ISSUE PAPER

March 2015

Development of a Performance-Based RFP for Correctional Health Care Services in Vermont

By Ben Watts, M.B.A., Research Associate, Community Oriented Correctional Health Services

Around the same time that the Vermont state legislature approved landmark health care reform legislation in spring 2011, it also passed "The War on Recidivism Act" (Act 41), aimed at stemming the growth of the state's correctional population and reducing recidivism. Among its provisions, Act 41 authorized a study into how the Vermont Department of Corrections (DOC) could best provide quality health services to inmates for less cost.[1]

Completed in January 2012, the study made a number of recommendations for improving both the financial and operational performance of the DOC health care system.[2] Among those recommendations, the report suggested that an alternative contracting model could significantly reduce inmate health care costs and improve the quality of services provided in Vermont's correctional facilities. However, the report did not recommend a specific contractual model.

This case study describes the policy environment that prompted the Vermont DOC's health care system, in partnership with community-based organizations, to develop the first statewide performance-based Request for Proposals (RFP) and subsequent contract for correctional health care services in alignment with federal and state health care reforms. It also describes how this massive paradigm shift was achieved, as well as lessons learned that may be helpful to other jurisdictions interested in pursuing a similar contract model for their correctional health service programs.

Methodology

In March 2013, the DOC contracted with Community Oriented Correctional Health Services (COCHS) to help the DOC determine how best to design a contract for correctional health care services, in alignment with ongoing federal and state health reforms. COCHS conducted a three-phase analysis of various provider models based on a series of Strengths, Weaknesses, Opportunities, and Threats (SWOT) analyses. Each of the three phases of analysis was based on two or three of eight variables that COCHS, in conjunction with the state, used to evaluate the models' capacities for strengthening the connection between the DOC and community-based systems of care:

1. Continuity of Care
2. Care Planning
3. Staffing
4. Capacity for Data Sharing (Health Information Technology)

COCHS
COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

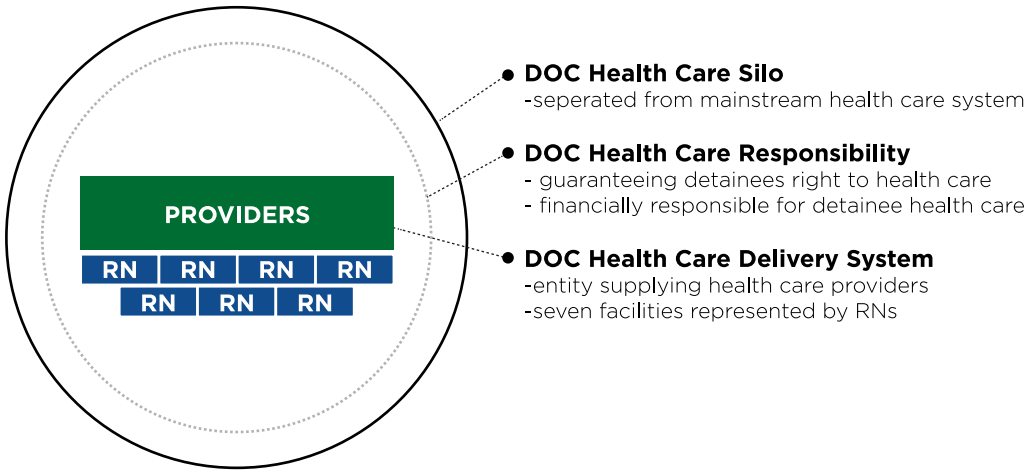
5. Procedures for Prior Approval, Quality Assurance, and Utilization Management
6. Data Collection and Metrics
7. Governance
8. Finance

These eight variables established implicit criteria to assess the effectiveness and feasibility of the proposed contract models. COCHS assessed these variables to determine which contract model would best serve the DOC's needs for providing high-quality, cost-effective care to inmates and coordinating that care with community providers.

As part of its methodology, COCHS interviewed nearly 200 executives and other key informants in the state Agency for Human Services, Vermont legislature, Office of the Court Administrator, as well as at hospitals, federally qualified health centers, designated mental health/substance abuse treatment agencies, and peer recovery and support programs. The interviews focused on how key stakeholders addressed continuity of care, care planning, staffing, and other factors to meet the needs of justice-involved individuals. COCHS used this feedback to develop the criteria for the RFP.

Figure 1 is a visual representation of Vermont's correctional health care system as it existed in March 2013. The internal perimeter represents finance, and the external perimeter represents the service delivery system. As the diagram indicates, the financing mechanism (through the state general fund) and the provider workforce (a contracted privatized system) were closed off from the mainstream health care system, with limited structural pathways for continuity of care. The outer, darker delivery circle shows how the DOC was siloed from the community-based health care system.

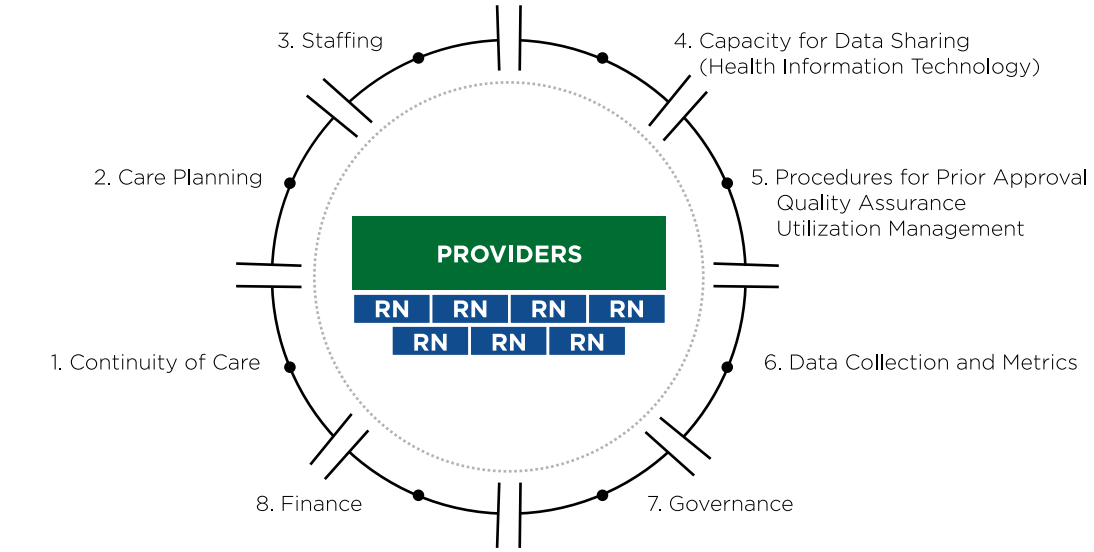
Figure 1: Closed Correctional Health Care System



The DOC's goal was to create "roads" for integrating the DOC and community-based health care systems, as demonstrated in Figure 2. The eight roads represent each of the variables that

COCHS assessed for reforming the delivery system. In this graphic, the DOC delivery system is conceptualized as a provider network with standards and outcome-based measures similar to and compatible with those used in the community-based health care system. Providers treating individuals in DOC custody agree to certain rules, including billing at contracted rates.

