as pre-trial detainees.

References

1. *Estelle v. Gamble,* 429 U.S. 97 (1976).
2. *West v. Atkins,* 487 U.S. 42 (1988).
3. *West v. Atkins,* 487 U.S. 42 (1988).
4. Rold, William J. *30 Years After Estelle v. Gamble: A Legal Retrospective,* National Commission on Correctional Health Care, CorrectCare, Summer 2006. Referring to West v. Atkins, 487 U.S. 42 (1988).

CHAPTER 2 *Legal Framework: The Right to Medical and Mental Health Care*

Prior to the 1970s, incarcerated individuals typically received substandard medical care, often provided by untrained individuals. Only the most egregious examples of neglect were considered impermissible.

The last forty years have seen a remarkable expansion in the provision of health care to incarcerated individuals. Case law has helped define incarcerated individuals' rights, and legislative measures have empowered the Department of Justice with authority to evaluate correctional health care systems in order to enforce these rights.

This chapter addresses:

- ***Correctional Health Care: A Historical Perspective***
- ***Civil Rights of Institutionalized Persons Act (CRIPA)***

Correctional Health Care: A Historical Perspective

Establishing Incarcerated Individuals' Right to Medical Care: Estelle v. Gamble and Farmer v. Brennan

In the 1976 Supreme Court case of *Estelle v. Gamble,* an inmate, J.W. Gamble, brought a civil rights action against the chief prison doctor, the warden and the director of the state department of corrections, claiming that he was subjected to cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution for inadequate treatment of a back injury that occurred during prison work.[1] Although the Supreme Court did not rule in Gamble's favor, it nevertheless concluded that because incarcerated individuals are denied their liberty by virtue of their incarceration, it is unconstitutional to deny them medically necessary care. The court established the standard of "deliberate indifference to serious illness or injury" to define the Eighth Amendment obligation to provide health care to incarcerated individuals.[2]

"Deliberate indifference" involves both an objective and a subjective component. The objective component is met if the deprivation is "sufficiently serious"[3] and may be inferred when a prison "knows of and disregards an excessive risk of inmate health."[4]

In the 1994 case of *Farmer v. Brennan*, the Supreme Court further held that, under the Eighth Amendment, prison officials are required to ensure that detainees receive "adequate" medical and mental health care.[5]

This right to adequate medical care is not limited to incarcerated adults. The Supreme Court has held that the pre-trial detainees "retain at least those constitutional rights... enjoyed by convicted prisoners,"[6] and that confined juveniles also must receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures.[7]

Evolving Standard of Care

Since *Farmer v. Brennan,* no single federal court decision has described the specific services that must be provided to incarcerated individuals. Rather, federal courts have varied in their interpretation as to what qualifies as "adequate" medical care. Consequently, the rulings do not define a uniform standard of health care under which services must be provided to incarcerated individuals.

Despite this ambiguity, there are emerging trends among the courts. Specifically, several lower courts have held that in order to withstand an Eighth Amendment challenge, correctional medical treatment must be "at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards."[8]

Continuity of Care

It is important to note that the obligation to provide medical care to incarcerated individuals does not necessarily terminate at discharge. Rather, several courts have established that, under certain circumstances, correctional facilities are obligated to provide and pay for incarcerated individuals' medical care after discharge, in accordance with the medical staff's directives.

For example, in *Wakefield v. Thompson* the court held that an inmate's constitutional rights were violated when a correctional officer refused to provide the inmate with a two week prescription of psychotropic medication upon his release from prison, even though it was ordered by medical staff to continue treatment to control his delusions. The court held that "the state has a responsibility under the Eighth Amendment to provide outgoing prisoners being treated for a medical condition with a sufficient supply of medication to cover their transition to the outside world."[9]

The requirement for post-release treatment is consistent with the standard of care applicable to all physicians. For example, the American Medical Association code of ethics states that "the patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care."[10]

The requirement for post-release treatment is also consistent with the concept of prohibiting "patient abandonment." Patient abandonment (which is effectively a claim of malpractice/negligence) is a complex concept. Abandonment claims usually arise when a patient believes that he/she suffered injury due to the failure of a provider to continue to perform his/her professional duty. To prove a legal claim of abandonment, a plaintiff patient must demonstrate that the relationship was terminated at a critical stage in the patient' s treatment without good

