



Health Intake, Assessment, and Routine Care Processes in County Jails
A Brief Overview for a NACo Webinar
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This presentation will describe the health care services assembly line as it operates in many jails across the country. It has been prepared by Keith Barton and Mike DuBose with valuable input from Ed Harrison, the president of NCCHC, the National Commission on Correctional Health Care. Mike DuBose has worked for years in the Washington, DC, jail and has audited jails throughout the United States. Keith Barton has worked as a physician (MD) in the Alameda County Jail in Dublin, California.

1. [What is a jail?] We thought we should first spend a moment explaining how jails differ from prisons.
 - a. Jails are typically county institutions, while prisons are state or federal institutions.
 - b. Jails typically house people:
 - After arrest while they are waiting to post bail or awaiting trial
 - Who have been tried, found guilty, and sentenced to less than one year of incarceration. [Most prisoners who have been sentenced to a longer period of incarceration are sent to state or federal prisons.]
 - Who have violated conditions of parole (“technical violations”). [These are initially held in jail, although they may be transferred to prison later.]
 - ICE detainees and Federal Marshal prisoners may also be found in some jails.
 - c. Jails usually operate under the authority of the county sheriff, or in some states, under a warden. Sheriffs are often independently elected officials, while wardens report directly to the county board of supervisors or to an administrative Director. In most case, the jail operates with funds provided by the county budget.
 - d. Jails invariably have a high rate of turn over. It is not uncommon for 60% of the population held in jails to enter and leave within 2 to 4 weeks. At the same time, some people may be held for several years while awaiting trial and disposition of charges. A jail that holds 1000 inmates might process 10 to 20 thousand people in the course of one year.
 - e. Just as counties vary enormously across the country and within each state, jails also differ in terms of the physical plant, the staffing levels, and the various programs and services they provide.
 - f. Nearly every county in the country has a jail, the vast majority of which have fewer than 100 beds. In major metropolitan areas, however, jail populations typically hold from 1000 to 3000 inmates, and in the largest urban areas, jails house 10,000-20,000 detainees. Therefore, although fewer in number, larger jails account for most of the detainee population across the nation.

- g. In most cases, jails are understaffed, under-funded, and not very well designed to carry out all of the missions now expected of them. This is especially true as the proportion of the homeless mentally ill population has risen after the state institutions for the mentally ill have ceased operating.
 - h. The war on drugs has increased the number of low level drug offenders in the criminal justice system, and a majority of people housed in jails have a substance use disorders.
 - i. The population in jails also has higher rates of hypertension, diabetes, asthma, tuberculosis, and sexually transmitted diseases than does the general population.
 - j. Because of the high rates of turn over, county jails are logical places to locate public health efforts directed to the homeless and mentally impaired populations and to coordinate (or triage) services for drug and alcohol disorders.
2. [Jail Health Services] As the size and character of jails have changed over the past 40 years, health services in jails have increased, with an impetus from the federal courts, starting in 1976 with the watershed decision, *Estelle v Gamble*.
- a. [Introduction]
 - i. A number of court cases have invoked the phrase “cruel and unusual punishment” when jails deny inmates access to health care, food, exercise or hygiene. “Necessary” health care generally means care which is adequate to treat serious health needs. Providing adequate care to everyone in jail, while working within the budgetary and operational constraints of a correctional institution, is quite a challenge and not always possible. As we have been discussing, this might change under health care reform in certain important ways.
 - ii. Larger jails often provide additional services, such as drug treatment, individual mental health treatment, and preventative care/education. Larger institutions usually employ more highly-trained staff, and have a better infrastructure to support the delivery of health care services.
 - b. [Intake Processing (aka Receiving Screening)] There is an intake process that most jails utilize when people are brought to the jail, usually by the police department.
 - i. Most jails will not accept an individual who is not stable at the time of intake. Arrestees who initially arrive with active seizures, broken bones, serious blood loss, unconsciousness, or breathing difficulties, are first sent to an emergency room for evaluation and stabilization. In most cases, however, an admission intake process is performed shortly after a person arrives at the jail. [In some jails the delay for intake processing could exceed 24 hours, and in addition, the arrestee may have been held in police station or a city jail prior to arriving at the county jail.]