Figure 2: Integrated Correctional Health Care System



Several other external factors influenced the process of developing the performance-based RFP, including:

- The emergence of accountable care organizations
- Passage of Act 48, "An act relating to a universal and unified health system"
- The award of a State Innovation Model (SIM) grant by the federal government
- A movement within the Vermont state government toward results-based accountability

Accountable Care Organizations

An accountable care organization (ACO) is a network of hospitals, federally qualified health centers (FQHCs), mental health and substance abuse treatment agencies, and specialty providers that share financial and medical responsibility for providing coordinated care to patients. ACOs are intended to reduce health care spending, improve the quality of care, and improve patient outcomes. The ACO model promotes a team-based approach to care, with

the patient's primary care physician at the core. Many ACO models include a combination of financing mechanisms like capitated payments, fixed fees, and financial incentives for achieving a high level of performance on certain quality assurance metrics.

OneCare Vermont is the state's largest Medicare ACO, comprising a network of hospitals, primary care physicians, specialty providers, FQHCs, and rural health clinics and coordinating health care services for approximately 42,000 patients. Because of its size, reach, and function as a combined financing and service delivery system, OneCare Vermont matters not only to the mainstream health care system but to the correctional health care system as well. To inform the RFP development process, COCHS interviewed several leaders at OneCare Vermont.

With COCHS's assistance, the DOC developed service delivery and financing structures that mirrored those used by OneCare Vermont and other ACOs. Recognizing the primacy of patients' relationships with their primary care physicians, the DOC wanted the correctional health care program to use a team-based approach to providing care. In addition, the DOC incorporated financing structures, including incentive payments for high performance, similar to those used by ACOs.

Act 48

In most jurisdictions, corrections departments sit under the umbrella agency for public safety. In Vermont, however, the DOC resides within the Agency for Human Services (AHS) and shares AHS's mission of improving the health and well-being of all Vermonters.[3] Within this unique organizational structure, the DOC sought to develop and implement a correctional health care system that aligned with Act 48, which requires all health care services to be delivered in a coordinated, timely, evidence-based, high-quality, and cost-effective manner.[4] In correctional settings, these requirements take on meanings that are quite different than in more mainstream health care settings.

Act 48 requires that all health care services be delivered in a coordinated manner. Generally, health care services provided in correctional facilities are effective to the extent that inmates continue receiving them once they return to the community.[5] A reformed DOC health care system needed to establish processes, policies, and measures related to care coordination and continuity of care to ensure, for example, that an inmate's community-based treatment plan would be continued whenever possible upon admission to a DOC facility. Upon discharge, individuals would have referrals to or appointments at primary care clinics such as FQHCs, designated mental health/substance abuse treatment agencies, peer recovery and support programs, and other clinically indicated services.

Act 48 also requires that all health care services be delivered in a timely way. In correctional settings, assuring timely health care services can be difficult. Yet the incarcerated population has many acute physical and mental health needs that require timely response. When patients are in custody, the exacerbation of health issues may present risks to the safety and security of the patient, staff, other inmates, and the facility. To decrease these risks, COCHS and the DOC specified timeframes for assessing inmates' health and mental health needs, providing follow-up care, and regularly reviewing and updating treatment plans.

In addition, Act 48 encouraged the DOC to provide evidence-based health care services. For example, the DOC considered tools like the Screening, Brief Intervention, and Referral to Treatment[6] (SBIRT) model. SBIRT takes an early intervention approach to targeting individuals with patterns of substance in order to prevent them from requiring more extensive or specialized treatment. The SBIRT model has been used in hospitals and FQHCs in Vermont and across the United States.[7] To align with the types of evidence-based practices used in community-based health care settings, the DOC selected SBIRT as the model for assessing inmates' substance use treatment needs and connecting inmates with necessary services.

Act 48 requires that all health care services be of high quality. To that end, the DOC wanted to align its quality assurance activities with a set of metrics known as HEDIS – the Healthcare Effectiveness Data and Information Set – that are widely used by hospitals, health centers, and health plans throughout the United States.[8] Accordingly, COCHS and the DOC developed metrics for program quality that corresponded closely to the HEDIS metrics while addressing the unique requirements of providing high-quality, evidence-based, and cost-effective health care in a correctional environment.

Very importantly, Act 48 required the DOC to contain costs related to providing care to the incarcerated population. At the time, Vermont had the second-highest per-inmate health care costs in the country.[9] The DOC had a cost-plus contract with a proprietary health service vendor under which the DOC paid the vendor for the actual costs of providing health care services to inmates, plus a fee to support the vendor's corporate and regional offices. This meant that the contractor had little incentive to control costs. The DOC wanted to change that incentive by transferring much of the financial risk for providing comprehensive health care services from the DOC to the proprietary vendor.

Act 48 also created the Green Mountain Care Board (GMCB), a five-member regulatory body tasked with ensuring that changes in the health system improve quality while stabilizing costs. In addition, the Board tests and evaluates new ways to finance and deliver health care.[10] COCHS met with each GMCB member to get support and ideas for reforming the DOC health care system. In general, the Board saw that reforming the DOC health care system could reduce overall health care expenditures across the state and address the underlying health, mental health, and substance abuse issues that disproportionately impact justice-involved individuals. In line with the goals of Act 48, the Board also encouraged the DOC and COCHS to consider a financing structure linking contractor performance on a set of metrics to financial incentives.

State Innovation Model Grant

In 2013, the federal government awarded Vermont a $45 million State Innovation Model (SIM) grant to fund the Vermont Health Care Innovation Project (VHCIP), which is jointly overseen by the GMCB and the Commissioner for the Department for Vermont Health Access[11] (another department within AHS and Vermont's Medicaid office).

The VHCIP provides a forum for coordinating policy and resources to develop the organizations, technology, and financing systems necessary for a high-performing health care system in Vermont. The DOC wanted the RFP for correctional health care services to support the VHCIP's objectives.

Accordingly, the DOC considered how to build partnerships with key organizations in the community. The key informant interviews conducted by COCHS helped identify FQHCs, mental health/substance abuse treatment agencies, and hospitals that were willing to work with the DOC. They also shared the DOC's and COCHS's vision of using health information technology to support a stronger connection between services provided in the DOC and those provided in the community.

The electronic health record (EHR) system that the DOC had in place at that time lacked the capacity to accurately collect, track, or report data related to all clinical activities, including data on chronic diseases, hospitalizations, or the medication needs of the inmate population. To address those shortcomings, the DOC and its health services vendor had developed a variety of paper-based and electronic workarounds to track health-related data. However, the EHR could not support the goals of the VHCIP; nor did it allow the DOC to sufficiently monitor health care operations in its facilities.

That needed to change. Accordingly, the RFP required offerors to propose a more robust EHR with the capacity to interface with the Vermont Health Information Exchange (VHIE). That way, health care information for Vermont's correctional population would become part of the "big data" set that historically included data only on patients outside the confines of incarceration. In addition, the new interface would support care coordination and continuity of care as individuals transitioned between correctional and community-based health care systems. Interventions could be targeted toward the highest utilizers of health care services—regardless of their incarceration status—to better manage chronic conditions, prevent more serious health episodes, improve health outcomes, and reduce overall spending.

