

Meaningful Use and Corrections: Unknown Opportunities

By Ben Butler, Chief Information Officer, Community Oriented Correctional Health Services

Introduction

Across the country, jurisdictions are becoming increasingly cognizant of the enormous number of dollars they spend every year on health care provided in local and county jails, the opportunities to offset those expenditures under Medicaid expansion in some states, and the need for health information technology (health IT) in order to fully leverage those opportunities. And, like other health care providers exploring health IT implementation, they are weighing whether to participate in the federal government's incentive programs to promote adoption of electronic health record (EHR) systems, which are commonly referred to as "meaningful use."

Meaningful use is the linchpin of the Medicare and Medicaid EHR Incentive Programs, established under the Health Information Technology for Economic and Clinical Health (HITECH) Act to provide incentive payments to eligible providers that adopt and demonstrate "meaningful use" of certified EHR technology. Providers demonstrate meaningful use by "attesting" to certain criteria for different stages of meaningful use.

Interest in meaningful use among correctional health services (including both in-house health care providers and contract providers) is manifesting itself at different levels. A few correctional health services have recently begun to participate in meaningful use. Others are thinking about it, while still others are pursuing plans to acquire and implement EHR systems associated with meaningful use, even though they do not intend to participate in the program.

This article provides an overview of the meaningful use landscape, emphasizing the applicability of meaningful use to health care provided in jails, as well as exploring the benefits and difficulties of participating in this program for jail health care providers. It also describes the steps that jail health care systems must pursue in order to participate in meaningful use.

The meaningful use program consists of two separate programs: one for Medicare and one for Medicaid. As safety net providers, correctional facilities may participate only in the Medicaid program. Against this backdrop, the article addresses the reasons why jail health services should explore participating in Medicaid meaningful use. Meaningful use offers jails an opportunity not only to access funds for needed EHR systems but also, crucially, to connect with the mainstream health care system and significantly improve the health of a very high-risk and historically disenfranchised population, a goal that is strongly connected to reducing health disparities and to the triple aim of health care.



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Although jails are critical safety net providers, historically they have not been recognized as such. An estimated 11.7 million people pass through the nation's 3,300 jails annually. They are disproportionately male, persons of color, poor, with high rates of chronic and infectious disease, injuries, mental illness, and substance use disorders. Because they tend to cycle in and out of jail quite rapidly—average length of stay is 22.8 days—they are in frequent contact with the local communities in which they reside and thus have significant impacts on community health.¹

Prior to 2014, the vast majority of the jail-involved population lacked health insurance of any kind, with one study finding that 90 percent of people released from jail were uninsured.² But as more individuals become insured under Medicaid expansion, a significant number of them will have justice involvement. This means that they very likely will receive some of their health care while in jail.

Upon release, they will return to their local communities, where, if they are enrolled in Medicaid, they will—very possibly for the first time—be able to access health care from other than an emergency provider for their ongoing health problems. In an ideal world, the health care they received in jail would be connected to the health care that they receive in the community, both to ensure continuity and avoid duplication of care.

But that ideal is not the reality. Currently, most health care provided in jail resides in a black box. This is a critical break in the continuum of care for a very high-risk and costly population.

Information technology that enables the sharing of health data through interoperable EHR systems and health information exchange (HIE) can take jail health care out of the black box and connect it with community health care. And interoperability, as required under meaningful use, will be the key to making that happen. In an environment with IT interoperability, providers can share health data seamlessly and the continuum of care can be made whole and its effectiveness maximized.

However, jails face a serious obstacle to participating in meaningful use, which was not designed with jails in mind. The requirement for patient engagement under meaningful use will be extremely challenging, if not impossible, for jails to meet. Although jails are required to provide needed health care to individuals in their custody, their primary purpose is to maintain custody and security of those individuals, who, as noted, tend to cycle in and out jail very rapidly, sometimes within a matter of days. In such an environment, it is very difficult to “engage” patients in their health data.