- ii. This intake procedure involves an initial screening to determine health issues that require prompt attention. This health screen is usually performed by a lower level staff person such as:
 - (1) a correctional officer using a questionnaire who exercises no independent decision making ability from a clinical perspective
 - (2) The screen could be conducted by an LPN with a questionnaire and other assessment tools that may include mental health symptoms, medical symptoms, dental symptoms, sexual risks, and medication history
 - (3) Diabetics may have a blood sugar test performed during the intake screening.
 - (4) Many jails apply a TB skin test during the screening. Some jails take a chest X-Ray on all admits; others X-Ray only PPD + inmates.
 - (5) Many jails screen all admits for syphilis; however, some experts dispute the value of this test when the incidence of syphilis is low.
 - (6) Some jails require routine HIV screening at intake with an "opt-out" provision.
 - (7) In some jails, the initial encounter is a "mini-assessment" that is more detailed. If no conditions are uncovered, this "mini-assessment" is the only health care provided in the jail unless the detainee seeks attention in sick-call. The 'mini-assessment' is customarily performed by an LPN or RN, (less often) a PA or NP or (rarely) an MD.
 - (8) If any of these screening procedures reveals a serious problem, the individual is referred to a licensed primary care provider (NP, PA, DO, or MD) for a more extensive assessment. However, the definition of a serious problem and the timing of the provider assessment vary a great deal from one jail to another.
 - (9) Jails which obtain NCCHC accreditation agree to conduct a medical history and physical examination within the first 14 days after admission to the jail. This examination is often performed by a nurse, although some jails would utilize a mid-level provider. (By the 14th day, a large number of people have already left the jail, so this affects a fairly small proportion of arrestees. Hence the initial screening has more value for implementing health screening and public health measures.)
- c. [Medication]
 - i. During the initial screening or assessment, the detainee also will be asked about any medication or street drugs recently used. Depending on the types of medication identified, the jail intake staff may attempt to verify the medication, by calling the arrestee's doctor, clinic, or pharmacy. They may also assess the detainee for risk of drug and alcohol withdrawal and refer them for further evaluation. If prescription medication can be verified, there are several possible outcomes:
 - (1) continue the medication until evaluated by medical or mental health staff in the jail

- (2) However, it would be more common to stop the medication for anywhere from 5 to 72 hours until the inmate is seen by medical or mental health staff in the jail.
 - (3) In some cases, the provider on call would be contacted for medication orders
 - (4) In some jails, there could be standing orders to continue certain medications.
 - (5) Some medications may be substituted based upon differences in formulary composition.
 - (6) Some medication may be delayed until seen by a specialist as in the case of HIV medication.
 - (7) Some medication in common use in a community clinic may be proscribed in a jail, due to a possible abuse potential. Seroquel is one example.
- ii. Individuals with serious mental illnesses are usually referred to a psychiatrist within 24 hours and the verification of medication history begins at intake. The psychiatrist may continue, discontinue or change psychotropic medication. What qualifies as serious mental illness varies from one jail to another. Some jails have dedicated housing units (and dedicated staff) for inmates in drug withdrawal and for inmates with serious mental illnesses. A few jails utilize prescription medication (methadone or buprenorphine) to manage heroin withdrawal in such settings.
 - iii. Individuals with symptoms of active TB or other highly contagious disease, or who are unstable or suffering from drug withdrawal, for example, are referred for more intensive assessment and immediate temporary housing and observation. Some jails have negative pressure rooms for respiratory isolation. Other jails send inmates to local hospitals to assess them for possible active TB.
- d. [Discharge planning] In some jails, discharge planning would also begin during the intake process based upon the information obtained at the time of the intake. This plan is usually updated closer to the release date. [See below.]
 - e. [Accessing Health Care After the Intake Process] Following the intake and assessment, if the individual has a non-urgent or non-emergency medical need, they are required to fill out a sick call slip to access health care. This includes requests for medical, dental and or mental health services. These requests are triaged by nurses on a daily basis. There may be a co-pay for sick call services.
 - f. [Staffing]
 - i. One of the major challenges in jails is the variability in the state regulations around scope of practice for different medical and nursing credentials. Some states allow more practice latitude than others for less-trained individuals, but

- nationally it is common for jails to hire nurses for positions that exceed their authorized scopes of practice.
- ii. For example, RNs are often allowed to assess and triage, but in jails, this function may be performed by LVNs.
 - iii. In addition, in some jails, nurses conduct sick-call in the housing units for conditions that do not require mid-level providers and in some cases, sick call is guided by standing nursing orders. [In most cases, the nurse is limited to dispensing OTC meds in these encounters.] The nurse may refer sicker patients to mid-level practitioners, while in other jails, sick-call is conducted in the housing units exclusively by mid-level providers. Again, this raises the issue of scope of practice and workforce capacity.
 - iv. So, on one hand, nurses may be granted responsibilities in jails that they would not exercise in community clinics. On the other hand, jails cannot locate enough physician and mid-level practitioners to do all the work, which means that someone else has to do it.
 - v. Another factor to consider, in terms of staffing and responsibilities, is that the majority of jail inmates have not had health care insurance since they were minors; many have drug use disorders, and many have limited reading skills. The care they obtain from an LVN may exceed what they can access out of the jail, short of going to an emergency room for health care.
 - vi. Conditions that require procedures beyond the capabilities of the on-site personnel are sent out to either the ER or to a specialist for evaluation. In some cases the specialist is contracted to come on-site to provide the care. The specialists most commonly working on-site in jails are psychiatrists, orthopedists, oral surgeons, and optometrists. Visits may range from weekly to every two or three months.
 - vii. Larger jails also have facilities for taking X-Rays and they may employ a physical therapist. Most jails have staff to draw blood for analysis. Many jails provide dental services, though primarily for extractions.
 - viii. Yet another issue which is somewhat unique to jails is the sudden loss of security clearances for nursing or medical staff. Most jails require all staff to pass a security clearance process, and if new information is revealed after the individual began working¹, the security clearance can be lost and the staff person is abruptly terminated. Health provider plans must hire adequate staff to prepare for this sort of eventuality.
- g. [Documenting Quality of Care] Quality of Care in jails has been receiving more attention over the years.