Making the Case for Post-Release Treatment

In February 2009, the *Journal of the American Medical Association* published the results of a study of HIV-infected inmates released from the Texas Department of Criminal Justice prison system. The study found that only 5% of parolees filled their prescriptions for antiretroviral therapy (ART) soon enough to avoid interrupting their treatment. The report stated that because "the majority of former inmates are without private or public health insurance for the first several months after release, accessing ART in a timely fashion represents a formidable challenge. Unfortunately, these treatment barriers occur precisely at a time when judicious continuation of ART is most critical. In the weeks following release from prison, former inmates are particularly vulnerable to resuming sexual and substance abuse–related behaviors with new and former contacts. Those who discontinue ART at this time are at increased risk of developing a higher viral burden, resulting in greater infectiousness and higher levels of drug resistance, potentially creating reservoirs of drug-resistant HIV in the general community."[13]

cause or reasonable notice sufficient to enable the patient to find another provider, and that the patient was, in fact, injured as a result.[11]

Continuity of care in the context of juvenile detention is also being addressed through legislation. For example, California passed legislation that requires Medi-Cal, the state's Medicaid program, not to terminate eligibility for child beneficiaries if they become incarcerated in a juvenile detention facility.[12] The legislation is premised on the belief that maintaining youths' eligibility for Medi-Cal while they are incarcerated preserves continuity of care for youths and reduces the time and effort spent on re-application for Medi-Cal upon release.

The Eighth Amendment and Contracted Providers

It is important to note that states and counties cannot delegate their obligation under the Eighth Amendment and state law to provide adequate medical care to those individuals they have incarcerated.

This principle was established in the Supreme Court case of West v. Atkins, in which an incarcerated individual alleged that a private physician, under contract with North Carolina to provide orthopedic services at a state prison, provided inadequate medical treatment.[14] The incarcerated individual sued the physician in federal district court for violation of his Eighth Amendment rights. The court held that the contracted physicians who provide medical services to inmates are acting on behalf of the government (i.e, are acting as "state actors") for purposes of the Eight Amendment. The court further held that governments that hire physicians to provide medical services remain liable for failing to provide constitutionally adequate care.[15]

Civil Rights of Institutionalized Persons Act (CRIPA)

CRIPA Introduction and Overview

Case law largely shapes incarcerated individuals' right to health care. Nevertheless, a current compelling impetus to improving health care in corrections is the federal government's investigations and enforcement efforts, which are authorized under the Civil Rights of Institutionalized Persons Act (CRIPA).[16]

Through CRIPA, the U.S. Attorney General has authority to investigate conditions in public residential facilities, including jails and juvenile detention facilities, and take appropriate action if a pattern or practice of unlawful conditions deprives persons confined in the facilities of their constitutional rights. The actions taken may include enforcing court orders and/or instituting a civil action against a correctional facility for equitable relief to ensure the implementation of the minimum corrective measures necessary to protect the incarcerated individuals' constitutional rights.[17] The Attorney General has delegated day-to-day responsibility for CRIPA activities to the Civil Rights Division within the Department of Justice (DOJ).

From January 20, 2001, through September 30, 2008, the DOJ opened 94 CRIPA investigations, issued 71 findings letters, filed 32 cases, and obtained 69 substantial agreements.[18] Many of these investigations and findings letters allege that correctional facilities did not protect incarcerated individuals from serious harm and/or undue risk of serious harm by failing to provide adequate medical and mental health care, in violation of Farmer v. Brennan.

Under the Prison Litigation Reform Act (PLRA), prisoners confined in a jail, prison, or other correctional facility are prohibited from bringing an action with respect to prison conditions under the Civil Rights Act or any other Federal law until administrative remedies that are available have been exhausted.[19]

In a 2008 report, the Civil Rights Division indicated that it has prioritized vigorously enforcing the laws of institutionalized persons, which includes the right to medical care.[20]

Generally Accepted Professional Standards of Care: Assessing the Adequacy of Medical and Mental Health Services

During CRIPA investigations, the DOJ evaluates a correctional facility's health care system to determine whether services are constitutionally sufficient or deficient.

The investigations often focus on the adequacy of:

- intake screening;
- acute care;
- chronic care;
- specialty care;
- dental care;
- treatment and management of communicable disease;
- access to health care;
- follow-up care;
- record keeping; and
- medication administration.

According to CRIPA investigative reports, a service is constitutionally deficient if it fails to satisfy "generally accepted professional standards of care," further defined as a "decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment."[21]

CRIPA investigations also take note of clinical staffing in correctional facilities – in particular, that correctional facilities should maintain a sufficient number of clinical staff to provide medical and mental health services, and that all persons providing medical or mental health care must meet applicable licensure and/or certification requirements.[22]

Investigations have also found that correctional facilities should:

- maintain medical records that satisfy professional standards;
- develop and implement quality assurance programs adequate to identify and correct serious deficiencies in medical and mental health care; and
- implement systems and practices, such as adequate record-keeping and follow-up exams, to manage the serious medical conditions of detainees during the length of their incarceration.