Those already part of the mainstream health care system—including policymakers and health plans—generally have little understanding of the issues surrounding jail health care and the challenges that jail health services face when trying to integrate into community systems of care. But as the meaningful use program undergoes a period of adjustment and public comment, there is an opportunity both for jails to provide their input and make their challenges known and for policymakers to gain a better understanding of how they can make meaningful use more accessible to jails, thus promoting health care connectivity.

Overview of Meaningful Use

HITECH, enacted in 2009 as part of the American Recovery and Reinvestment Act, directed the Office of the National Coordinator for Health Information Technology (ONC) to promote the adoption and meaningful use of certified EHR technology. In response, ONC established a certification program, developed EHR certification criteria, and selected certification bodies. The certification bodies guarantee that the EHRs they certify have the technological capability, functionality, and security to meet meaningful use criteria, and maintain quality and consistency across certified products.

HITECH also authorized the Centers for Medicare & Medicaid Services (CMS) to create the Medicare and Medicaid EHR Incentive Programs to encourage eligible professionals and hospitals to adopt and meaningfully use certified EHRs. The meaningful use incentive program is spread over three stages, during which eligible providers must attest to core objectives and menu options and submit data for select clinical quality measures. Eligible providers must use an EHR with current certification (the 2014 edition, as of this writing).

Correctional health providers cannot apply for Medicare meaningful use but they can apply for Medicaid meaningful use, which is a less restrictive and more generous program. Medicare-eligible providers may receive incentives of up to \$44,000 over six years, while Medicaid-eligible providers may receive up to \$63,750. Like the Medicare program, Medicaid is divided into three stages of meaningful use. However, for Medicaid meaningful use there is also a preliminary stage called Adopt or Implement or Update (AIU), during which an eligible provider must adopt, implement, or update a certified EHR to receive the first incentive payment of \$21,250. Stages 1 and 2 are two years each, and stage 3 is one year. The difference between the two incentives programs reflects sensitivity to the challenges that Medicaid providers face as safety net providers. To be considered an eligible provider for Medicaid meaningful use, at least 30 percent of the provider's patient encounter volume must be with enrolled Medicaid patients or at least 30 percent of the provider's encounters must be paid by Medicaid. This 30 percent threshold needs to be met for each of the six years of attestation.

Underlying both incentive programs are certain goals: improving the quality, safety, and efficiency of care while reducing disparities; engaging patients and families in their care; promoting public and population health; and promoting the privacy and security of patient information. These goals in turn support the "triple aim" of health care: improvement in patient care, improvement in population health, and reduction of costs.³

Benefits of Meaningful Use for Correctional Health Services

There are several reasons for correctional health services to be interested in Medicaid meaningful use. Most obvious is the potential to collect \$21,250 for each provider who attests for AIU. For a correctional facility with a large number of eligible providers, this is indeed an attractive incentive. Not only physicians but also dentists, nurse practitioners, certified nurse midwives, and physician assistants may be eligible for Medicaid meaningful use. If the correctional facility goes on to attest for subsequent stages of meaningful use, each provider receives \$8,500 for each of the five attestation periods included in meaningful use stages 1 through 3, for a total payment of up to \$63,750 per provider.

In addition to the financial benefit of meaningful use, the meaningful use measures themselves offer another kind of benefit by setting a floor for standardized documentation and interoperability, which are important for HIE—and thus potentially quite important for jails.

The primary reason for this has to do with transition of care when a patient is handed off from one health care provider to another. At this point of system vulnerability, errors and lapses in care are more likely to occur. HIE—the ability of providers to seamlessly share a patient's health records—can be essential to improving care transitions and preventing common errors and lapses.

Few people would think of arrest and incarceration as a transition of care, but it is. After booking, arrestees undergo medical intake, where they are assessed for underlying health conditions. Common conditions among this population include asthma, diabetes, high blood pressure, mental illness, heart disease, HIV, substance use disorder, hepatitis C, or cancer.

It is important for these conditions to be identified quickly, in order to ensure proper health care for the person while in custody and to prevent negative health consequences. This has indeed happened many times. HIE could be very beneficial in helping jails identify detainees' underlying health conditions in a timely manner and prevent negative health outcomes.