¹ Reasons for revoking a security clearance can be as (apparently) benign as allowing an inmate to use an institutional phone, to passing messages to an inmate's family, to bringing in gifts for inmates. Fraternizing between staff and inmates is strongly discouraged. The risks to staff are not limited to thefts and assaults. Any large jail will have accounts of a staff member who left behind a stable family to marry or co-habit with an inmate.

- i. There are both internal and external processes available to assess and document quality of care. Some of these processes may be mandated as part of an operational policy, a contract, or imposed by the courts. Others are voluntary best-practice policies, such as.
 - (1) Internal/external audits and inspections [NCCHC accreditation is an example of a voluntarily imposed external audit.]
 - (2) Quality assurance reviews in a specific discipline
 - (3) Utilization Reviews that focus on medication usage or in-patient hospital care
 - (4) Internal peer-review practices
 - (5) Chart reviews regarding both/either nursing and physician notes
 - (6) Performance benchmarking systems such as HEDIS² measures [Also, the NCCHC is proposing a program, with the acronym of CHORDS, that would allow jails to submit performance data and then compare themselves anonymously to the performance of other jails, grouped by region and by size.]

h. A court may intervene in the operations of a jail and appoint a receiver to monitor conditions in the jail, or a court may impose demands in a consent decree. The most common goal of a consent decree is to alleviate over-crowding.

- i. [Security Issues and Limitations] Another common event in jails is that the clinic roster does not accurately reflect the number of people who show up for a clinic visit.
 - i. This happens between, say, 10 and 30% of the time in many jails. This could be due to any number of circumstances, of which four are common.
 - (1) The inmate may have been released or bailed out, but he is still on the clinic roster.
 - (2) The inmate has a scheduled visit by his attorney or family member.
 - (3) An inmate is called to court..
 - (4) The inmate refuses to go to the clinic when called, possibly because he is feeling better or is engaged in some other activity. Typically, the inmate must sign a release when he refuses a sick call appointment.
 - ii. The health staff could respond to these disruptions in a variety of ways.
 - (1) The clinic staff could assume that the inmate did refuse and let the matter drop.
 - (2) The inmate is rescheduled to the next clinic appointment. However, when chronic care clinics are infrequent, this may involve a significant wait.
 - (3) The clinic staff could telephone to speak to the inmate or to the officers on duty, to get a better understanding of what happened.

² Healthcare Effectiveness Data and Information Set

- (4) The clinic staff could go to the cell block and assess the inmate there. There are a number of obstacles to doing this, but it may be feasible.
 - (5) The clinic staff could instruct the nurse on the housing unit to see the inmate in sick call and make an assessment of the inmate.
 - (6) The clinic staff could put the inmate on the sick call list to see a physician the next day in sick call.
3. [The Discharge Process] At some point, the inmate will be ready to leave the jail.
- a. The timing of the release is difficult to predict, unless s/he is serving a fixed sentence in the jail. Sometimes the inmate is released from the court house and never returns to the jail. Both of these factors complicate discharge planning.
 - b. There is wide variance in discharge planning. Some jails provide a comprehensive package that might include primary care appointments, drug treatment, social services, entitlements, housing, job training, medication, and a transportation voucher. At the other extreme – and this is quite common – the inmate is released without much preparation, possibly in the middle of the night.
 - c. A few jails provide risk-reduction counseling or pamphlets to reduce the risk of drug overdose following release from custody. Information on clean needle exchange programs and the use of naloxone (to treat drug over-dose) may be included.
 - d. The majority of settings provide some quantity of "bridge medications" from 3 to 30 days supply at the time of release. Individuals receiving medications for HIV infection customarily receive a 30 days supply and a referral to a community-based provider for follow-up and ongoing care.
 - e. HIV infected individuals may qualify for ADAP at the point of release. However, this should be explored by each jurisdiction, since regulations vary by state.
 - f. Finally, it should also be noted that bridge medication may be specified in the operating Policies and Procedures, but this is no guarantee that the medication will consistently be issued, particularly when inmates are released after business hours or released directly from the court.