CRIPA investigative findings letters often highlight actual incidents that reflect inadequate care. Exhibit A of this manual includes several such incidents.

CRIPA Court Orders

One of the results of a CRIPA investigation may be the imposition of court orders requiring correctional facilities to significantly change the way in which they provide medical and mental health services. These modifications may be costly and could result in negative publicity.

As an example, in 2007 the United States District Court for the Northern District of Texas entered into an agreed order with Dallas County and the Dallas County Sherriff after determining that certain conditions at the Dallas County Jail violated the constitutional rights of incarcerated individuals.[23] The agreed order included several requirements pertaining to the provision of health care at the Dallas County Jail, including, but not limited to the following:

- implementing and complying with policies to provide adequate medical and mental health intake screening to all incarcerated individuals;

- providing adequate and timely acute care for incarcerated individuals with serious and life-threatening conditions, and assurances that such care adequately addresses the serious medical needs of incarcerated individuals;

- adopting and implementing a system to track incarcerated individuals with serious and/or chronic illnesses, including mental illnesses, to ensure that these incarcerated individuals receive necessary diagnosis, monitoring and treatment;

- implementing and refining its communicable disease testing, monitoring, and treatment programs;

- ensuring that incarcerated individuals have adequate access to appropriate health care;

- ensuring that treatment and administration of medication to incarcerated individuals is implemented in accordance with generally accepted professional standards of care; and

- developing and implementing quality assurance programs adequate to identify and correct serious deficiencies in medical care and mental health care.

References

1. *Estelle v. Gamble,* 429 U.S. 97, 101-02 (1976).
2. *Estelle v. Gamble,* 429 U.S. 97, 104 (1976).
3. *Farmer v. Brennan,* 511 U.S. 825, 834 (1994).
4. *Farmer v. Brennan,* 511 U.S. 825, 837 (1994).
5. *Farmer v. Brennan,* 511 U.S. 825, 832 (1994).
6. *Bell v. Wolfish,* 441 U.S. 520, 545 (1979) (citations omitted).
7. Youngberg v. Romeo, 457 U.S. 307, 323-24 (1982).
8. Fernandez v. United States, 941 F.2d 1488,1493-94 (11th Cir. 1991) (quoting United States v. DeCologero, 821 F.2d 39, 43 (1st Cir. 1987)); Tillery v. Owens, 719 F. Supp. 1256, 1305 (W.D. Pa. 1989), aff'd, 907 F.2d 418 (3d Cir. 1990).
9. Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999).
10. American Medical Association, Code of Ethics, Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship (JAMA. 1990; 262: 3/33).
11. See American Medical Association document, "Ending the Patient-Provider Relationship", www.amaassn.org/ama/pub/category/4607.html.
12. Cal. WIC. Code § 14011.10.
13. Baillargeon, J., et al. *Accessing Antiretroviral Therapy Following Release From Prison,* Journal of the American Medical Association, Vol. 301, No. 8, 2009, p. 848-857.
14. *West v. Atkins,* 487 U.S. 42 (1988).
15. Rold, William J. *30 Years After Estelle v. Gamble: A Legal Retrospective,* National Commission on Correctional Health Care, CorrectCare, Summer 2006. Referring to West v. Atkins, 487 U.S. 42 (1988).
16. For more information on CRIPA and for a listing of the Civil Rights Division's investigations, findings letters, cases, and substantial agreements, go to http://www.justice.gov/crt/split/cripa.php.
17. Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 *et. seq.* Note that privately owned and operated correctional facilities are not covered by CRIPA (a) if the licensing of such facility by the state constitutes the sole nexus between such facility and such state; (b) the receipt by such facility, on behalf of persons residing in such facility, of payments under Title XVI, XVIII, or under a state plan approved under Title XIX of the Social Security Act, constitutes the sole nexus between such facility and such state; or (c) the licensing of such facility by the state, and the receipt by such facility, on behalf of persons residing in such facility, of payments under Title XVI, XVIII, or under a state approved plan under Title XIX of the Social Security Act, constitutes the sole nexus between such facility and such state.
18. *Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act,* Fiscal Year 2008, pg. 2.
19. 42 U.S.C. § 1997e.
20. *Department of Justice Activities Under the Civil Rights of Institutionalized Persons Act,* Fiscal Year 2008, pg. 1.
21. *United States of America v. Dallas County, Texas; Lupe Valdez, Sheriff of Dallas County, Texas,* November 6, 2007. Civil No. 307 CV 1559-N, II(F).
22. DOJ's letter to the Cook County Board President and Cook County Sherriff regarding findings from the Civil Rights Division's investigation of the Cook County Jail, Chicago, Illinois (July 11, 2008) pp. 42-43, and Investigation of the Dallas County Jail, December 8, 2006, p. 4; see also DOJ's letter to County Judge regarding findings from the Investigation of Civil Rights Division's investigation of the Harris County Jail, (June 4, 2009) pp. 24-25
23. *United States of America v. Dallas County, Texas; Lupe Valdez, Sheriff of Dallas County, Texas,* November 6, 2007. Civil No. 307 CV 1559-N.