The emphasis of meaningful use on HIE implicitly supports the integration of jail health care into the health care mainstream. With HIE, one transition of care would be like another, whether in jail or in the community. This is a direction some jails are pursuing. For example, in a recent request for proposals (RFP), the Connecticut Department of Corrections sought specific assistance in meeting the meaningful use objective of integrating the Department's certified EHR system with the state's HIE. The stated goal of this integration is "to improve the quality, timeliness, and effectiveness of patient care by providing real-time access to comprehensive **clinical information wherever and whenever needed**" (emphasis added).⁴

The 1976 Supreme Court decision *Estelle v. Gamble* offers another incentive for correctional health services to participate in meaningful use. *Estelle v. Gamble* established that a correctional institution's deliberate indifference to the health care needs of individuals in their custody contravenes the Eighth Amendment's ban on cruel and unusual punishment. The Court ruled that correctional institutions must provide appropriate care in accordance with "the evolving community standards of decency that mark the progress of a maturing society."⁵

As EHRs and HIE become more common, it is possible that adoption of such technology could be viewed as part of the community standard of health care and that a jurisdiction could be held deliberately indifferent for failing to implement such technology in the correctional institution. A grand jury in San Diego criticized the sheriff there for not using a "computer system" in compliance with "Federal regulations for Meaningful Use."⁶ This reference suggests that meaningful use might become a standard that, if not applied, could mean that the sheriff is not providing an acceptable level of care. The San Diego sheriff's department intends to solicit bids for a new EHR that will meet 2014 meaningful use certification requirements.

Another potential benefit of meaningful use for jails stems from the stage 2 requirement to submit electronic data to immunization registries. The clinical importance of this measure is to keep vaccinations up to date and to prevent “over-vaccination.” This in turn improves public health. But for jails, there is another implication that speaks to the role of jails within the public health arena. A menu option in stage 2 meaningful use includes the reporting of specific cases to specialized registries. A specialized correctional registry could serve as a powerful tool for evaluating the health of detained and incarcerated people, identifying correlations between certain conditions and justice involvement, and in turn possibly leading to the development of better interventions.

The potential benefits of meaningful use described here would accrue not only to correctional institutions and local jurisdictions but also to health plans that serve Medicaid populations. Because of Medicaid expansion (for those states that choose to expand Medicaid), these health plans now have a stake in the integration of jails into the health care mainstream via meaningful use. In Medicaid expansion states, significant numbers of new Medicaid plan enrollees will likely have justice involvement. HIE, data standardization, and population health are just as important for health plan providers as they are for jail health services providers. Managed care providers will need to know what treatment their patients have received while in jail and what they need once they are released. Health plans typically have little understanding of the health needs of the justice-involved population and how the health of this population affects both the health of the general population and overall health care costs. They will have to increase their understanding, and do so quickly, in order to succeed under Medicaid expansion. The participation of jails in meaningful use can only help to advance that understanding.

Obstacles to Jail Participation in Meaningful Use

It is only recently that correctional institutions have even been able to participate in Medicaid meaningful use. When HITECH passed, correctional facilities were not considered Medicaid-eligible providers. For the most part, people in jail are young men without dependent children who did not qualify for Medicaid coverage (except in states that expanded their Medicaid programs prior to 2014). In addition, even if an individual had Medicaid, coverage would be terminated or suspended upon incarceration because of a federal regulation prohibiting the use of Medicaid dollars to pay for services for individuals who are incarcerated. This regulation is commonly known as the “inmate exception.”

In 2010, the passage of the Patient Protection and Affordable Care Act (ACA) changed who is eligible for Medicaid. Starting in 2014, Medicaid was expanded based on income alone. However, because of the Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, Medicaid expansion is now optional for states. As of this writing, 26 states and the District of Columbia have opted to expand their Medicaid programs in accordance with the ACA. In these states, it is now possible, at least theoretically, for many of the jail-involved to enroll in Medicaid.