The DOC also needed to reform the financial structure of its health services program. Its contract with the incumbent correctional health service contractor was set to expire in January 2015, creating an opportunity to develop a financing system consistent with the goals of Act 48 and the VHCIP. Financing and service delivery structures used by ACOs typically include financial incentives for providing coordinated care and the seamless sharing of health-related information. Accordingly, COCHS and the DOC designed the RFP to include financial incentives for the contractor to coordinate care of individuals as they cycled through the community, the DOC, hospitals, and other settings. Unlike traditional fee-for-service financing structures that reward the provision of a higher volume of (sometimes unnecessary) services, ACOs offer incentives for containing costs through a combination of capitated payments, fixed fees for certain services, and financial incentives for high performance. Similarly, COCHS and the DOC developed a financing structure that included a combination of capitated per-inmate-per-month payments, fixed fees for the provision of off-site services, and flat rates to support the regional and corporate offices.

Such a system would transfer much of the responsibility for providing cost-effective care away from the DOC to the contractor. The DOC and COCHS recognized that RFP respondents might adjust their capitated rates to offset this transfer of risk to them. To mitigate against this, the DOC eliminated many of the financial penalties from previous RFPs. In addition, the DOC offered financial rewards if the contractor demonstrated a high level of performance on a set of outcome-based measures. The DOC's use of outcome-based measures coincided with Vermont's shift toward a result-based accountability model.

Results-Based Accountability

During COCHS's involvement, the Vermont state government transitioned toward a results-based accountability system of contracting, per Act 186, officially adopted in June 2014.[12] This law required the use of data to assess the effectiveness of government programs in achieving population-based outcomes, improving quality of life, and ensuring accountability on behalf of taxpayers. It specified performance measures for each state agency, including AHS. The law also created a position for a chief performance officer who would report to the General Assembly on the number of state contracts with performance-based requirements and the rate of compliance with those performance indicators.

To align the new correctional health service contract with the goals of Act 186, COCHS and the DOC decided to build performance-based outcome measures into the RFP. They designed an RFP that focused on the unique requirements of providing health care services in a correctional environment while reflecting the health reforms unfolding at the community level.

These three developments—the passage Act 48, the creation of the VHCIP, and the state's move toward results-based accountability—created both the opportunity and the impetus for COCHS and the DOC to integrate community-based and corrections-specific outcome measures in a new way.

Designing a Performance-Based Platform for the RFP

Performance-based RFPs (and contracts), also known as risk-based, pay-for-performance, or performance-linked RFPs, have several characteristics that differentiate them from the cost-plus structures historically used by the DOC. Performance-based RFPs include:

- Requirements that are generally described in terms of the outcomes that are expected rather than the processes that are performed.
- Procedures for reducing the remittance when specific requirements are not met.
- Financial or other incentives for high performance.
- Measurable standards defined in terms of quality, timeliness, and outcomes.

Outcome Measures

Under the Eighth Amendment, correctional facilities must protect inmates from cruel and unusual punishment. In *Estelle v. Gamble,* the U.S. Supreme Court ruled that deliberate indifference to a jail or prison inmate's serious medical needs constitutes a violation of the Eighth Amendment. *Estelle* and cases that followed[13] established three basic rights: the right to access adequate care, the right to care that is ordered, and the right to a professional medical judgment. But there is no right pertaining to positive health outcomes for inmates; nor is there a constitutional requirement that correctional health care programs adhere to the same standards as those used by FQHCs, hospitals, and other care providers.

In addition, defining a health care system strictly in terms of its clinical and administrative processes does not sufficiently guarantee that the requirements of the Eighth Amendment will be satisfied, nor does it guarantee that the health care needs of inmates will be addressed. An effective way to comply with the Eighth Amendment is to demonstrate improvement in inmate health status, so that jurisdictions may specify the outcomes expected from their health services vendors.[14] A jurisdiction may grant the contractor flexibility to develop the policies and procedures required to meet the contractually specified metrics. In turn, the jurisdiction would monitor the vendor's performance. For the purposes of correctional health service contracts, results generally matter more than the methods used to achieve them.

Prior to COCHS's involvement, RFPs for correctional health care services in Vermont were designed to comply with the National Commission on Correctional Health Care's (NCCHC) accreditation standards, which largely recommend operational structures, policies, and procedures of correctional health service programs. Although those RFPs laid out many policies and procedures, Vermont's correctional health service program did not achieve many of the desired outcomes.

The Vermont DOC has long recognized that justice-involved individuals who have access to high-quality medical, mental, and substance abuse treatment are less likely to re-offend. The DOC has a mandate that requires the correctional health service vendor to "provide to inmates the same professional standards of care that would be found to be provided to any citizen of the community at large."[15] Essentially, the mandate connects the quality assurance practices used in Vermont's correctional facilities to those used by community-based hospitals, FQHCs, and mental health/substance abuse treatment agencies.

The key informant interviews conducted by COCHS helped define a "professional standard" of care for Vermont's correctional facilities. To fulfill the requirements of the both the DOC mandate and the Eighth Amendment, COCHS designed an innovative model for the DOC's quality assurance activities based on HEDIS measures[16] and research conducted by the RAND Corporation on outcomes-based metrics for correctional health service programs.[17]

HEDIS measures describe the outcomes that are expected rather than the specific policies and procedures that should be performed. For example, in its RFP, the DOC included a metric with a strong evidence base related to providing "medical assistance with smoking and tobacco use cessation [by] advising smokers and tobacco users to quit."[18] HEDIS does not specify how this outcome should be achieved; the DOC and the contractor determine the policies and procedures. However, the DOC specified tobacco cessation screening as part of the initial health assessment, which must be conducted within seven days of admission to the facility. The contractor is responsible for having policies and procedures that ensure completion of initial health assessments within seven days and that also ensure that medical assistance with tobacco use cessation is provided for those inmates who report tobacco use. In this way, the DOC ensures that inmates receive timely interventions that are based on sound medical practice.

A study by the RAND Corporation noted that although many correctional health service programs generate a good deal of data, these data tend to have little bearing on quality assurance activities. For example, many jurisdictions collect information on the number of inmates who experience chest pain, but this information does not indicate the number of inmates with

chest pain who received the necessary medical attention to diagnose and treat their condition. The RAND researchers suggested defining this metric in a numerator and denominator format. They defined the denominator as the total number of inmates who experienced chest pain in the past 30 days. They defined the numerator as the number of inmates from the denominator for whom an EKG was obtained and reviewed.[19] The Vermont DOC included this metric in the RFP because the metric has a sound evidence base and assures that inmates have access to medically necessary services. It is the contractor's responsibility to have the necessary policies and procedures in place to identify inmates who experience chest pain and to obtain and review an EKG for those inmates in a timely manner.