CHAPTER 3 *An Emerging Consensus: The Community-Based Standard of Care*

This chapter addresses:

- ***Defining the Community-Based Standard of Care for Jails***
- ***Defining the Community-Based Standard of Care for Juvenile Detention***

There is an emerging consensus, as reflected in case law and CRIPA reports, that the Constitution protects incarcerated individuals' right to health care in a manner that is consistent with current and generally accepted professional "standards of care." In legal terms, "standard of care" is generally understood to mean the level at which the average, prudent provider in a given community would practice.

It is important to note that there is no nationally recognized and/or enforced standard of care for purposes of corrections. Rather, standards of care vary based on a community's unique characteristics, such as its health needs and demographics.

There are, however, key elements highlighted in various CRIPA reports that shed light on which services are considered key components of an effective correctional health care system, as described below.

Defining the Community-Based Standard of Care for Jails

Many CRIPA investigations, findings letters, cases, and agreements pertaining to adult jails highlight the generally-accepted medical standards of care related to (1) intake screening; (2) health assessment; (3) management of chronic and communicable diseases; and (4) continuity of care post-release.

Examples include the following:

- ***Intake Screening:*** Incoming inmates should be screened to identify and triage serious inmate medical needs, including drug and alcohol withdrawal, communicable disease, acute or chronic needs, mental illness, and potential suicide risks."[1]

- ***Health Assessment:*** Correctional facilities should conduct health assessments within two weeks of admission.[2] This assessment should typically include a review of the intake information, a complete medical and mental health history, and a physical examination.[3]

- ***Management of Chronic and Communicable Diseases:*** Correctional facilities should have a functioning chronic and communicable disease registry to treat and prevent the progression of illness.[4]

- ***Continuity of Care:*** Discharge treatment planning should be provided for an inmate who has a serious mental illness to ensure continuity of care.[5]

Defining the Community-Based Standard of Care for Juvenile Detention

Although the generally-accepted standard of care pertaining to juvenile detention facilities is similar to adult jails, there are several key differences highlighted in the CRIPA investigations, findings letters, cases, and agreements. The key differences relate to (1) intake screening; (2) routine care; (3) mental health counseling; and (4) immunizations.

Examples include the following:

- ***Intake Screening:*** Incoming juveniles should be screened to identify psychiatric, medical, substance abuse, developmental, and learning disorders, as well as suicide risks.[6]

- ***Routine Care:*** Juveniles should be provided routine, preventative, and emergency medical and dental care, including identification, assessment, diagnosis, and treatment of health problems.[7]

- ***Mental Health Counseling:*** Mental health counseling should be sufficiently frequent and consistent to provide meaningful interventions for youth.[8]

- ***Immunizations:*** Proper and age-appropriate immunizations should be provided to all juveniles.[9]

References

1. DOJ's letter to the Dallas County Commissioners Court Presiding Officer regarding findings from the Civil Rights Division's investigation of the Dallas County Jail, Dallas, Texas (December 8, 2006), p. 4; see also DOJ's letter to County Judge regarding findings from the Investigation of Civil Rights Division's investigation of the Harris County Jail, (June 4, 2009) pp. 4 (stating that generally accepted standards of correctional medical care require that medical staff identify detainees with chronic conditions, such as diabetes, tuberculosis, and heart disease, and provide timely treatment for such conditions).

2. DOJ's letter to the County of Oklahoma Commissioners regarding findings from the Civil Rights Division's investigation of Oklahoma County Jail and Jail Annex, Oklahoma City, Oklahoma (July 31, 2008) p. 14.

3. DOJ's letter to the Dallas County Commissioners Court Presiding Officer regarding findings from the Civil Rights Division's investigation of the Dallas County Jail, Dallas, Texas (December 8, 2006), p. 6.

4. Investigation of Delaware Correctional Center, Symrna, Delaware; Howard R. Young Correctional Institution, Wilmington, Delaware; Sussex Correctional Institution, Georgetown, Delaware; John L. Webb Correctional Facility, Wilmington, Delaware; and Delores J. Baylor Women's Correctional Institution, New Castle, Delaware (December 29, 2006) p. 5-6.