But the ACA alone did not enable correctional facilities to participate in Medicaid meaningful use, since they still were not permitted to submit claims to Medicaid. In September 2012, CMS expanded its definition of who could be considered an eligible provider to participate in Medicaid meaningful use. Previously it required providers to demonstrate that at least 30 percent of paid

encounters were for Medicaid. But now providers could also qualify if at least 30 percent of their patients were enrolled in Medicaid—regardless of whether the providers actually billed Medicaid for patient care or whether their patients' coverage status was suspended.⁷

CMS understood the implication of this ruling. In March 2013, the agency sent an announcement to jail and prison administrators entitled *How Your Agency Can Receive Financial Incentives for Using Electronic Health Records*. This information was republished on websites such as the National Sheriffs Association, Council of State Governments, and the National Commission on Correctional Healthcare.

Correctional health providers that do qualify to become eligible providers and attest for the preliminary AIU phase may still find it difficult to attest to some of the core objectives in stage 1 and stage 2. For example, in stage 1, the objective to implement e-prescribing means that the jail pharmacy must have its own electronic pharmacy system or an interface with an external pharmacy system.

But when it comes to corrections and attesting to meaningful use, the real elephant in the room is patient engagement. In stage 1 and stage 2, clinical summaries must be supplied to at least 50 percent of patients seen by each eligible provider. In stage 1, this clinical summary must be supplied within three days; for stage 2, the turnaround is one day.

For jails, this objective poses serious problems. First, there is the extraordinarily high inmate turnover rate, which makes it difficult to distribute such a document before an inmate is released. In addition, jails are places of confinement where safety and security are primary. Jail inmates are not permitted to maintain a secure location for storage of personal items. The sensitive health information contained in a clinical summary would be highly vulnerable to loss, discovery, or theft, and the uses that such information could be put to in a hostile environment could destabilize safety and security.

In the same vein, another core objective requires eligible providers to make electronic copies of patients' personal health information available to them. During stage 1, more than 50 percent of patients seen by each provider must be afforded the opportunity to view, download, or transmit their electronic health information within four business days of the information becoming available to the provider. Stage 2 further requires that more than 5 percent of patients seen by an eligible provider must actually view, transmit, or download their electronic health information. The security and safety concerns are obvious.

People in jail might be able to view their health data from a secure kiosk, but downloading such information would be highly problematic, and transmitting this information to another provider would probably not be permitted. There also is the question of how to share health information with individuals after they are released. Most sheriffs' departments are highly unlikely to allow former inmates to access their IT systems in order to view their health information. Even if a jail might consider it, accessing the health IT system would require a degree of coordination beyond the capacity of most jails.

Under meaningful use, all three actions—view, display, and transmit—must be available to patients. Some have proposed an exclusion from core objectives related to patient engagement for institutions that have policies prohibiting access to medical data.

As of this time, another meaningful use obstacle for correctional institutions concerns the failure of many EHR vendors that develop products specific to the correctional environment to advance beyond 2011 certification.⁸ Correctional health care providers that have not yet begun to attest for meaningful use may harbor the misconception that 2011 certification is acceptable for initial attestation. It is not. Jails beginning to attest now must have an EHR with 2014 certification.

Finally, the most pressing obstacle for jails is time. The last year to start participating for AIU is 2016. Jails that are contemplating taking this step should begin planning for it quickly.

Correctional Institutions Participating in Meaningful Use

To understand accurately how jurisdictions are approaching meaningful use, it is useful to view attestation across a spectrum of interest and commitment.

In some jurisdictions, there appears to be a broad desire to take advantage of the functionality of a certified EHR system. Examples include South Dakota's Department of Corrections and sheriff's departments in San Diego County and Cameron County, Texas.⁹ All of these jurisdictions have either issued or are considering issuing RFPs for EHRs that include 2014-certified EHRs. Interestingly, two of these jurisdictions, Cameron County and South Dakota, are in non-expansion states and thus are unlikely to participate in meaningful use because it will be difficult for them to reach the 30 percent Medicaid enrollment threshold. Yet they are making meaningful use certification a requirement or significant consideration for procuring a new EHR, suggesting that meaningful use EHR certification might be becoming a *de facto* standard for corrections, separate from its potential incentive benefit.