The performance-based structure of the RFP granted the contractor considerable authority for achieving the outcomes specified by the DOC. However, this authority did not preclude the DOC from specifying how the contractor delivered some aspects of the correctional health service program. The DOC included many of its existing policies, procedures, and directives in the RFP, thereby standardizing both the outcomes and many of the processes expected from the contractor.

Reducing Remittance

In general, performance-based RFPs include procedures for reducing remittance when specific requirements are not met. In Vermont, policies for reducing remittance allow the DOC to hold the vendor accountable for all terms of the correctional health services contract, including the performance-based criteria. In the RFP, the DOC specified a 5 percent holdback of all remittance should the contractor fail to provide the DOC with monthly reports demonstrating fulfillment of the contract terms. This was especially important because the DOC Health Services Division has only six administrators to oversee health service operations at eight correctional facilities throughout the state. Minimizing administrative burden for staff was an important objective. Accordingly, the DOC specified that the contractor propose an EHR with the capacity to collect, track, and report the data necessary to calculate each of the performance-based indicators. In addition, the DOC required the contractor to generate all monthly performance reports, which would greatly reduce administrative burden. The RFP specified that holdbacks would be released once the contractor delivered the reports to the DOC. The DOC also reserved the right to levy penalties and liquidated damages as a result of poor performance or negligence on the part of the contractor. All holdbacks, penalties, or liquidated damages would be deducted from the contractor's total remittance for the month.

Financial and Other Incentives

Vermont's RFP for correctional health care services included financial incentives for the contractor to achieve certain performance-based metrics. The contractor earns a proportion of an incentive payment for each metric, depending on how actual performance rates against a set of thresholds and benchmarks established by the DOC. The financial incentives needed to be large enough to motivate the vendor to dedicate the necessary financial, human, and technological resources for achieving the desired outcomes. On a monthly basis, the contractor provides the DOC with the data to calculate each of the performance-based metrics, and the DOC calculates and awards any corresponding financial incentive.

Measurable Standards

Performance-based RFPs and contracts include measurable standards that address the quality of work, the timeliness of care, the quantity or duration of a particular service, and improvements in health outcomes. Vermont's RFP included performance standards derived from HEDIS, research conducted by the RAND Corporation, and the DOC's own internal reporting requirements. COCHS developed a unique performance-based incentive calculator that uses a numerator/denominator format and an associated threshold and benchmark to calculate the vendor's financial reward. To minimize the administrative burden, the RFP specified that offerors propose a new EHR capable of collecting, tracking, and reporting the data needed to calculate those numerators and denominators.

Aligning Corrections-Specific Metrics with Health Care Reform Initiatives

The DOC and COCHS developed corrections-specific performance metrics that supported the goals of Act 48, the VCHIP, and results-based accountability (Act 186). Following are several examples of how the metrics align with those goals.

Act 48 states that systematic barriers must not prevent individuals from accessing health care services. Research demonstrates that lack of health insurance can be a significant barrier to treatment, and that enrolling eligible individuals in Medicaid or other health insurance programs can reduce the risk of recidivism and improve health outcomes.[20] It was important, therefore, for the DOC to include criteria in the RFP that addressed health insurance enrollment for the justice-involved population. COCHS developed a measure to track insurance enrollment for individuals transitioning back to the community. Table 1 shows how this metric was structured.

Table 1. Metric related to insurance enrollment at discharge.

Metric	Numerator	Denominator	Threshold	Benchmark
Insurance Enrollment At Discharge (but process begins at booking)	Number of individuals enrolled into Medicaid or an exchange-purchased policy upon discharge from correctional facilities.	Number of individuals discharged from correctional facilities, excluding those already enrolled or otherwise insured, and excluding those who refused enrollment.	85%	100%

Using the performance-based financial incentive calculator developed by COCHS, the vendor receives a proportional incentive payment based on actual performance. Financial incentive payments are calculated using the formula:

[(Actual Performance - Threshold) / (Benchmark – Threshold)] x (Available Incentive Payment)

For example, if the vendor enrolls 90 percent of discharged individuals into a Medicaid or other policy upon discharge, the vendor receives 33 percent of the available financial incentive

payment. To receive the maximum financial reward, the vendor must enroll 100 percent of all individuals from the denominator into a health insurance plan upon re-entry to the community.

This metric supports the goals of Act 48 because research demonstrates that coordinating insurance enrollment eliminates a barrier to the receipt of primary care, mental health, and substance abuse treatment services by individuals re-entering the community. It may also reduce costly overuse of emergency room services for relatively minor conditions, improve the management of chronic health conditions that disproportionately impact justice-involved individuals, and reduce recidivism. This metric also takes advantage of the opportunities within the Affordable Care Act (i.e., Medicaid expansion) to extend health care coverage to thousands of justice-involved individuals in Vermont.[21] [22]

In addition, this metric supports the goals of the VHCIP. The Department for Vermont Health Access (DVHA), which processes all applications for the state Medicaid program, also plays a role in overseeing the VHCIP. Therefore, this metric requires inter-departmental coordination between the DOC and the DVHA to enroll individuals in Medicaid or another insurance plan upon discharge. On a monthly basis, the DOC assesses the contractor's performance on this metric. If the contractor fails to achieve the threshold on this metric, the DOC and the contractor assess the policies and procedures related to enrolling individuals in health insurance plans to determine whether they need to be strengthened. The DOC monitors the contractor's compliance with any remediation plan during subsequent reporting periods to affirm a continuous focus on quality improvement.

Lastly, this metric is consistent with the state's commitment to results-based accountability. Having health insurance enables individuals to access health care services that address underlying health, mental health, and substance use conditions that may have contributed to their involvement with the criminal justice system in the first place, thereby improving their quality of life.

In another example, justice-involved individuals need coordinated support to access primary care and mental health and substance use treatment services. To assess this complicated task, COCHS developed a number of metrics, including one for re-entry planning. Table 2 describes the structure of this metric:

Table 2. Metric related to mental health and substance abuse re-entry planning.

Metric	Numerator	Denominator	Threshold	Benchmark
Mental Health/ Substance Abuse Re-entry Planning	Number of individuals from the denominator who were referred to a patient-centered medical home, either an FQHC or designated mental health/ substance abuse agency, upon re-entry.	Total number of individuals with a mental health/substance abuse diagnosis who re-entered the community.	85%	100%

This metric supports the goals of Act 48 and the VHCIP by requiring the correctional health service vendor to coordinate linkages to community-based services as individuals are released from DOC custody. Ensuring that referrals or appointments are coordinated means that patients can continue the treatment they received while in custody or access medically necessary services that may not have been available while in DOC custody. This metric also asserts the DOC's commitment to addressing the opiate problem in Vermont by linking justice-involved individuals to providers of medication-assisted treatment, an evidence-based approach to treating opiate abuse that combines medication and behavioral therapies.[23,24]

This metric supports the state's move toward results-based accountability, as coordinated access to mental health and substance abuse treatment will improve Vermonters' quality of life. (Refer to Appendix 1, "Summary of Performance-based Metrics," which describes each of the metrics included in the RFP, including several related to providing justice-involved individuals with highly coordinated treatment.)