5. Investigation of Delaware Correctional Center, Symrna, Delaware; Howard R. Young Correctional Institution, Wilmington, Delaware; Sussex Correctional Institution, Georgetown, Delaware; John L. Webb Correctional Facility, Wilmington, Delaware; and Delores J. Baylor Women's Correctional Institution, New Castle, Delaware (December 29, 2006) p. 11

6. DOJ's letter to the Los Angeles County Board of Supervisors Chairperson regarding findings from the Civil Rights Division's investigation of the Los Angeles County Probation Camps (October 31, 2008).

7. Investigation of the Scioto Juvenile Correctional Facility, Delaware, Ohio (May 9, 2007).

8. DOJ's letter to the Los Angeles County Board of Supervisors Chairperson regarding findings from the Civil Rights Division's investigation of the Los Angeles County Probation Camps (October 31, 2008).

9. *Investigation of the Scioto Juvenile Correctional Facility, Delaware, Ohio,* May 9, 2007.

CHAPTER 4 *The Procurement Process*

This chapter addresses:

- ***Defining the Procurement Process***
- ***Using the Procurement Process to Secure Correctional-Based Health Care Services***

Defining the Procurement Process

Contracting for services that are paid for, in whole or in part, with federal, state, and/or local public funds should follow well-documented and thorough procurement processes. In general, procurement processes include both a request for proposal and a procurement contract.

The request for proposal process enables the organization to evaluate bidders based on their ability to provide the requisite services, as well as other criteria which the purchasing organization deems appropriate and necessary, and, if properly structured, avoids the influence of conflicting interests.

The procurement contract formalizes the relationship between the purchaser and the chosen vendor and establishes each party's various assurances and responsibilities.

Using the Procurement Process to Secure Correctional-Based Health Care Services

Procurement processes are particularly important in the context of correctional health care contracting because, as previously discussed, private contractors to state and local governments who provide health care services to prisoners are acting on behalf of the government for purposes of the Eighth Amendment of the Constitution.[1] In other words, the governments that hire private contractors to provide medical services remain liable for failing to provide constitutionally adequate care.[2]

It is important to note that the procurement processes described here in Chapter 4 are not required by law. Rather, they are simply suggested practices to help the county and/or municipal government identify the contractor that is most advantageous. However, specific procurement requirements may be required under state and county law (and, in some instances, federal law). Correctional facilities are therefore encouraged to review their applicable procurement-related laws and regulations prior to soliciting bids and/or entering into contracts for the purchase of health services using public funds.

Request for Proposal

The request for proposal should provide applicants with background information about the correctional facility (i.e., incarcerated individuals' age, gender, average length of incarceration, medical and mental health needs, rates of chronic and communicable disease, etc.). This information enables the applicant to determine, at the outset, whether it has the appropriate experience, mission, capacity, and skill set to respond to the request for proposal.

The request for proposal should include a detailed description of the requisite scope of services, consistent with the applicable standard of care developed and utilized by the purchaser. In addition to describing the specific services, such as intake screening and provisions for discharge planning, the request for proposal should also describe the purchaser's expectations regarding the quality of care, hours of operation, and providers' qualifications (i.e., particular skills, educational degrees, licenses, credentials). The request for proposal should also indicate whether the applicant must provide services in accordance with any performance-based standards, such as through the American Correctional Association.

It is also important that the request for proposal ask applicants to document their relevant experience. Given that the incarcerated population has a high incidence of medical conditions, mental health disorders, and drug and alcohol addiction, the applicant should specifically address its familiarity and expertise in working with this underserved and at-risk population. Similarly, applicants for contracts to serve juveniles brought to detention centers should describe their experience serving the needs of adolescents with age and culturally competent care. In addition, applicants should document their involvement with other social service providers in the community and their ability to care for the incarcerated individual post-release.

The applicants should then be evaluated based on cost, appropriateness and accuracy of responses, qualifications, experience, and any other criteria which the purchaser deems necessary to provide the services. Ideally, the procurement should comply with the correctional facility's "Code of Conduct" policy governing the performance of employees and government officials engaged in the award and administration of contracts. For example, no individual should participate in the selection, award, or administration of the contract if a real or apparent conflict of interest would be involved. Such a conflict would arise when the individual, any member of his or her immediate family, or his or her partner has a financial or other interest in the vendor selected for an award.[3] In addition, no individual evaluating the applications should solicit or accept gratuities, favors, or anything of monetary value from contractors.