Other jurisdictions are considering meaningful use but have not made a firm commitment to pursue it. Rhode Island's dual prison/jail system and Oregon's Multnomah County fall into this category. Rhode Island is selecting an EHR and appears to have put off a meaningful use decision until an EHR is purchased. Multnomah County has a 2014-certified EHR and is weighing whether to proceed with participating in the incentive program.

There are also a few correctional institutions that have published RFPs for EHRs specifying not only that they require meaningful use certification but also that they intend to actually participate in meaningful use. This is the course taken by the corrections departments in Connecticut, which, like Rhode Island, has a dual jail/prison system, and in Kentucky, which has a more traditional prison system.¹⁰

Finally, King County in Washington state and New York City have actually begun attesting for Medicaid meaningful use. Both jurisdictions have attested for AIU. In King County, six providers, including a dentist, qualified as eligible providers for 2013, and another provider will be deemed eligible in 2014. In New York City, 51 providers have qualified as eligible providers for 2013.¹¹

Steps Toward Eligibility

Correctional health service providers who want to participate in the Medicaid meaningful use program must start by attesting for AIU. A number of steps are involved. Keep in mind that, because Medicaid is a state/federal partnership, these steps may vary somewhat, depending on individual state requirements.

To attest for AIU, providers must first adopt or implement or upgrade to the current EHR certification, which is the 2014 edition. The explicit use of “or” is intentional. Correctional facility providers (or the external health care providers with whom the facility has contracted) may fulfill one of these options. “Adopt” means that there is a binding legal or financial agreement to purchase a certified EHR; “implement” means that the system is installed; and “upgrade” means that a non-certified EHR (or an EHR with an out-of-date certification) is upgraded. Providers cannot attest more than once for AIU, regardless of which option they initially fulfilled. For a provider to proceed and attest for meaningful use stage 1, the provider must have a 2014-certified EHR installed.

Next, the correctional health service providers must qualify as eligible providers for Medicaid meaningful use. This is, by far, the most complicated part of the process and includes determining eligible provider criteria, processing administrative requirements, registering providers for the Medicaid meaningful use program, reassigning incentive payment to correctional health services, ascertaining that the Medicaid patient volume exceeds 30 percent, and finding out what the state Medicaid agency requires to qualify a provider as Medicaid-eligible. The steps below are drawn from the experiences of New York City and King County, with important differences between the two jurisdictions highlighted.

Eligible Provider

To be considered as an eligible provider for meaningful use, the provider must be licensed in the state where the facility is located. The provider’s professional license must not be limited or restricted, and the provider must not be excluded from Medicaid, Medicare, or other federal programs. This is an important consideration because correctional facilities in some locations have difficulty recruiting clinical staff. Even if a provider is eligible, the provider cannot receive an incentive payment for AIU if the provider has already received an AIU payment for working at another location.

Administrative Steps

In order to register for Medicaid meaningful use, the provider must obtain a national provider identifier by registering at the National Plan and Provider Enumeration System website. This will generate both an identification number and a user account for the provider. In addition, the provider must enroll as a fee-for-service Medicaid provider in the state where the jail is located. Because of a high level of provider interest in participating and the fast turnaround required for processing, New York City hired a credentialing coordinator to assemble the application paperwork for providers. In King County, providers completed the new provider enrollment

form online and provided additional documents and signed agreements in order to register in ProviderOne, Washington state's system for provider payments. King County had a credentialing coordinator assist providers in completing the registration.

Registering for Medicaid Meaningful Use

Provider registration is straightforward. The provider logs onto the CMS registration and attestation website using his or her national provider identification number and password, chooses to register for the Medicaid incentive program, specifies his or her state and provider type, and enters the EHR certification number (at this point it is not necessary to have purchased a certified EHR).