As a final example, the RFP included metrics for monitoring patients' compliance with a prescribed medication regimen, especially for medications to manage chronic diseases, including psychiatric disorders. The management of chronic disease is particularly important for older justice-involved patients who have higher rates of chronic conditions like high blood pressure. [25] COCHS adapted a HEDIS metric related to "controlling high blood pressure" to conform to the service delivery structure in the DOC and align with the requirements of Act 48, the VHCIP, and Act 186. Table 3 describes this metric:

Table 3. Metric related to controlling high blood pressure.

Metric	Numerator	Denominator	Threshold	Benchmark
Controlling High Blood Pressure	Number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90 mm Hg) and monitored in chronic disease clinic every 90 days or less.	Number of patients in custody who have elevated blood pressure for which medication is prescribed.	85%	100%

This metric is consistent with the goals of Act 48 because the underlying research supporting

this metric indicates that treating high blood pressure with appropriate medications can reduce the risk of more serious (and costly) health care episodes like heart attack, stroke, and renal disease. In turn, this metric also aligns with the goals of results-based accountability because improving the management of chronic disease could improve population health and quality of life. [26]

Within the performance-based structure developed by COCHS, this metric fundamentally requires the contractor to have policies and procedures in place regarding the development, implementation, and review of chronic disease treatment plans for all inmates. The correctional health service contractor receives a financial incentive for providing timely and regular follow-up care to individuals with high blood pressure or other chronic diseases. (Refer to Appendix 1 for other metrics related to the management of chronic disease.) Supported by a robust EHR, the DOC will have an abundance of outcomes-based data to assess whether individuals with chronic conditions receive an adequate level of care while in Vermont's correctional facilities.

Lessons Learned from the Vermont Experience

COCHS assessed the potential for connectivity and alignment between the DOC and health care reform initiatives impacting community-based FQHCs, mental health/substance abuse treatment agencies, and peer recovery and support programs. Feedback garnered from key stakeholders during that assessment influenced the criteria included in the performance-based RFP. COCHS learned a number of lessons that have implications for other jurisdictions interested in aligning with state and national-level health care reform initiatives. Specifically, COCHS learned that:

1. A robust EHR system helps surmount communication and policy barriers between corrections and other governmental agencies and health care providers.
2. High-level state commitment is needed to drive reforms of the magnitude that the Vermont DOC implemented for its health service program.
3. Community-based organizations understand that they have a role in serving the justice-involved population using evidence-based practices.
4. The Eighth Amendment constitutional rights of offenders do not mitigate against the need to incorporate community-based standards of care.
5. Performance-based contracting structures in corrections are an innovation that can be scaled and that can improve health and safety and reduce costs.

Importance of an EHR

Historically, health care services provided in correctional facilities have had few connections to the health care system in the community. With the rollout of the Affordable Care Act and Vermont's expansion of Medicaid in 2014, many justice-involved individuals became eligible for health care coverage for the first time. Outside the correctional setting, justice-involved individuals who access emergency rooms, FQHCs, or other community-based providers have their

medical histories captured by EHRs, and their health information becomes integrated into the state's HIE. But with limited capacity to electronically share information among the DOC and community-based hospitals, FQHCs, and mental health/substance abuse agencies, the objectives of Act 48, the VHCIP, and results-based accountability could not be achieved.

To address this issue, the RFP for correctional health care services required the vendor to propose a robust EHR system capable of interfacing with the state HIE. That way, pertinent health information like medications, problem lists, and laboratory results could be shared bi-directionally between Vermont's correctional facilities and providers in the community; this functionality supports activities related to continuity of care and care coordination.[27] In addition, the RFP required an EHR that can generate reports for each performance-based metric specified by the DOC, thereby improving the DOC's ability to monitor health care services provided to inmates and ensuring that the vendor remained accountable for all contract terms.

High-Level State Commitment

Strong commitment from the legislature, governor's office, and state agencies was critical for integrating Vermont's correctional health care system with the reform initiatives occurring in the state and across the nation. The legislature and the DOC systematically assessed the problems related to providing and monitoring care in a correctional setting, and key legislators and AHS leaders did not waiver in their support of the DOC's reform efforts. Strong political will at every level of state government, as well as partnerships with community-based organizations, was essential for aligning the Vermont DOC's health care system with state and federal health care reform initiatives.

The Role of Community-Based Organizations

COCHS assessed the level of connectivity achievable between the DOC and community-based providers. Through a process of key informant interviews, COCHS assessed community-based providers' practices related to eight variables (continuity of care, care coordination, etc.), and, to the extent possible, included those practices in the RFP. COCHS also assessed stakeholders' willingness to partner with the DOC. Most stakeholders recognized the unique health care needs of justice-involved individuals and affirmed their support of efforts to reform the DOC's health service program. Key informants clearly understood that the DOC should be a partner in implementing health care reform initiatives.

In fact, the final contract added several case management positions to the program, with responsibilities for coordinating referrals, appointments, and insurance enrollment of DOC patients who are transitioning to community-based providers. This structure should improve access to timely, high-quality, and cost-effective care and optimize the contractor's capacity to achieve a high performance level on metrics related to care coordination and continuity of care. It should also be very feasible, given the strong sense of responsibility that community-based organizations have expressed for providing justice-involved individuals with high-quality health care services that are in sync with Vermont's health care reform initiatives.

Implications of the Eighth Amendment

The Eighth Amendment to the U.S. Constitution protects inmates of public institutions from cruel and unusual punishment. Reports of inadequate health care services across the nation highlight the responsibility of jurisdictions to provide health care services to inmates. For example, a report on the state of correctional health care services in the Idaho State Correctional Institution found serious problems related to the delivery of medical and mental health care. Many of the problems occurred frequently, were long-standing, and resulted in serious harm to inmates—even though authorities were aware of the problems. The report concluded that the authorities had been "deliberately indifferent to the serious health care needs of their charges."[28]

The report showed that complying with a particular programmatic structure does not always sufficiently address the health care needs of inmates. To comply with the Eighth Amendment, the report advised Idaho to develop a comprehensive set of processes and related outcomes to ensure that inmates receive timely, effective, and evidence-based care. In addition, the report said that systems should be put in place to collect and monitor pertinent health care data, identify deviations from acceptable performance levels, and make operational corrections whenever necessary.

COCHS and the DOC designed metrics to monitor the timely provision of clinically indicated care in a correctional setting. In fact, many of the quality standards included in the DOC's RFP had more rigorous thresholds and benchmarks than the quality standards used in community-based health care settings. Linking performance on the DOC's metrics to financial incentives essentially rewards the contractor for continuously monitoring and improving the correctional health service program. In turn, the performance-based structure of the RFP and subsequent health services contract provides the state with optimal protection against claims of deliberate indifference while aligning the DOC with its desired goals.

Scalability of Performance-Based Contracting

The Vermont DOC is more complex than most jurisdictions: It is a combined jail/prison system consisting of eight facilities located throughout the state. The performance-based RFP developed by COCHS required an equal level of complexity to assure compliance with the requirements of the Eighth Amendment and state and federal health care reforms. Most jail systems are operated by local counties and would not have nearly the same degree of complexity as the Vermont DOC. Therefore, other jurisdictions might use the Vermont DOC as a model for their health care reforms, with appropriate modifications to match their own unique needs and circumstances.