Purchase of Services Agreement

Once the appropriate contractor is identified and key terms are negotiated, the parties should execute a formal agreement. The agreement should include terms describing:

- payment;
- scope of work;
- expectation that services will satisfy the generally-accepted community standard of care;
- licensure and credentialing obligations;
- confidentiality obligations;
- ongoing monitoring and evaluation of services, such as through quality assurance initiatives and audits;
- ownership of medical records;
- information sharing processes and hardware;
- training procedures for working in a correctional setting; and
- staffing patterns and levels.

It is also important to address how the parties will handle potential conflicts. For example, the contract may include terms describing dispute resolution and/or mediation processes.

Additional expectations and requirements should be described, including the contractor's assurance that it, as well as its employed and contracted providers, agrees to abide by the correctional facility's policies and procedures regarding safety measures, operations, and state regulations.

References

1. *West v. Atkins,* 487 U.S. 42 (1988).

2. Rold, William J. *30 Years After Estelle v. Gamble: A Legal Retrospective,* National Commission on Correctional Health Care, CorrectCare, Summer 2006. Referring to *West v. Atkins,* 487 U.S. 42 (1988).

3. See Uniform Administrative Requirements for Awards and Sub-Awards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations, 45 C.F.R. § 74.42.

CHAPTER 5 *Health Centers: Logical Partners for the Provision of Care*

This chapter addresses:

- ***Defining a Health Center***
- ***Health Center Model: Qualifications to Provide Health Care Services in the Correctional Facility Setting***

Increasingly, correctional facilities are contracting with community-based Federally Qualified Health Centers (referred to hereinafter as a "health centers") for the provision of medical and mental health care. Health centers are natural partners, having provided comprehensive community-based health care and related services to medically underserved populations nationally for over 40 years.[1] Health centers currently serve as the medical and health care home for 20 million people nationally.[2]

Defining a Health Center

A 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., a health center "look-alike"). There are presently over 1,200 health centers operating at 7,500 sites in every state and territory.[3] Health centers are located in high-need areas identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice.[4]

Health centers are open to all residents of their service area (with limited exceptions for health centers serving only one or more federally-defined special populations—migrant, homeless, and public housing) and provide a full continuum of primary and preventive care services, regardless of the individual's ability to pay.

Health centers also provide (among other things):[5]

- 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.

Health centers tailor their services to their communities' unique cultural and health needs.

Nearly all health center patients are low income, with 70% having family incomes at or below the federal poverty level. In addition, 38% of health center patients are uninsured and another 36% depend on Medicaid.[6]

Health centers, as federally designated entities, may be eligible for certain benefits, including 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.[7]

The health center mission is to "increase access to and availability of primary health services to medically underserved and vulnerable populations who reside in a health center's community."[8]

Health Center Model: Qualifications to Provide Health Care Services in the Correctional Facility Setting

Many health centers are uniquely qualified to provide health care services to the incarcerated population.

Although there are many attributes of the health center model that complement the correctional health system model, the key attributes include, but are not limited to, the following:

- experience serving underserved and marginalized populations;
- continuity of care systems;
- qualified, trained, and socially competent providers;
- chronic disease management;
- established quality assurance programs; and
- established medical records systems that promote thorough documentation and quality of care.

The Underserved and Marginalized Population

The incarcerated adult population is mostly poor, urban and undereducated. Surveys indicate, among other things:[9]

- 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.

Prior to incarceration, offenders typically have 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.[10]

Given this lack of access to primary health care, offenders frequently present at the correctional facility with significant health care needs.

The Academy of Pediatrics defines a medical home as primary care that is:[11]

- accessible;
- continuous;
- comprehensive;
- family centered;
- coordinated;
- compassionate; and
- culturally effective.

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."*[12]

Community health centers are often the medical home for individuals who previously used the emergency room for non-emergent and non-urgent health care needs. Accordingly, health centers are already experienced with addressing health needs of a community's underserved and lower income population. They are intimately familiar with the unique health trends specific to the community. This experience, expertise, and sensitivity to cultural considerations enable health centers to provide incarcerated individuals with culturally appropriate and high quality services that address their individual needs.

Continuity of Care

Often individuals are released from correctional facilities without medication, treatment plans, or access to primary and preventive care. Consequently, their health needs are unmet, creating significant challenges for reintegrating within society.

Health centers can help resolve this disruption by offering a full continuum of primary and preventive care and, thus, providing continuity of care both during incarceration and post-release. Because health centers have sites within the community and see all residents of the service area regardless of their ability to pay, incarcerated individuals can continue to receive health care from the health center, and perhaps from the same provider, post-release. Rather than coordinate piecemeal services through several providers, the health center can function as the individual's "one stop" medical home.