Reassigning Incentive Payment to Correctional Health Services

It is easy to confuse who is attesting for meaningful use and who is receiving the incentive payment. The meaningful use program is for individual providers. Naturally, the entity that purchases and maintains the EHR has the greatest fiduciary interest in receiving the incentive payments. When registering, the eligible provider can select to reassign payment to a medical group with which the eligible provider has a contractual relationship by entering the group's tax identification number. However, reassignment is voluntary.

How then can correctional health services be certain that its eligible providers will reassign? Many health care organizations have contracts with their eligible providers specifying as a condition of their employment that any incentive payments belong to the health care organization. But many correctional facilities subcontract their health care services to proprietary companies and, in that case, other arrangements might be needed to effect reassignment. Incentive bonuses were used in New York City, where health care services are subcontracted. The Department of Health and Mental Health Services, which oversees jail health care, had no direct contractual relationship with its providers. Instead, the proprietary company that supplied the providers received the incentive payment and redirected it to the Department. In King County, health services are provided by a division within the public health department for Seattle and King County, through a memorandum of understanding with the Corrections Division.

Patient Volume

To be eligible for Medicaid meaningful use, providers must verify that at least 30 percent of their patient volume is from encounters with individuals enrolled in Medicaid. There are two ways to demonstrate this: individually or by a group proxy methodology. To demonstrate provider volume individually, each provider must meet the 30 percent threshold based on his or her own patient encounters. The group proxy methodology counts the encounters of the entire group practice and verifies that at least 30 percent of all the encounters are with Medicaid-enrolled individuals. When providers in the practice attest for meaningful use, they use the numbers for the entire group. If an individual provider does not reach the 30 percent provider threshold, that provider can still use the group proxy number, assuming that the group as a whole meets the threshold, to qualify as an eligible provider. For most correctional facilities, the

group proxy methodology would seem to be the far better option. Both New York City and King County used the group proxy methodology to determine provider eligibility. However, there were important differences.

New York City counted encounters that occurred within the jail system. This meant ascertaining whether individuals entering jail had a Medicaid number. Fortunately, the Office of Health Insurance Services, which has access to Medicaid enrollment data, is co-located with Correctional Health Services within New York City's Department of Health and Mental Hygiene. The Office of Health Insurance was already looking up Medicaid numbers for discharge planning services of incarcerated people with serious mental illness. It also had access to the jail's certified EHR system. To meet the 30 percent Medicaid enrollment threshold, the Office of Health Insurance performed a "look-up" on all individuals entering the jail.

King County Public Health is the health care provider for the jail and the safety net provider in the community. To qualify its providers for meaningful use, it counted the encounters from the entire practice of clinics in and outside the jail, verifying not on the basis of enrollment status but on the percentage of paid claims. As a result, King County did not have to track the enrollment status of every individual in the jail. King County Public Health was confident that the paid encounters in the community would reach the 30 percent threshold, even including jail encounters that were not paid for by Medicaid. The only caveat for jail providers to be considered eligible providers was that they had to generate at least one claim in the ProviderOne system, which meant that jail providers rotated through the community-based clinics as part of their practice assignment.

King County's example has interesting ramifications for public health systems that provide health care to jails in states that are not expanding their Medicaid programs. Using King County's solution, these public health departments might still be able to validate their jail providers as eligible providers. They would have to use the group proxy methodology and the number of paid encounters would need to be sufficiently large to reach the 30 percent threshold, including unpaid jail encounters.

State Medicaid Agency

State Medicaid agencies validate whether a provider is eligible to participate in the Medicaid meaningful use program. Traditionally, these agencies have determined eligibility by Medicaid claims and may not have developed systems to verify eligibility based on encounters with individuals who are enrolled but have no associated claim. This was not a problem for King County because of the method it chose to verify provider eligibility. New York City had to work with its state Medicaid agency to determine which data elements were needed to verify an individual's Medicaid enrollment status. The Department of Mental Health and Hygiene had biweekly calls with the state Medicaid agency and submitted reports generated by the certified EHR that included inmate demographics and Medicaid numbers.