Conclusion

Vermont has achieved a massive paradigm shift in aligning its correctional health services program with state and national health care reform initiatives. The breadth of reform achieved in such a short timeframe would have been difficult without the passage of Act 41 and Act 48, the award of the SIM grant, or Vermont's transition to a results-based accountability contract model. The DOC now has a health care system designed to provide coordinated, timely, evidence-based, high-quality, and cost-effective care. In addition, the performance-based criteria of the

contract allow the DOC to monitor linkages between the DOC and community-based hospitals, FQHCs, and mental health/substance abuse treatment agencies to provide continuous access to the services that justice-involved individuals need to address underlying health conditions. Now, regardless of whether justice-involved individuals are in the DOC or in the community, they can expect to receive continuous access to the health care services they need. A high level of support and involvement from community-based organizations helped establish the linkages needed to ensure that justice-involved individuals have access to both coverage and services that can improve their health and ultimately reduce recidivism. As the DOC begins to collect data related to the model's performance, we will learn whether Vermont's approach leads to measureable improvements in health outcomes and reductions in recidivism. We will also learn whether Vermont's performance-based contracting model may be used to help other jurisdictions fulfill the requirements of the Eighth Amendment and align the health care systems with reform initiatives occurring both nationally and within their states.

Appendix 1. Summary of Performance-Based Metrics

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
1	Pharmacy List/ Med List Verified and Received from Community Pharmacy/Doctor	Number of inmates whose med list was received within 4 hours of admission Monday-Saturday 9am-8pm, or 24 hours outside of that timeframe.	Number of inmates who had verifiable medication lists from community pharmacy/ doctors.	85%	100%
2	Care Coordination – Reentry Planning	Upon discharge, number of patients from the denominator whose records were shared electronically with a PCMH upon discharge.	Number of patients with a serious medical or MH diagnosis whose discharge was verified by DOC discharge data and report on electronic file-sharing activities by date and patient.	85%	100%
3	MH/SA Re-entry Planning	Number of individuals from the denominator who were referred to PCMH (FQHC or DA) community-based MH/SA treatment upon re-entry.	Total number of individuals with MH/SA + on SBIRT diagnosis who re-entered the community.	85%	100%
4	Insurance Enrollment At Discharge (but process begins at booking)	Number of individuals enrolled into Medicaid or an exchange-purchased policy upon discharge from correctional facilities.	Number of individuals discharged from correctional facilities, excluding those already enrolled or otherwise insured, and excluding those who refused enrollment.	85%	100%
5	Follow-Up After Hospitalization for Mental Illness – 24-48 hours	Number of individuals in denominator who received a follow-up session with MH provider within 24-48 hours.	Number of patients who returned to the DOC facility following an in-patient hospital stay or emergency room encounter for a primary mental health diagnosis.	85%	100%
6	Initial Health Assessment completed within 7 days after admission	Total number of initial health assessments completed within 7 days of admission, or reviews if released and readmitted within 90 days.	Total number of admissions to DOC facilities in the past 30 days.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
7	Medical Assistance With Smoking and Tobacco Use Cessation – Advising Smokers and Tobacco Users to Quit	Patients in the denominator group who have been 1) advised to stop smoking, or 2) offered assistance with tobacco cessation.	Patients who have been in custody for more than 7 days and have self-reported use of tobacco at the initial nurse health intake assessment.	85%	100%
8	MH screening completed within 4 hours of admission	Number of patients from the denominator who received an initial mental health screening within 4 hours of prison admission.	Total number of patients admitted.	85%	100%
9	Adult BMI Assessment	Number of charts in denominator group with the BMI recorded.	Number of H&Ps performed during the month.	85%	100%
10	Non-Urgent Sick Calls for MH, Medical, and Dental Seen Within 48 hours (M-F) or 72 hours (S-S)	Total non-urgent sick calls (that describe a clinical symptom) that are seen within 48 hours (M-F) or 72 hours (S-S).	Total number of non-urgent sick calls (that describe a clinical symptom) seen.	85%	85%
11	Chest Pain	Number of patients from the denominator for whom an EKG was obtained and reviewed.	Total number of patients with chest pain.	85%	100%
12	Controlling High Blood Pressure	The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) and monitored in Chronic Disease Clinic every 90 days or less.	Number of patients in custody who have elevated blood pressure for which medication is prescribed.	85%	100%
13	Routine Preventative Dental – Annual Cleaning/Exam	Number of preventative cleanings/exams completed on the denominator.	Number of patients in custody who had not received an annual cleaning/exam within the last year or more.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
14	Comprehensive Diabetes Care – Eye Exam	Number from the denominator who received a documented retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the past 12 months.	Patients with diabetes on insulin or oral medication who have been in custody more than 6 months.	85%	100%
15	Comprehensive Diabetes Care – HbA1c Testing (see special notes)	HbA1c has been obtained and results have been discussed with the patients in the denominator group at least once.	Patients with diabetes on insulin or oral medication who have been in custody 2 months or more.	85%	100%
16	Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	HbA1C result has been repeated on the denominator group at least one time and has been below 9% on the most recent test.	Patients with diabetes on insulin or oral medication who have been in custody more than 6 months.	85%	100%
17	Comprehensive Diabetes Care – LDL Screening	LDL cholesterol level is recorded in the chart of the denominator group and, when indicated, a plan of treatment has been discussed with the patient with a follow-up test scheduled within 90 days.	Diabetic patients who have been in custody for 2 months.	85%	100%
18	Continuity of Care – Patient seen for follow-up after off-site visit	Number of patients from the denominator who were seen for a follow-up appointment after an off-site visit.	Number of patients who received an off-site service.	85%	100%
19	Diabetes – Offloading	Number of patients from the denominator who were prescribed an appropriate method of offloading (pressure relief) within the 12 month reporting period	Total number of patients age 18 and older with a diagnosis of diabetes and foot ulcer in custody >/= 12 months.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
20	Use of Imaging Studies for Low Back Pain	Patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.	Patients with a primary diagnosis of low back pain.	85%	100%
21	Chlamydia Screening in Women – Total Rate	Number of patients in the denominator screened for chlamydia.	Number of females admitted to the correctional facility who received an initial health assessment.	85%	100%
22	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Number of patients in the denominator not treated with antibiotics.	Number of patients diagnosed with bronchitis (and no other infections disease that would require antibiotics).	85%	100%
23	Psychopharmacology – Bipolar	Number of patients from the denominator who have evidence of use of a mood stabilizing agent during the first 12 weeks of pharmacotherapy treatment during the measurement period.	Number of patients ages 18 or older diagnosed by DOC or community-based MH staff with bipolar 1 disorder with symptoms of episodes that involve bipolar depression in custody for 4 weeks or more.	85%	100%
24	Psychopharmacology - Schizophrenia	Number of patients from the denominator whose medical record of the preceding 6 months provides documentation for the dosage used.	Total number of patients age 18 or older with a diagnosis of schizophrenia who are receiving antipsychotic medication at a dosage that is outside the recommended range (300 and 1,000 CPZ equivalents) at a specified point in time.	85%	100%