This continuity of care supports the continuance of medication and treatment plans, helps connect individuals with various social services, and links the individual with a medical home. Providing this support to individuals during the vulnerable post-release transition period may reduce recidivism while promoting both public health and public safety interests, thus benefiting the individual, the corrections system, and the public at large.

Qualified and Trained Providers

In order to ensure that medical and mental health services are provided in accordance with the generally accepted standard of care, correctional facilities should ensure that all persons providing medical or mental health care are appropriately qualified and meet applicable licensure and/or certification requirements.[13]

A key advantage of contracting with health centers for the provision of care in corrections is their emphasis on recruitment and retention of high quality health professionals. According to health center guidance, all health centers are expected to maintain a core staff of primary care clinicians with training and experience appropriate to the culture and identified needs of the community. It is also encouraged that health center physician staff are board certified or residency trained, and other clinicians should be licensed and certified as appropriate under state law.[14]

Health centers are required to develop and follow a formal credentialing

process, including querying the National Practitioner Data Bank and verifying providers' education and licenses. It is further suggested the credentialing and privileging processes meet the standards of national accrediting agencies, such as the Joint Commission and the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

Provider education is also a critical aspect to the health center model. Health centers are expected to ensure access to continuing professional education that maintains licensure of the provider and is appropriate to the needs of each health center, its staff and the community served.[15]

Demonstrated Excellence in Managing Chronic Disease

Rates of chronic diseases are particularly high among the incarcerated population. Consequently, a key component of providing adequate correctional health care services is ensuring that chronic diseases are appropriately managed.

Health centers are well-equipped to satisfy this standard. It is documented that health centers meet or exceed nationally accepted practice standards for management of chronic conditions. In fact, the Institute of Medicine and the Government Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV.[16]

Health centers also educate their patients about their conditions, thus involving them in disease management which, in turn, promotes compliance with treatment regimens.

Extensive Quality Assurance Programs

To ensure that incarcerated individuals receive adequate health care in accordance with their Eighth Amendment rights, correctional facilities should engage in consistent and effective quality assurance reviews in order to monitor and assess the quality of medical care offered at the facility. According to one CRIPA investigative report, "An adequate quality assurance and performance measurement instrument is necessary to examine the effectiveness of health care delivered at [the correctional facility], to discuss medical care results, and to implement corrective action so that the quality of care is improved."[17]

Such quality assurance measures are key components of the health center model. As federally designated entities, health centers must measure the effectiveness and quality of their services and continuously refine their programs to achieve the greatest impact.[18] In order to achieve this quality assessment, all health centers must have a quality improvement system that addresses both clinical services and management.[19]

Such quality improvement systems should have the capacity to examine various criteria such as patient satisfaction and access, quality of clinical care, quality of the work force and work environment, cost and productivity, and health status outcomes.[20] In addition, quality improvement systems should assess these criteria using standard performance measures and accepted scientific approaches.

The health center quality assessment process relies on community-based standards of care. In analyzing performance data, health centers are encouraged to establish performance standards in concert with other health centers serving similar populations. In addition, health centers are encouraged to compare their results with other similar providers at the state and national level, and set realistic goals for improvement.[21]

Medical Records System

Several CRIPA investigative reports state that various correctional facilities failed to maintain complete, accurate, readily accessible, and systematically organized medical records. One such report noted that a correctional facility's backlog of unfiled medical records "seriously interferes with the continuity and coordination of care at [the correctional facility]" and that this "inefficient filing system greatly increases the risk of error in treatment, assessment, and care."[22]

Health center medical records systems are scrutinized extensively because health centers receive federal and state funds. Hence health centers are likely to satisfy CRIPA standards for medical record systems. Health center guidance specifically states that health centers should "utilize a medical records system that promotes thorough documentation and quality of care such as the Problem Oriented Medical Record POMR) and uses flow sheets and recording forms when appropriate."[23] This clinical information must feed data and information into the health center's quality improvement program.

In addition, all federally-funded health centers are required to annually submit reports to the Bureau of Primary Health Care's Uniform Data System (UDS), including data

on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.[24] The data are reviewed to ensure compliance with legislative and regulatory requirements, to improve health center performance and operations, and to report overall program accomplishments.

Additional Considerations for Contracting with Health Centers

Notwithstanding the attributes discussed above, not all health centers are appropriate partners for corrections, and therefore all health center proposals should be evaluated closely prior to executing a purchase of services agreement. For example, the health center should have sites located within a reasonable distance of the correctional facility and should have or be able to secure the necessary staff for the additional work in the contracting correctional facility. In addition, correctional facilities with unique behavioral health needs, particularly those related to juveniles, should ensure that the health center has the necessary expertise and qualifications to appropriately provide for the incarcerated individuals' needs. At times, behavioral health services may need to be provided by a separate contractor, depending on the local configuration of service agencies, their staffing, and skills.