It is unclear how far other states will go in assisting jails with determining eligibility based solely on Medicaid enrollment without claims. The corrections department in Connecticut has a close relationship with its state Medicaid agency and does not anticipate problems with establishing provider eligibility through Medicaid encounters only. It also enjoys the advantage (along with New York City), of residing in a state that expanded its Medicaid program prior to 2014, so it is likely that Connecticut will reach the 30 percent threshold.

It is crucial for any correctional system considering Medicaid meaningful use attestation to determine with its state Medicaid agency whether it is even feasible to attempt participation. In the end, if attesting for meaningful use is not feasible, it still might be wise to consider adopting certified EHR technology and many of the meaningful use measures. Meaningful use has been extraordinarily successful in promoting health IT and with that extraordinary success might come the expectation that all health care sites, regardless of location, would have similar technical capacity.

Impact of Meaningful Use on Correctional Health Systems

Meaningful use is not just—or even primarily—about technology. It is really about change. The meaningful use goals were designed to support ONC's federal health IT adoption program, whose mission is explicitly based on the "triple aim" of improving patient care, improving population health, and reducing health care costs. ONC also has a strong interest in applying meaningful use to reduce health disparities in underserved populations. For example, ONC's Regional Extension Center (REC) Program is charged with helping safety net providers that serve underserved populations, such as federally qualified health centers, implement EHR systems and achieve meaningful use.

But what impact will meaningful use have on correctional health care services? To understand that, it is helpful to review health care in jails and what health care providers in these environments encounter that makes them very different from mainstream health care delivery settings.

In their 2013 paper *The Triple Aim of Correctional Health: Patient Safety, Population Health and Human Rights*, Ross MacDonald, Amanda Parsons, and Homer Venters of the New York City DOHMH propose a new "triple aim" for correctional health care, one that takes into account how significantly health care is impacted by being embedded in corrections.¹² Although the DOHMH authors include improving population health as a goal in their correctional triple aim, they depart from the mainstream by articulating a focus on improving patient safety and improving human rights.

Even where the two sets of triple aims overlap—improving population health—the reality of population health in jail is quite different from that of population health in the community. Because of the confined conditions in jails and a population in continuous flux, surveillance for highly contagious diseases like tuberculosis and sexually transmitted disease is constant in jails. In addition, more virulent diseases may spread to the community, if treatment is not maintained after an incarcerated individual is released. During the 2009/2010 H1N1 flu epidemic, 55 percent of all jails did not receive vaccinations.¹³

Another issue that is much more important for jail population health than for community health involves tracking injuries that occur within corrections settings. As Dr. Homer Venters observed during a recent conference panel discussion: “Correctional settings are places where abuse happens. The question is not that it happens, but is it that it happens a lot or a little.”¹⁴

Finally, when addressing population health disparities, jails are a crucial piece of the puzzle. As noted, the jail-involved population has disproportionately high levels of chronic and infectious illness, mental health, substance use, and other health problems. It is also a highly vulnerable population, predominantly comprising young impoverished men of color. Because it is also a highly mobile population, in terms of cycling frequently between jail and the community, there is an opportunity to link health care provided in jail with health care provided in the community via health IT. In fact, if this opportunity is not leveraged, it will be extremely difficult—if not impossible—to make significant headway in reducing health disparities.

Concern about abuse helps explain why the two other correctional aims target improvements in patient safety and human rights. Around the country, stories abound that underscore the need for these aims: a mentally ill, homeless, former Marine died in an overheated cell after the correctional officer in charge of the mental health observation unit abandoned her post;¹⁵ a woman with bulimia serving a 30-day sentence died because she was denied her potassium pills, even though her lawyer and doctor warned the jail that her need was critical;¹⁶ a homeless man going through alcohol withdrawal died on a jail infirmary floor 18 hours after his arrest while correctional officers ignored his cellmates’ appeals for help.¹⁷

Clearly, Medicaid meaningful use cannot solve all these problems. Nevertheless, MacDonald, Parsons, and Venters make clear that they consider EHRs with health information exchange to be the “greatest intervention” for the treatment of persons in jail.¹⁸ They also believe that the passage of health reform implies that external community standards will begin to be applied to the jail health care environment.