25	Psychiatric Medication Management	Number of patients from the denominator who had at least three contacts with MH practitioner during the 84-day acute treatment phase during the measurement period.	Number of patients in custody for 84 days or more who are diagnosed with new MDD episode and treated with an antidepressant medication during the measurement period.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
26	Follow-up for Individuals Prescribed ADHD Medication – Initiation Phase	Number of patients from the denominator who had at least three follow-up (or visit) contacts with a practitioner with prescribing authority during the 84-day acute treatment phase during the measurement period.	Number of patients in custody for 84 days or more who are diagnosed with ADD or ADHD and treated with a stimulant medication during the measurement period.	85%	100%
27	Follow-up for Individuals Prescribed ADHD Medication – Continuation and Maintenance Phase	Number of patients from the denominator group who had at least one follow-up visit with an APRN or psychiatrist during the 90 day continuation phase during the measurement period and is reassessed every 90 days or less.	Number of patients in custody for 14 days or more who are diagnosed with ADD or ADHD and treated with a stimulant medication during the measurement period for at least 90 days.	85%	100%
28	Antidepressant Medication Management – Acute Phase	Number of patients from the denominator who had at least three follow-up (or visit) contacts with MH practitioner (psychiatrist, APRN) during the 84-day acute treatment phase during the measurement period.	Number of patients 18 and older who are diagnosed with new MDD episode and treated with an antidepressant medication during the measurement period.	85%	100%
29	Antidepressant Medication Management – Continuation Phase	Number of patients from the denominator group who had at least one follow-up (or visit) contacts with MH practitioner (psychiatrist, APRN) during the 90 day continuation phase during the measurement period and is reassessed every 90 days or less.	Number of patients in custody for at least 90 days who are diagnosed with new MDD episode and treated with an antidepressant medication during the measurement period.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
30	Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	Number of patients from the denominator who were prescribed equal to or greater than 40 mg prednisone equivalents by IV or PO for 5 days.	Total number of patients with acute severe COPD exacerbation.	85%	100%
31	Asthma Management	Number of patients from the denominator who were prescribed equal to or greater than 40 mg prednisone equivalents by IV or PO for 5 days.	Total number of patients with acute severe asthma exacerbation.	85%	100%
32	Use of Spirometry Testing in the Assessment and Diagnosis of COPD.	Number of patients from the denominator who had spirometry or peak flow results documented.	Total number of patients 18 and older with a diagnosis of COPD, asthma, or self-reported history of smoking.	85%	100%
33	Telemedicine – Psychiatry	Number from the denominator assessed by telemedicine rather than off-site.	Referrals for psychiatry assessments.	85%	100%
34	Telemedicine – Dermatology	Number from the denominator assessed by telemedicine rather than off-site.	Referrals for dermatology assessments.	85%	100%
35	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Deliveries that received a prenatal care visit in the first trimester or within 4 days of booking.	Number of deliveries.	85%	100%
36	Prenatal and Postpartum Care (Postpartum Care)	Number of deliveries that had a postpartum visit between 21 and 56 days after delivery.	Number of deliveries.	85%	100%
37	Breast Cancer Screening	Clinical breast exam screening or mammography performed in the denominator group.	Number of women receiving initial health assessments.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
38	Adverse Health Events	Number of adverse events, including death, in which a physician reviewed the patients' charts within 30 days of the event. The charts have documentation to support that the physician followed-up with treatment health/MH staff, as appropriate.	Number of adverse events.	85%	100%
39	Hospital Re-Admissions within 30 days	Number of individuals with unique discharge diagnoses in the denominator.	Total number of hospital discharges during the month.	85%	100%
40	Utilization – MH	Number of individuals from the denominator who received 1 hour/week or more of individual or group therapy.	Number of individuals diagnosed with a serious mental illness whose plan of care specified that the individual should receive 1 hour/week of individual or group therapy.	85%	100%
41	Utilization – SA services	Number of individuals from the denominator who received SBIRT, group, or individual SA treatment.	Number of individuals diagnosed by DOC or community provider with a substance use disorder.	85%	100%
42	Dental Screenings Completed within 30 days	Number of dental screenings completed within 30 days following admission for newly admitted patients.	Number of admissions in the past month.	85%	100%
43	Routine Meds Given Beyond 2 Hours *	Number of routine medication administrations given within 2 hours.	Number of routine medication administrations.	90%	100%
44	Urgent/Stat Meds Given Beyond 1 Hour *	Number of urgent/stat medication administrations given within 1 hour of request.	Number of urgent/stat medication administrations.	95%	100%
45	Controlled Substance Diversion	Number of individuals from the denominator who received a random drug screening.	Number of individuals taking controlled substance for chronic pain.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
46	Urgent Sick Calls Seen on Same Day	Urgent sick calls entered into the EMR and seen on the same day.	Total number of urgent sick calls.	85%	100%
47	Use of Chronic Pain Treatment Agreement	Number of patients from the denominator who signed a chronic pain treatment agreement.	Number of patients taking an opioid for more than 30 days.	85%	100%
48	Adherence to Act 75	Number of queries to the VPMS.	Number of patients in one or more of the circumstances described in Act 75, Section 11, §4289(d)(1-4), which states, "Health care providers shall query the VPMS with respect to an individual patient in the following circumstances: (1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance; (2) when starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more; (3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treatment chronic pain; and (4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title."	85%	100%
49	Transfer Screening – Qualified Health Care Professionals Review	Number of patients transferred to the facility whose health records were reviewed by the receiving facility within 12 hours of transfer.	Number of patients transferred to the facility within a 30-day period.	85%	100%

#	Metric	Numerator	Denominator	Minimum: Year 1 – 85% Year 2 – 90% Year 3 – 95%	Maximum: Year 1 – 100% Year 2 – 100% Year 3 – 100%
50	Discharge Planning – Referrals	Number of patients with a communicable disease who were released from custody and who had a referral to a PCMH, CHT, or other community provider for follow-up care.	Number of patients with a communicable disease or serious medical or mental health condition who were released from custody.	85%	100%
51	Discharge Planning – Prescriptions	Number of inmates with prescriptions who re-entered the community with insurance coverage (Medicaid or other) and who received prescription(s) for all necessary medications to be filled at a pharmacy of their choosing.	Number of inmates with prescriptions who re-entered the community during the reporting month.	85%	100%
52	Non-emergency, Formal Grievances Resolved	Number of non-emergency grievances resolved within 20 business days.	Number of non-emergency grievances.	85%	100%
53	Emergency Grievances Resolved	Number of emergency grievances resolved within ten (10) calendar days.	Number of emergency grievances submitted.	85%	100%

** Metric #43 will have a minimum/maximum range of 90%/100% for Year 1 and 95% for Years 2 and 3. Metric #44 will have a minimum/maximum range of 95%/100% for Years 1-3.*

Endnotes

1 No. 41. An Act Relating to Effective Strategies to Reduce Criminal Recidivism. *http://www.leg.state.vt.us/docs/2012/Acts/ACT041.pdf.* Published May 20, 2011. Accessed May 29, 2013.