Correctional facilities that are considering a partnership with a community health center are advised to review the COCHS manual, *Affiliations between Health Centers and Local Correctional Facilities to Provide Continuity of Care for Offenders,* available at www.cochs.org. The manual provides health centers with the knowledge and tools necessary to evaluate, identify and implement a correctional facility affiliation that is appropriate for the particular health center and community.

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CONCLUSION

Although there are no uniform and explicit criteria to determine whether a particular health care service, or lack thereof, qualifies as cruel and unusual punishment under the Eighth Amendment of the Constitution, there is an emerging consensus that correctional health care services should be consistent with current and generally acceptable community standards of care. As documented in the DOJ's various CRIPA reports, generally accepted correctional standards of care necessitate that correctional facilities address the health care needs of incarcerated individuals through various clinical procedures and processes, such as intake screening, health assessments, managing chronic and communicable disease, and providing discharge treatment planning.

Although they do not shield a state and/or local government from liability, procurement processes can be used as a tool by correctional facilities to ensure that the most experienced, qualified, and overall advantageous vendor is selected. This includes carefully developing a request for proposal, closely reviewing applications, selecting a vendor, and drafting a procurement contract describing the parties' rights and obligations.

Given their documented success providing high quality services to underserved populations, health centers are emerging as a logical vendor for the provision of correctional health care services. Correctional facilities are accordingly encouraged to consider whether their community's health center may be an appropriate contractual partner.

APPENDIX *CRIPA Investigation Findings*

Jails

■ In August 2003, an inmate with diabetes reported a sudden onset of blurry vision, which indicates potential acute retinal disease that can lead to blindness without prompt evaluation and treatment. This inmate did not receive an adequate eye examination and had not been referred to an ophthalmologist at the time of our third tour, over one month later.[1]

■ On April 28, 2004, inmate C.D. sustained trauma to his left eye. Although Jail staff was aware of the injury, C.D. was not seen by a physician for seven days, until he was hospitalized. By this time, C.D.'s injury was inoperable and he is now blind in that eye.[2]

■ In June 2007, Lyle P. was booked into Cook County Jail. At intake, Lyle reported his HIV infection and his strong adherence to his medication regimen, but he did not receive his medication prescription. Nearly two weeks passed before he was finally seen by an infectious disease specialist. Because of the two week lapse in medication, the specialist chose to delay treatment, which further enhanced the risks for Lyle to develop potentially fatal drug resistance.[3]

■ Five days after his 2007 intake to Cook County Jail, Henry H. had a new onset seizure and suffered a fractured jaw during the incident. It took six days for him to be seen by an oral surgeon and he was never evaluated for the cause of his seizure, as he should have been.[4]

■ An inmate who arrived at intake with infectious skin lesions did not get the necessary antibiotic treatment until his fourth day at King County Correctional Facility, by which time he had developed cellulitis (a potentially serious bacterial infection, which left untreated, may turn into a life-threatening condition).[5]

Juvenile Detention Facilities

■ A youth arrived on November 24, 2006, with a notation in his chart that he had been taking medications prior to his arrival [at the probation camp], and an "ASAP" request for a psychiatric evaluation. No response was noted in his chart. Two more requests for a psychiatric evaluation followed on December 7, 2006, and December 18, 2006, both also marked "ASAP," and both had no response noted. The psychiatrist did not see the youth until December 29, 2006, ¬more than a month after the youth arrived at the camp.[6]

■ A youth's assessment documented her depression and anger. Before being placed in the [juvenile detention] facility, she had been the victim of

a serious sexual assault, had been placed in a psychiatric hospital, and had been suspended from school for fighting. The facility psychiatrist recommended that the youth receive psychotherapy in order to address her past trauma. Her single, simplistic treatment goal was: "Youth will identify one way that her behavior has consequences for her and for others" and listed the same treatment modalities as for any other youth at the [juvenile detention] facility. Several days after her treatment plan was completed, the youth attempted to hang herself with a shoelace. In a suicide risk evaluation following this incident, the youth asserted that "as long as she is feeling this bad, she will try to kill herself." Despite these signs of serious mental distress, her treatment plan remained unchanged following the suicide attempt.[7]

- On December 19, 2003, two youth fought during breakfast. A youth correctional officer used physical force to place a youth in his cell. The youth reportedly had a bloody mouth after the incident. No medical reports document either incident. Documents provided by the State did not include medical or mental health reports indicating that the victim received treatment.[8]

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