The ACA’s expansion of Medicaid eligibility holds the most significant ramifications for jail health care. Many of the individuals cycling through jail will now be eligible for Medicaid, and some jails have already begun enrolling inmates in Medicaid at release. Given that two-thirds of all Medicaid recipients are covered by managed care organizations and may wind up being covered by emerging care models such as Medicaid accountable care organizations (ACOs), these entities, which essentially will be sharing the care continuum with jails, should have an interest in how their patients experience health care while in jail.

As the impacts of health reform spread, health care delivered in jails may come to be viewed through the lens of performance measurements like HEDIS, which is used for the managed care industry, especially since jail will essentially be sharing patient care with health plans. Health care delivered in a jail could very well have a direct impact on a health plan’s performance metrics. Thus, an understanding of jail health care delivery becomes pertinent to outside stakeholders, and attestation for meaningful use, with its objective clinical quality measurements and connectivity, becomes crucial to these outside organizations.

More directly, meaningful use's objectives, requirements, and goals—such as maintaining a problem list, reporting clinical quality measures, submitting data to immunization registries, and establishing health information exchange—might enable the two health care systems, jail and community, to share data more effectively.

For decades, the *Estelle v. Gamble* decision has guided health care policy within jails with its prohibition against deliberate indifference. Now there is a rare confluence of events. Medicaid expansion and Medicaid meaningful use may expand the standard of care in jails in new directions. Although this is a challenging new world to navigate, jails are nevertheless trying to find ways to participate in meaningful use. Now that health plans are likely to be sharing in the care of the jail-involved population, the importance of the technical infrastructure supported by meaningful use in order to achieve continuity of care may become far more apparent.

Conclusion

It is too early to predict how jail health care might be integrated into the mainstream of health care and what role meaningful use might play in this process. For now, jails planning to participate in meaningful use seem more concerned—and rightly so—with the immediate task of attesting for meaningful use rather than with the full implications of meaningful use for mainstreaming jail health care.

How and when mainstreaming comes about will probably be, as so often happens with jails, unique to each jurisdiction. Various scenarios may be envisioned:

- Correctional health services react to external forces like health plans or community providers that have an interest in maintaining performance measurement across health care settings.
- Correctional health services take the initiative to engage with external stakeholders to establish acceptable performance measures.
- Correctional health services engage and react with external stakeholders to regularize health care delivery between jail and non-jail settings.

There are many other possibilities. This will be a dynamic and fluid process, and there is probably no right or wrong approach to mainstreaming and the role that meaningful use can play.

It is important to note that the meaningful use program itself is in flux. There has been much discussion about the difficulties surrounding attestation for meaningful use for all sectors of the health care industry, including vendors, hospitals, and individual providers. As of June 2014, only eight hospitals and 447 eligible providers nationally had attested to stage 2 meaningful use.¹⁹ The American Medical Association has suggested that providers should be able to attest if they meet only 75 percent of the core objectives.²⁰ A recent report from the American Health Information Management Association on ineligible providers noted how important the benefits of meaningful use, such as health information exchange, would be for these largely safety net providers.²¹

For correctional facilities, this is a time of both uncertainty and opportunity. CMS and ONC are eager for providers to attest and they are soliciting input. CMS recently issued a Notice for Public Rule Making to loosen rules concerning which certified EHRs an eligible provider may implement in order to attest for stage 2. Jails and health plans have an opportunity to express their concerns about meaningful use, such as the challenges surrounding patient engagement in a correctional environment. Correctional health care providers might want to communicate to health care policymakers about disparities and how jail-involved populations often receive infrequent health care at best. Although meaningful use was not designed with correctional health systems in mind, there is a real opportunity—magnified now by Medicaid expansion under the ACA—to integrate jail health care into the community continuum of care and improve health for a very vulnerable population.

Endnotes

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