2 Hoffer, D. 2014 *Correctional Healthcare: Annual cost overruns, but contract oversight has improved. http://www.leg.state.vt.us/reports/2013ExternalReports/294178.pdf*. Published October 24, 2013. Accessed January 27, 2015.

3 Vermont Agency for Human Services. http://humanservices.vermont.gov/. Accessed January 25, 2015.

4 No. 48. An act relating to a universal and unified health system. http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf. Published May 26, 2011. Accessed January 25, 2015.

5 National Association of Drug Court Professionals. Adult drug court best practice standards. http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf. Published 2013. Accessed January 25, 2015.

6 SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, brief intervention, and referral to treatment. http://www.integration.samhsa.gov/clinical-practice/SBIRT. Accessed January 25, 2015.

7 National Association of Community Health Centers. Health center reimbursement for behavioral health services in Medicaid. https://www.nachc.com/client/MentalHealthSA_PPSReport-%20Final%20Nov%202010.pdf. Published November 2010. Accessed January 25, 2015.

8 National Committee for Quality Assurance. HEDIS & performance management. http://www.ncqa.org/HEDISQualityMeasurement.aspx. Accessed January 25, 2015.

9 The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. State prison health care spending: An examination. http://www.pewtrusts.org/~/media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf. Published July 2014. Accessed January 25, 2015.

10 Green Mountain Care Board. About us. http://gmcboard.vermont.gov/aboutus. Accessed January 25, 2015.

11 State of Vermont Health Care Innovation Project. Brief summary of State Innovation Model grant budget. http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SIM_Summary030613%5B1%5D.pdf. Accessed January 27, 2015.

12 S. 293. An act relating to reporting on population-level outcomes and indicators and on program-level performance measures. http://www.leg.state.vt.us/docs/2014/bills/Passed/S-293C.pdf. Accessed January 25, 2015. Also see Niles, H. New state accountability program signed into law. VTDigger.org. http://vtdigger.org/2014/06/11/new-state-accountability-program-signed-law/. Published June 11, 2014. Accessed January 25, 2015.

13 *Estelle v. Gamble*, 429 U.S. 97 (1976); Also see *Brown v. Plata*, 131 S.Ct. 1910 (2011) .

14 Stern, M. Balla v. Idaho Prisoner Medical Report 2012. https://www.prisonlegalnews.org/media/publications/stern_balla_v_idaho_prisoner_medical_report_2012.pdf. Accessed January 28, 2015. Also see *Balla v. Idaho State Bd. of Corrections*, 595 F.Supp 1588 (D. Idaho 1984).

15 State of Vermont Agency of Human Services, Department of Corrections. Policy 351 Health Care Services. http://doc.vermont.gov/about/policies/rpd/correctional-services-301-550/351-360-programs-health-care-services/351%20Health%20Care%20Services.pdf. Accessed January 27, 2015.

16 Agency for Healthcare Research and Quality. Measures by national quality strategy website. http://www.qualitymeasures.ahrq.gov/browse/by-national-quality-strategy.aspx#17,8. Accessed January 26, 2015.

17 Teleki, SS, Damberg, CL, Shaw, R, Hiatt, L, Williams, B, Hill, TE, and Asch, SM. The current state of quality or care measurement in the California Department of Corrections and Rehabilitation. Journal of Correctional Health Care. 2011;17(2):100-121.

18 Agency for Healthcare Research and Quality. Medical assistance with smoking and tobacco use cessation: percentage of members 18 years of age and older who were current smokers or tobacco users who received advice to quit during the measurement year website. http://www.qualitymeasures.ahrq.gov/content.aspx?id=47224. Accessed January 26, 2015.

19 Teleki, SS, Damberg, CL, Shaw, R, et. al. The current state of quality or care measurement in the California Department of Corrections and Rehabilitation. *Journal of Correctional Health Care.* 2011;17(2):100-121.

20 McDonnell, M, Brookes, L, Lurigio, A, Baille, D, Rodriguez, P, Palanca, P, Heaps, M, and Eisenberg, S. Realizing the potential of national health care reform to reduce criminal justice expenditures and recidivism among jail populations. Community Oriented Correctional Health Services website. http://www.cochs.org/files/CHJ%20Final.pdf. Published January 2011. Accessed January 27, 2015.

21 McMahon, S, and Heiss, C. Promoting health access to keep people with mental illness out of jail. Center for Health Care Strategies. http://www.chcs.org/promoting-health-access-keep-mentally-ill-jail/. Published December 14, 2014. Accessed January 27, 2015.

22 McDonnell, M, Brookes, L, Lurigio, A, Baille, D, Rodriguez, P, Palanca, P, Heaps, M, and Eisenberg, S. Realizing the potential of national health care reform to reduce criminal justice expenditures and recidivism among jail populations. http://www.cochs.org/files/CHJ%20Final.pdf. Published January 2011. Accessed January 27, 2015.

23 Vermont Department of Health. (June 2014). The challenge of opioid addiction. http://www.healthvermont.gov/adap/treatment/opioids/documents/OpioidChallengeBrief_June2014.pdf. Published June 2014. Accessed January 26, 2015; *Also see* Bromage, A. Powder trail: Tracing Vermont's heroin epidemic to its sources. *Seven Days*. May 15, 2013. http://www.sevendaysvt.com/vermont/powder-trail-tracing-vermonts-heroin-epidemic-to-its-sources/Content?oid=2243560. Accessed January 25, 2015; *Also see* Keck, N. Surge in heroin and prescription drug abuse in Vt. towns. Vermont Public Radio website. Published October 15, 2012. Accessed January 25, 2015.

24 About medication-assisted treatment. Substance Abuse and Mental Health Services Administration website. http://dpt.samhsa.gov/patients/mat.aspx. Accessed January 25, 2015.

25 Community Oriented Correctional Health Services. Background facts for the working group on health reform and criminal justice: Implications for the delivery of behavioral health services to the criminal justice population cycling through jails. http://cochs.org/files/who_is_in_jail.pdf. Published February 2010. Accessed January 27, 2015.

26 Improving hypertension control. National Committee for Quality Assurance website. http://www.ncqa.org/PublicationsProducts/OtherProducts/QualityProfiles/FocusonCardiovascularDisease/ImprovingHypertensionControl.aspx. Accessed January 25, 2015.

27 Butler, B. Health information exchange between jails and their communities: A bridge that is needed under healthcare reform. *Perspectives in Health Information Management.* Winter 2014:1-6. http://perspectives.ahima.org/health-information-exchange-between-jails-and-their-communities-a-bridge-that-is-needed-under-healthcare-reform/#.VMkr3i6htpB. Accessed January 24, 2015.

28 Stern, M. Stern Balla v. Idaho Prisoner Medical Report 2012. https://www.prisonlegalnews.org/media/publications/stern_balla_v_idaho_prisoner_medical_report_2012.pdf. Accessed January 28, 2015.